2022 Employee Benefits Open Enrollment

Welcome to your open enrollment period for **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 and making other benefits changes such as the FSA or HSA.

The Open Enrollment period for **APBHT** starts **Monday, November 15, 2021**, and ends **Friday, December 10, 2021**, 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** FlippingBook Open Enrollment Guide by visiting:

https://online.flippingbook.com/view/1029022689/

What's New or Changing?

Medical, Rx, Vision: No changes to current benefits.

Dental: No changes to current benefits.

Basic Life/AD&D: No changes to current benefits

Action Items

- You can enroll between November 15th and December 10th, 2021.
- 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 **Saturday, January 01, 2022**, and will remain in effect until **Saturday, December 31, 2022**. Only qualifying events will allow you to make a change before that date.

Please submit all forms no later than Friday, December 10, 2021

Where to Go if You Have Questions:

Should you have any questions about your benefits or questions in general, contact your plan administrator, Kim Pigg, kim@coastalaska.org.

APB HEALTH TRUST

2022 EMPLOYEE BENEFITS GUIDE

Effective January 1, 2022 to December 31, 2022

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This guide is not intended to be a complete description of the insurance coverage offered, nor is it a binding contract. Controlling provisions are provided in each benefit plan policy. Should there be a difference between this guide and the office plan documents, the official plan documents will govern.

More information about specific terms and conditions of each plan is included in the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC).

Welcome to APBHT 2022 Benefits!

Your needs, and those of your family, are unique to you. That's why we provide a comprehensive and flexible benefits program that you can customize to fit your personal situation. Our program offers you and your family important healthcare coverage and financial security.

Some of the benefits we offer are paid for in full by the company. For others, it is a shared contribution between you and the company. Other benefits are also available to you at reasonable group rates.

Your benefits are an important part of your total compensation. Please take the time to review and evaluate all the options available to you and your family.

Benefits Overview

EMPLOYER PAID BENEFITS	
Benefits	**Carrier**
Basic Life/AD&D	Symetra

BENEFIT OPTIONS REQUIRING EMPLOYEE CONTRIBUTIONS	
Benefits	**Carrier**
Medical, Rx, Vision	Premera Blue Cross Blue Shield of Alaska
Dental	Premera Blue Cross Blue Shield of Alaska

Open Enrollment

Open Enrollment is your once a year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family.

Changes to medical, dental and vision benefits made during Open Enrollment will go into effect **January 1, 2022**.

What's New or Changing?

What's New or Changing?

1. **Medical, Rx, Vision**: No changes to current benefits.

2. **Dental**: No changes to current benefits.

3. **Basic Life/AD&D**: No changes to current benefits.

Action Items

- You can enroll between November 15th and December 10th , 2021.
- 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.

Making Benefit Changes During the Year

The benefit elections you make during your open enrollment period will be in effect through December 31, 2022.

If you have a "qualified life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources. Proof of life events is subject to approval by your company. Changes are effective retroactive to the date of the event. You have 30 days after a qualifying event to make enrollment changes.

Qualifying life events include:

- Your marriage
- Your divorce or legal separation
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse, domestic partner or covered child
- Change in you or your spouse/domestic partner's work status that affects benefits eligibility (for example, starting a new job, leaving a job, changing from part-time to full-time, starting or returning from an unpaid leave of absence, etc.)
- Your spouse's Open Enrollment
- A change in your child's eligibility for benefits
- Gain or loss of Medicare or Medicaid during the year
- Relocation

Other qualifying events may also apply.
Please contact Human Resources.

Eligibility and Enrollment

Who is Eligible?

You are eligible for benefits if you are:

- An active full-time employee working **30** or more hours per week

Your dependents are eligible if they are:

- Your legal spouse or domestic partner
- Your and/or your domestic partner's child(ren)* up to age 26
- Your disabled child(ren)* up to any age (if disabled prior to age 19)

** Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship.*

When Can You Enroll in Benefits?

You can enroll for benefits:

- 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.
- During the annual Open Enrollment period.
- During the plan year, if you experience a Qualifying Life Event.

Please Note:

Federal regulations require your company to obtain the following information during enrollment:

- Social Security numbers for your dependents covered by the medical plan
- Dates of birth and your relationship to your dependents

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective on the **first of the month following 30 days**.

Termination of Coverage

If you or a covered dependent no longer meet the eligibility requirements or if your employment ceases, your medical/rx/vision and dental coverages will end on the last day of the month in which you become ineligible. You may be eligible to elect COBRA for yourself and your eligible dependents for medical/rx/vision and dental coverages.

Basic Life/AD&D coverages will end on the day you become ineligible. Your life coverages are convertible.

You are responsible for informing Human Resources if any of your dependents become ineligible for benefits.

About Domestic Partner Coverage

To enroll your same-sex or opposite-sex domestic partner and his or her dependents for coverage, you will be required to submit appropriate declaration forms, and proof of domestic partnership may be necessary.

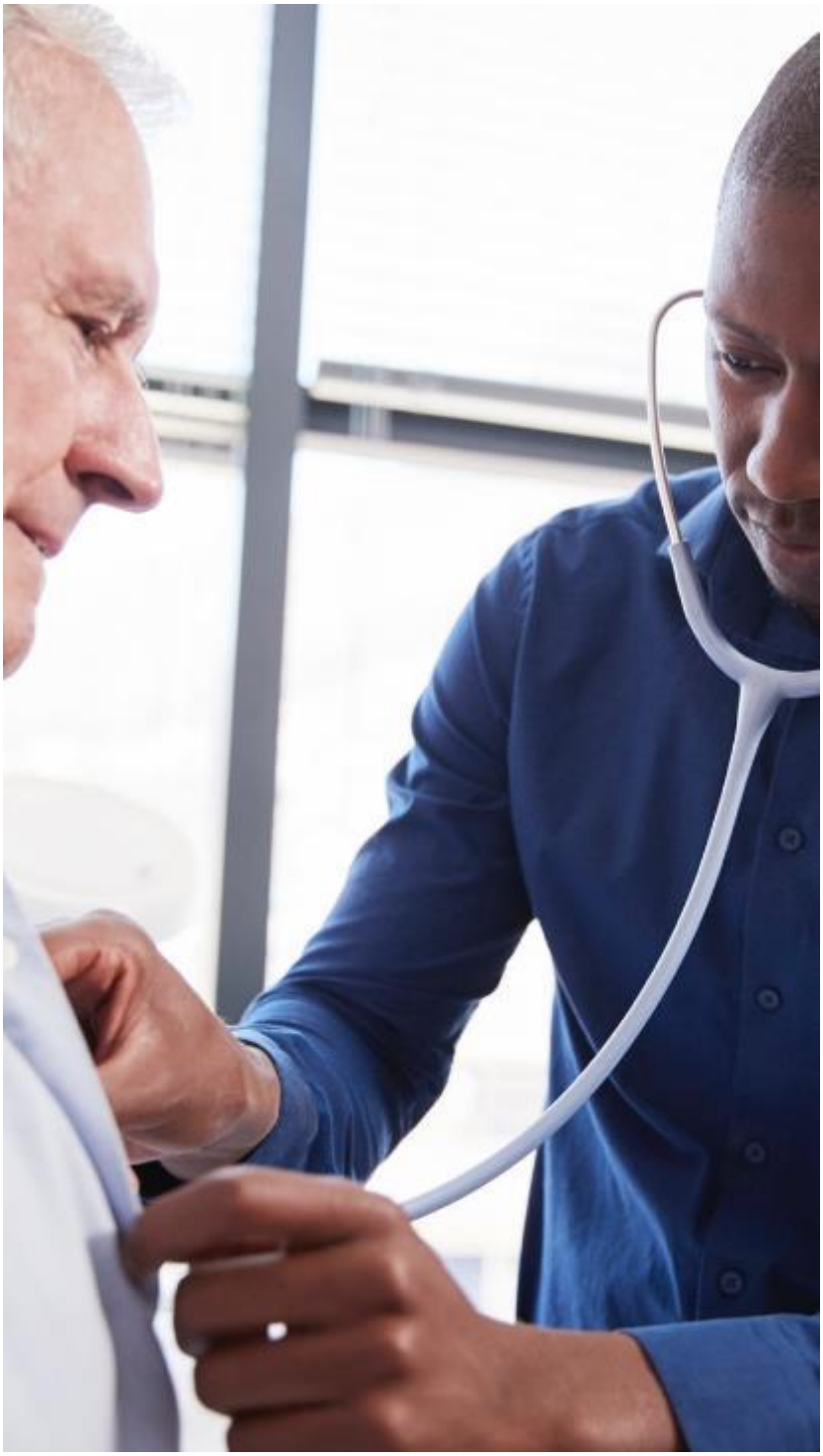
Under federal law, your company contribution toward the cost of healthcare coverage for your domestic partner and his or her dependents is considered taxable income to you.

Domestic partner premiums will be deducted on a post-tax basis. You may wish to consult with a tax adviser for more information.

Medical Plan

APBHT offers medical plan through **Premera Blue Cross Blue Shield of Alaska** with the following features:

- Option to receive care from in-network or out-of-network providers; higher benefits are paid when using in-network providers.
- Preventive care is covered at 100% when using an in-network provider.
- Includes prescription drug coverage.
- Deductibles and out-of-pocket maximums accumulate on a calendar year.
- If you enroll in the HSA plan, you can open and contribute to a Health Savings Account (HSA) to help cover some of your medical plan costs (refer to HSA section for more information).
- Always refer to your plan booklet for specific benefit levels and limitations.



How to Find a Doctor

Find a Doctor, Dentist, and more at https://www.premera.com. Login to your Premera account and click the "Find a Doctor" tab in the upper left hand corner. Follow the online instructions to perform a general search. Or, go mobile with Premera Mobile app (available for Windows Phone, Android, and iPhone). Premera Mobile allows one touch access to finding doctors and urgent cares facilities, customer service, 24-Hour NurseLine, etc.

Medical Plan

	HP HSA Aggregate $2,000/20%/$3,500 Essentials
Medical	**You Pay**
	In-Network
Plan Year Deductible *(Individual / Family)*	$2,000 / $4,000 (Aggregate)
Coinsurance	20% Preferred / 40% Participating
Plan Year Out-of-Pocket Maximum[1] *(Individual / Family)*	$3,500 / $7,000 (Embedded)
Preventive Care[2]	Covered In Full
Primary Care Office Visit	In Network Deductible, then 20% Preferred / 40% Participating
Specialty Care Office Visit	In Network Deductible, then 20% Preferred / 40% Participating
Urgent Care Facility	In Network Deductible, then 20% Preferred / 40% Participating
Virtual Care – Telemedicine (General Medical)	In Network Deductible, then 20% Preferred
Emergency Room Care	In Network Deductible, then 20% Preferred
Inpatient Hospital	In Network Deductible, then 20% Preferred / 40% Participating
Outpatient Surgery	In Network Deductible, then 20% Preferred / 40% Participating
Routine Radiology / Lab	In Network Deductible, then 20% Preferred / 40% Participating
Advanced Radiology *(MRI, CT, PET Scan)*	In Network Deductible, then 20% Preferred / 40% Participating

Limitations and maximums may apply. Please refer to the plan summaries and Summary of Benefits and Coverage for more information.

[1] Plan Year Out-of-Pocket Maximum includes deductibles, copays and coinsurance

[2] Preventive Office Visit, Immunizations, Preventive Laboratory Screens, Preventive Imaging, Preventive Routine Mammography

Medical Plan – Additional Benefits

	HP HSA Aggregate $2,000/20%/$3,500 Essentials
	You Pay
	In-Network
Pediatric Vision Exam 1 PCY Under age 19	In Network Deductible, then 20% Preferred
Pediatric Vision Hardware 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

Prescription Drugs

When you enroll in a medical plan, you receive comprehensive prescription drug coverage through **Premera Blue Cross Blue Shield of Alaska**.

Some medications may be subject to prior authorization, quantity limits or step therapy requirements to be approved for coverage.

	HP HSA Aggregate $2,000/20%/$3,500 Essentials
Prescription Drugs Deductible	**Medical Deductible**
	You Pay
Retail (preferred generic/preferred brand/preferred specialty/all non-preferred)	After Deductible is met $15/$30/$50/30%; Coinsurance is waived
Mail Order (preferred generic/preferred brand/preferred specialty/all 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

Retail Pharmacy	Mail Order	Specialty Pharmacy
✓Locate a participating retail pharmacy ✓View a list of approved drugs	✓ Use for maintenance drugs such as medication for high blood pressure, arthritis or diabetes ✓No additional cost for delivery	✓Medication used to treat complex conditions like multiple sclerosis, hepatitis C and rheumatoid arthritis ✓Prescription can only be filled once every 30 days

Where to Seek Care

myCare Alaska

Primary and urgent care are available virtually!

Getting care is as easy as sending a text message. You can connect with a doctor in seconds from any computer or mobile device. A doctor will reply in less than 60 seconds.

- Available from anywhere you can access the internet, 24 hours a day and 7 days a week.
- This is a text-based virtual care program that allows you to securely message, send photos, or video chat with a doctor instantly.
- Ask general or urgent medical questions from your desk – no need to go into a medical office.

Get started at mycarealaska.com

When should I use myCare Alaska?

Use myCareAlaska when you:

- Feel sick, but it's not an emergency*
- Have a minor injury
- Have general medical questions
- Want to refill a prescription
- Are not sure where to go to get care

Examples of conditions to discuss:

- Coughs, fevers, sore throat
- Earaches, stomach pain, diarrhea
- Rashes, allergic reactions, animal/insect bites
- Back/abdominal pain
- Sports injuries, burns, heat-related illness
- Urinary tract infections
- Urgent or general health questions

**You should always call 9-1-1 for medical emergencies. A medical emergency is an event that you reasonably believe threatens you or someone else's life or limb in such a manner that immediate medical care is needed to prevent death or serious impairment of health.*

Where to Seek Care (Continued)

Doctor On Demand

For Primary/Urgent Care and Mental Health options

A video or phone-based consultation with a board-certified doctor. Doctor on Demand 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. Doctor on Demand 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.

Medical doctors are available on demand everyday, holidays included. Get care from home, or on the road.

Think of Doctor On Demand as your first stop for everyday care. Example of what Doctor On Demand treat:

- Cold & Flu
- Sinus Infections
- Urinary Tract Infections
- Allergies
- Anxieties & Depression, and much more

For more information, visit the Doctor on Demand website at: www.doctorondemand.com/premera

Talkspace: Therapy as Close as Your Phone

For Mental Health options

Premera believes behavioral health is critical to their member's overall health and well-being. 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.

Where to Seek Care (Continued)

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.

Boulder Care

For Substance use disorder

Boulder Care offers telehealth treatment for opioid use disorder and alcohol use disorder.

Participants can connect with their providers from anywhere through secure video and messaging on the Boulder App.

Teams of care providers collaborate to support participants with expert medical care, peer recovery coaching, and care coordination.

Get started at https://boulder.care/getstarted

Workit Health

For Substance use disorder

Workit Health offers telehealth treatment for opioid use disorder and alcohol use disorder.

Quit alcohol, drugs, smoking, or other addictions with online therapy in the Premera network.

Just like a traditional rehab, you will meet with clinicians, stay on track with coaching, join recovery groups, and complete addiction courses built by experts — all from the privacy of your own home.

For more information, go to https://www.workithealth.com/premera

Where to Seek Care (Continued)

Premera Designated Centers of Excellence

This benefit program includes enhanced services that support you and your dependents when you seek care from a Premera Center of Excellence (COE) provider. Premera Blue Cross Blue Shield of Alaska has selected Virginia Mason Medical Center in Seattle as a Premera Designated Center of Excellence (PDCOE) to provide certain specialty medical services for you.

What's included

- Access to three of the most common specialty procedures:
  - Total joint replacements (knee and hip)
  - Spine surgeries
  - Gynecological procedures
- Bundled payment arrangements for eligible specialty medical procedures which include:
  - Pre-surgical consultations and related services
  - Hospitalization, surgery, and related inpatient care
  - Post-surgical checkups
- If you are not on a qualified high-deductible health plan deductible, the employee cost share is waived.
- Predictive analytics, targeting, and outreach to identify eligible members, increase awareness, and educate members on the benefits of using a PDCOE provider for eligible services.
- Air travel for you and a companion, black car services from airport to hotel, and lodging at a select Virginia Mason Hotel (up to IRS limits).
- Dedicated care coordination from Premera medical travel experts and Clinical Programs clinicians during and after your procedure.

High-quality care

For the third year in a row, Virginia Mason is rated in the top one percent of healthcare facilities in the nation. Its network of specialty care medical centers and providers offer superior treatment results.

When you need one of the qualifying procedures, Premera will use predictive analytics to engage them at the right time and encourage them to seek high-quality, affordable care at Virginia Mason.

Fair prices

Cost for the same healthcare procedure can vary greatly from one provider to the next, this is why Premera is collaborating with providers to help eliminate unpredictable prices.

Premera Designated Centers of Excellence offer bundled rates for you who receive the specialty procedures covered by this benefit. A bundled rate is one lump sum for pre- and post-appointments and all related surgery costs.

Bundled rates help manage healthcare costs. They also help you know you are paying a fair price for the care you need. Plus, certain cost shares are waived for non-qualified preferred provider organization (PPO) health plans and qualified high-deductible health plans.

Premera makes it easy

- A medical travel expert will help answer your questions about eligibility, covered services and costs. They will also provide travel assistance, including making travel arrangements and handling travel prepayments.
- A Premera clinician will coordinate your out-of-state care with Virginia Mason, before, during, and after your procedure.

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

Where to Seek Care (Continued)

Emergency Care vs. Urgent Care

When you need help in a hurry, you have choices. Of course, when it's a **life-threatening problem, you should call 911 or go straight to the nearest hospital emergency room (ER).**

In the ER, true emergencies are treated first, so unless your life is in danger, you'll wait – sometimes for hours. The ER is also the most expensive option for care.

For non-life-threatening problems, call your doctor, call your nurse line or go to an urgent care center.

USE VIRTUAL CARE

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

OR

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 EMERGENCY ROOM

- 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

Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-advantaged savings vehicle available to individuals covered by a High Deductible Health Plan (HDHP). Funds in the account are used to pay for qualified medical, dental and vision expenses.

An HSA is a great way to save for the future. You can set aside money from each paycheck now and save funds to cover healthcare expenses that come up later. Plus, your contributions are free from federal income tax, so you're stretching your healthcare dollars while lowering your taxable take-home pay amount.

HSA funds can only be used for yourself, your spouse and your taxable dependents. Expenses for domestic partners and/or other dependents who do not qualify as tax dependents are not reimbursable under the HSA.

Advantages of an HSA

- Balance rolls over each year and accrues interest, so you won't lose your contributions.
- Triple tax savings — you do not pay federal tax* on:
  - Contributions to the account.
  - Spending on qualified expenses.
  - Interest that accrues.
- Account is portable, so the funds are yours even if you change medical plans next year or leave the company in the future.
- Use the funds for eligible medical, dental or vision expenses, including coinsurance costs, prescriptions, glasses, orthodontia and more—now or in the future.
- Money left in the savings account earns tax-free interest*.

**Tax treatment of HSAs for state tax purposes may vary by state.*

Health Savings Account (HSA)
(Continued)

2022 HSA Contributions and Limits			
Each year, you can contribute up to the IRS annual limit for HSAs			
	Individual	**Family**	
2021 IRS Annual Contribution Limits	$3,600	$7,200	Age 55+ Additional $1,000
2022 IRS Annual Contribution Limits	$3,650	$7,300	Age 55+ Additional $1,000

Funding and Enrolling in an HSA

To enroll in an HSA, you must enroll in the HDHP plan option. You can open an HSA account through a financial institution of your choice; however, you would have to make after-tax contributions, they would not be automatically deducted from your paycheck, and you would need to claim those contributions as a tax deduction when you file your taxes.

Once your HSA is opened, remember to designate a beneficiary for this account.

Who Can Open an HSA?

You can contribute to an HSA if you:

- Are covered under an HSA-qualified high deductible health plan (HDHP).
- Are not enrolled in Medicare***, TRICARE or TRICARE for Life.
- Cannot be claimed as a dependent on someone else's tax return.
- Have not received Veterans Affairs (VA) benefits within the past 3 months
- You (or your spouse) do not contribute to a Healthcare FSA.

**** Enrollment in Medicare Part A may be retroactive by up to 6 months when you begin taking social security retirement after your Social Security Normal Retirement Age (SSNRA). This may affect your HSA eligibility.*

Other restrictions and exceptions may also apply. For more information, visit www.irs.gov/publications/p969/.

How To Save

When Using Your Medical And Prescription Plans:

Use In-Network Doctors

By using in-network doctors, clinics, hospitals and pharmacies, you pay the lowest cost for care. When you visit out-of-network doctors, our health plan covers less of the cost.

Choose the Right Type of Care

When you need care, know your options. Urgent care centers, online doctor visits or a call to the medical plan nurse line can help save time and money.

Use freestanding imaging centers for MRIs, CT Scans and other imaging can help save money. Just be sure they are in-network.

Use Your Preventive Care Benefits

Most preventive care services are covered at 100% when you use in-network providers. 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.

Ask Your Doctor for Generic Drugs

The next time you need a prescription, ask your doctor if it is appropriate to use a generic drug rather than a brand name drug. Generic drugs contain the same active ingredients, are identical in dose, form and administrative method AND are less expensive than their brand name counterparts.

If you must take a brand name drug, ask your doctor for samples or coupons. Also check the drug manufacturer's website for available rebates and discounts.

Search GoodRx for Cheaper Rx Prices

Drug prices sometimes vary significantly between pharmacies. GoodRx collects and compares prices for every FDA approved prescription drug at more than 70,000 pharmacies.

Access GoodRx at www.goodrx.com to find the lowest price pharmacy near you and/or print FREE coupons. You can also get coupons on-the-go through Good Rx's mobile app – just show your phone to the pharmacist.

Dental Plan

APBHT offers dental plan through **Premera Blue Cross Blue Shield of Alaska**. Your choice of dentists can determine the cost savings you receive. In-Network providers are paid directly by **Premera** and agree to accept negotiated fees as "payment in full" for services rendered.

When you use out-of-network providers, **Premera** will apply the applicable percentage of the allowed amount and you are responsible for paying the balance of the bill.

In-network coverage is provided when you use **Premera network** providers.

The Dental benefit is only available to those eligible employees enrolling in the Medical benefit.

	Dental Optima 1500
	You Pay
	In-Network
Calendar Year Plan Deductible	$50 Per Individual / $150 Per Family
Calendar Year Maximum	Up to $1,500 per person each calendar year applies to Basic & Major Services
Preventive Services (no deductible)	0%
Basic Services (after deductible)	20%
Endodontics **Periodontics** (after deductible)	20%
Major Services (after deductible)	50%

Important Information!

If you do not enroll in dental benefits when you are first eligible, you will become a late entrant. Late entrants will only be eligible for exams, cleanings and fluoride applications for the first 12 months they are covered.

How to Find a Dentist

Find a Doctor, Dentist, and more at https://www.premera.com. Login to your Premera account and click the "Find a Doctor" tab in the upper left hand corner. Follow the online instructions to perform a general search. Or, go mobile with Premera Mobile app (available for Windows Phone, Android, and iPhone).

Basic Life/AD&D Insurance

APBHT provides Basic Life insurance coverage, which includes an Accidental Death and Dismemberment (AD&D) provision that also pays **the same amount** in the event of accidental death and certain other conditions. Basic Life and AD&D insurance is administered by **Symetra** and is paid for by your company. The Life/AD&D benefit is only available to those eligible employees enrolling in the Medical benefit.

- **Class 1:** 1x annual earnings up to $100,000
- **Class 2:** $20,000
- **Class 3:** $5,000

According to federal law, only the first $50,000 of employer-paid life insurance is not taxable. Premium paid by **APBHT** for coverage levels over $50,000 will be taxable to you and will be included on your year-end W-2 statement.

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

BenefitHub

Explore your APBHT 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

Hertz, CityPASS, SixFlags, amc THEATRES, Hotels, GROUPON, Budget, DELL, employee AUTO BUYING, Vitamix, Sam's Club, Nutrisystem, Office DEPOT OfficeMax, Lenovo, AVIS, TICKETMONSTER, hp, jiffy lube

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

2022 Premiums Costs

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

2022 HEALTH & DENTAL MONTHLY RATES				
Health Plan 01/01/2022 (Active Employees)	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical *	$905.38	$2,239.73	$1,903.65	$2,952.70
Dental *	$52.22	$106.86	$110.85	$171.26
Administration Fee	$15.00	$15.00	$15.00	$15.00
Total	**$972.60**	**$2,361.59**	**$2,029.50**	**$3,138.96**
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				

2022 COBRA RATES				
Health Plan 01/01/2022	**Employee Only**	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical and Dental	$976.75	$2,393.52	$2,054.79	$3,186.44
Medical Only	$923.49	$2,284.52	$1,941.72	$3,011.75
Dental Only	$53.26	$109.00	$113.07	$174.69

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

2021 Premiums Costs

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

2021 HEALTH & DENTAL MONTHLY RATES				
Health Plan 01/01/2021 (Active Employees)	**Employee Only***	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical *	$953.03	$2,357.61	$2,003.84	$3,108.11
Dental *	$54.97	$112.48	$116.68	$180.27
Administration Fee	$15.00	$15.00	$15.00	$15.00
Total	**$1,023.00**	**$2,485.09**	**$2,135.52**	**$3,303.38**
* Employer is required to pay at least 75% of Employee Only Coverage				

2021 COBRA RATES				
Health Plan 01/01/2021	**Employee Only**	**Employee & Spouse**	**Employee & Child(ren)**	**Employee & Family**
Medical and Dental	$1,028.16	$2,519.49	$2,162.93	$3,354.15
Medical Only	$972.09	$2,404.76	$2,043.92	$3,170.27
Dental Only	$56.07	$114.73	$119.01	$183.88

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

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

Wilson Albers, 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 Wilson Albers a call at 907-277-1616.

Benefit Definitions

What is a premium?

A premium (sometimes called a contribution) is the monthly cost you pay for health insurance, whether you use medical services or not. Premiums are deducted directly from your paycheck.

What is a deductible?

A deductible is the amount you pay out of your pocket before your insurance pays.

The deductible runs from January – December each year. Once you have met that dollar amount, you have met the requirements for the plan year.

What does a copay pay for?

Copayments or copays, are pre-set dollar amount you are expected to pay for office visits, procedures or prescription drugs under your insurance plan.

Once the copay has been met, the insurance company pays all remaining costs.

What counts towards my out-of-pocket maximum?

An out-of-pocket maximum is an annual cap on the dollar amount you are expected to pay out of your own pocket for services (including deductibles, copays, and coinsurance) throughout the plan year.

Once you meet the out-of-pocket amount, your insurance provider will cover 100% of remaining medical expenses for the year.

What does coinsurance mean?

Coinsurance is a set percentage of service costs that you will be expected to pay once you have met your annual deductible.

When your annual deductible is met, your insurance provider pays for their portion of the full cost of the service and you pay the coinsurance, or remaining percentage.

Enrollment Checklist

Remember that the choices you make during open enrollment will take effect on **January 1, 2022** and remain in effect until **December 31, 2022**. 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

Brought to you by:

WILSON ALBERS
AN ALERA GROUP COMPANY

Employee Notices

TO: Employees Eligible for Group Health Benefits under the Alaska Public Broadcasting Health Trust Group Health Plans

DATE: January 1, 2022

SUBJECT: Required Annual Notices for Group Health Plans

*****Important Information – Action May Be Required*****

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires Alaska Public Broadcasting Health Trust to provide you with notice of certain legal rights that you may have and legal obligations that apply to the ALASKA PUBLIC BROADCASTING HEALTH TRUST HEALTH & WELFARE BENEFIT PLAN. These rights and obligations are described in more detail in the enclosed notices.

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You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call:

Kim Pigg, Administration Manager
135 Cordova Street | Anchorage, AK 99501
(907) 277-6300 | kim@coastalaska.org

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see ***page 9*** *for more details.*

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

- HP HSA AGG $2000/20%/$3500 Essentials + Vision

If you would like more information on WHCRA benefits, contact your plan administrator:

Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Contact your plan administrator for more information.

Newborns' and Mother's Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Loss Ratio (MLR) Rule Notice

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market of 51+ employees, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 (85 for large

groups) percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is intended to inform you of the privacy practices followed by the Alaska Public Broadcasting Health Trust Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 10/22/2021.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Alaska Public Broadcasting Health Trust requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share

information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Alaska Public Broadcasting Health Trust for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities. We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Notice of HIPAA Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact:

Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

New Health Insurance Marketplace Coverage Options and Your Health Coverage

General Information

Now that key parts of the health care law have taken effect, there is a new way to buy health insurance: The Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. For 2021, open enrollment for health insurance coverage through the Marketplace was from November 1, 2020 through December 15, 2020, for coverage starting January 1, 2021. For 2022, open enrollment for health insurance coverage through the Marketplace will be from November 1, 2021 through December 15, 2021, for coverage starting January 1, 2022.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78% of your household income (for 2020), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.*

If you work full-time and are eligible for coverage under your employer's health plan, the plan satisfies the minimum value standard, and the cost is intended to be affordable based on employee wages.

If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact your Human Resource department at (907) 277-6300.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its costs. Please visit **www.healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

*A health plan provides "minimum value" if the plan's share of the total allowed benefit costs covered by the plan is at least 60% of such costs.

CREDITABLE COVERAGE – HP HSA AGG $2000/20%/$3500 Essentials + Vision

Important Notice about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Alaska Public Broadcasting Health Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Alaska Public Broadcasting Health Trust has determined that the prescription drug coverage offered by the ALASKA PUBLIC BROADCASTING HEALTH TRUST HEALTH & WELFARE BENEFIT PLAN is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Alaska Public Broadcasting Health Trust coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Alaska Public Broadcasting Health Trust coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current Alaska Public Broadcasting Health Trust coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Alaska Public Broadcasting Health Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year you are eligible from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. *If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).*

Date:	October 23, 2021
Name of Entity/Sender:	Alaska Public Broadcasting Health Trust
Contact - Position/Office:	Kim Pigg, Administration Manager
Address:	135 Cordova Street Anchorage, AK 99501
Phone Number:	(907) 277-6300

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

List begins on next page.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: www.myalhipp.com Phone: 1-855-692-5447	Health First Colorado Website: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+ Website: www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP + Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: www.dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Website: www.medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: www.dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults ages 19-64 Website: www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid Website: www.in.gov/medicaid Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: https://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: www.accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: kihipp.program@ky.gov KCHIP Website: www.kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: www.chfs.ky.gov	Medicaid Website: www.dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 HIPP toll free number: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: www.mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: www.medicaid.ncdhhs.gov Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: www.medicaid.utah.gov CHIP Website: www.health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: www.healthcare.oregon.gov/Pages/index.aspx or www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: www.greenmountaincare.org Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: www.coverva.org/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: www.eohhs.ri.gov Phone: 1-855-697-4347 Direct RIte Share Line: 401-462-0311	Website: www.hca.wa.gov Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: www.scdhhs.gov Phone: 1-888-549-0820	Website: www.mywvhipp.com Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: www.dss.sd.gov Phone: 1-888-828-0059	Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: www.gethipptexas.com Phone: 1-800-440-0493	Website: www.health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (Expires 1/31/2023)

Model General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice in case, once enrolled, your coverage under a group health plan (the Plan) ends due to a qualifying life event (described later). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability

would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to:

Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period* to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

*For more information on the 8-month special enrollment period visit:
www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

To obtain more information about the Plan and COBRA continuation coverage upon request, contact the following person:

ALASKA PUBLIC BROADCASTING HEALTH TRUST HEALTH & WELFARE BENEFIT PLAN
Kim Pigg
Administration Manager
(907) 277-6300
kim@coastalaska.org

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

New Federal Legislation Effective 1/1/2022

Included in the Consolidated Appropriations Act 2021 were requirements for health plans to provide protections against Surprise Medical Bills. These protections apply to services received on or after 1/1/2022 and apply to both grandfathered and non-grandfathered group health plans, as well as grandmothered plans and traditional indemnity plans without a network.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

As of February 2021, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of February 2021, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing

mandate at any time.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the US Dept. of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

Forms

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		Benefit Selection		
							M	F	Medical	Dental	Vision Only
☐	☐	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.*

An Independent Licensee of the Blue Cross Blue Shield Association

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.

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. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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).

አማርኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross Blue Shield of Alaska ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያነኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያኙ መብት አለዎት።በስልክ ቁጥር 800-508-4722 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross Blue Shield of Alaska. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-508-4722 (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)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross Blue Shield of Alaska tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-508-4722 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross Blue Shield of Alaska. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-508-4722 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross Blue Shield of Alaska. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-508-4722 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross Blue Shield of Alaska. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-508-4722 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross Blue Shield of Alaska. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-508-4722 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross Blue Shield of Alaska. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-508-4722 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross Blue Shield of Alaska. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-508-4722 (TTY: 800-842-5357).

日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Cross Blue Shield of Alaska の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-508-4722 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross Blue Shield of Alaska 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-508-4722 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross Blue Shield of Alaska. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອເລື່ອງຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-508-4722 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់។ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការវាំប់រងរបស់អ្នកតាមរយៈ Premera Blue Cross Blue Shield of Alaska ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាពដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការធានារ៉ាប់រងសុខភាពរបស់អ្នក ឬជ្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-508-4722 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross Blue Shield of Alaska ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜ਼ੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-508-4722 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد. این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross Blue Shield of Alaska باشد. به تاریخ های مهم در این اعلامیه توجه نمایید. شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید. شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-508-4722 تماس باشماره TTY (کاربران 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross Blue Shield of Alaska. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-508-4722 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross Blue Shield of Alaska. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-508-4722 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross Blue Shield of Alaska. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-508-4722 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross Blue Shield of Alaska. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-508-4722 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross Blue Shield of Alaska, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'amatalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 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).

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).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross Blue Shield of Alaska และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-508-4722 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross Blue Shield of Alaska. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 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).

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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**

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ALASKA PUBLIC BROADCASTING HEALTH TRUST

TO: Participant in Alaska Public Broadcasting Health Trust Plan

FROM: Kim Pigg, Administrative Manager

DATE: November 8, 2021

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 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.

Another useful resource is the APBHT Landing Page which is chock full of information, such as your FlippingBook Guide, which includes shortcuts taking folks to a specific benefit section, help for navigating the Landing Page, as well as the ability to send direct questions. The Landing Page and Guide can be found at the following link: https://online.flippingbook.com/view/1029022689/

If requested, a hard copy of any of these documents can be provided to you at no charge. This guide and other information provided on website is not intended to be a complete description of the insurance coverage offered, nor is it a binding contract. Controlling provisions are provided in each benefit plan policy. Should there be a difference between this guide/other reference materials and the office plan documents, the official plan documents will govern. More information about specific terms and conditions of each plan is included in the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC).

If you have any questions about these documents, please contact Alaska Public Broadcasting Health Trust Plan Administrator Kim Pigg, at kim@coastalaska.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 signed form to your general manager or human resource specialist for processing to the Alaska Public Broadcasting Health Trust Plan Administrator Kim Pigg, kim@coastalaska.org.

It is recommended that all enrollment forms are maintained by your station manager/human resource specialist for inclusion in your personnel file and/or with your health plan records as well as retaining a copy for your own files.