Employee **2027** Benefits Guide

Effective January 1, 2027 – December 31, 2027

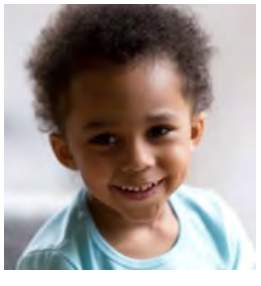
APB HEALTH TRUST










APBHT
2027 Employee Benefits

Welcome to your open enrollment period! 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 HSA.

The Open Enrollment period for your company starts **November 17, 2026**, and ends **December 15, 2026**.

For enrollment outside this period, please see Human Resources.

Please take a few minutes to review this memo so you are aware of any changes and action 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 (e.g., 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 the company's Landing Page and Open Enrollment Guide at:

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

What's New or Changing?

1. **Medical, Rx:** No changes to current benefits.
2. **Dental:** No changes to current benefits.
3. **Group Life/AD&D:** No changes to current benefits.
4. **Health Savings Account:** Annual limit amounts increased per IRS rules.

Action Items

- **All employees who waive coverage need to complete a waiver form.**
- **All Benefits:** It is not necessary to complete new enrollment forms during open enrollment unless you are making changes to your benefits, and/or adding or dropping dependents.

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 **January 1, 2027**, and will remain in effect until **December 31, 2027**. Only qualifying events will allow you to make a change before that date.

Please submit all forms to your station's General Manager no later than **December 15, 2026**. Should you have any questions in general, contact your station's GM or HR leader.

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These buttons are interactive!
Click to jump to more information.

Welcome

To our Valued Employees of Alaska Public Broadcasting Health Trust

We are pleased to present this overview of your employee benefits! APBHT offers a variety of benefits to help you protect your health, your family, and your way of life. As a valued employee, we want you to have the best benefits possible which is why we've carefully reviewed our benefits to ensure affordability, quality, and ease of use for 2027.

Some of the benefits we offer are paid for in full by APBHT. For others, it is a shared contribution between you and the Company. Your benefits are an important part of your total compensation at APBHT. Please take the time to review and evaluate all the options available to you and your family.

Kind regards,

Kim Pigg

Eligibility

Who is Eligible?

- 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 child(ren)†** up to age 26 and your disabled children up to any age (pursuant to plan documents and state law, please see Human Resources for more information)

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

**May include non-children dependents required to be covered under state law

Making Benefit Changes During the Plan Year

The benefit elections you make during your initial enrollment period will be in effect through the end of the plan year. If you have a "qualifying life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources within 30 days of the event. Proof of life events are subject to approval. Please reach out to your employer for specific documentation to be submitted for a qualified life event during the benefit year. Changes are effective prospectively unless the event is for birth, adoption, or placement for adoption.

Qualifying Life Event		
Change in Marital Status	Change in Dependents	Change in Employment
• Marriage • Divorce • Death of your spouse	• Birth, adoption or placement for adoption of an eligible child (Retroactive to the date of the event) • Death of your covered dependent • Gain or loss of Medicare or Medicaid during the year	• Change in you or your spouse's work status that affects benefits eligibility • Your spouse's Open Enrollment differs from yours • Relocation if the move impacts eligibility for the plan

Your Coverage

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 benefits will end.

You are responsible for informing Human Resources within 30 days if any of your dependents become ineligible for benefits.

Benefits can be canceled due to:

- Open Enrollment
- Termination (voluntary or involuntary)
- Retirement
- Qualified Life Event

Domestic Partners

Domestic partners are not generally eligible for continuation of coverage. See your plan documents or contact Human Resources for more information.

Contribution toward the cost of coverage for your domestic partner and his or her dependents is considered taxable income to you.

Domestic partner premiums will either be deducted on a post-tax basis or imputed as income based on the value of coverage. You may wish to consult with a tax adviser for more information.

Domestic partner's expenses under the FSA and/or HSA are generally not considered qualifying medical expenses.

A Note About Health Care Reform

If you choose to purchase individual coverage through the Marketplace, you should know that because APBHT's medical insurance meets specific ACA requirements, you may not be eligible to receive a federal subsidy. Additional information is available at www.healthcare.gov.

Enrollment

When Can I Enroll in Benefits?

You can enroll in 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.



How Do I Enroll?

To enroll in (or make changes to) your benefits, please complete your enrollment form(s) and submit to Human Resources by the end of the enrollment period.

Annual Open Enrollment

This is a once-a-year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family. Changes will go into effect January 1st.



How a Health Plan Works

Scan to view Glossary of Health Coverage and Medical Terms

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. With limited exceptions, an overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)

Evidence of Insurability (EOI)

EOI is an application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage. EOI may be required for life and/or disability insurance elections.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

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Medical Overview

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

- Deductibles and out-of-pocket maximums accumulate January 1st through December 31st
- Includes prescription drug coverage
- 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).
- Please refer to the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC) as well as the carrier materials for information regarding specific benefit levels, exclusions and limitations for all policies



Medical Provider Finder

To search for in-network medical providers:

Log onto **premera.com**

Network: AK Heritage Plus

Access care from your home through Telehealth Services.
Log onto: **Transcarent**

Download the Mobile App Today!

Download on the App Store

GET IT ON Google Play

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Medical

Only In-Network benefits are shown as a summary of your medical plan benefits has been offered to you. For details and limitations, please refer to your summary of benefits for specific requirements regarding pre-authorizations, coverage limits, and out-of-network costs.

	HP HSA AGG 2000 ESSENTIALS
You Pay In-Network	In-Network (Individual / Family)
Deductible	$2,000 / $4,000 (Aggregate)
Coinsurance	20% Preferred / 40% Participating
Out-of-Pocket Maximums	$3,500 / $7,000 (Embedded)
Coinsurance/Copays	
Preventive Care	Covered in Full
Primary Care	Deductible, then 20% Preferred / 40% Participating
Telemedicine	Deductible, then 20% Preferred
Specialist Care	Deductible, then 20% Preferred / 40% Participating
Urgent Care	Deductible, then 20% Preferred / 40% Participating
Emergency Room Care	Deductible, then 20% Preferred
Outpatient Surgery	Deductible, then 20% Preferred / 40% Participating
Inpatient Hospitalization	Deductible, then 20% Preferred / 40% Participating
Pharmacy Retail & Mail Order RX (up to 90-day supply shown; 30-day for Specialty)	
Prescription Deductible	Medical deductible applies
Retail (Preferred generic / Preferred brand / Preferred Specialty / Non-Preferred all drugs)	$15 / $30 / $50 / 30%
Mail Order (Preferred generic / Preferred brand / Preferred Specialty / Non-Preferred all drugs)	$37.50 / $75 / $50 / 30%
Drug List	E4 Essentials Formulary

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Medical

	HP HSA AGG 2000 ESSENTIALS
You Pay In-Network	In-Network (Individual / Family)
Routine Vision Exam 1 PCY	Covered in Full
Vision Hardware $200 PCY	Covered in Full
Pediatric Vision Exam 1 PCY Under age 19	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

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Prescription Drugs

Get the most from your prescription coverage.

When you enroll in a medical plan, you receive comprehensive prescription drug coverage through **Premera Blue Cross Blue Shield of Alaska.** For a list of approved drugs, log onto premera.com/visitor/drugs-pharmacy.

- If you take a maintenance medication, you can save money by enrolling in mail order RX
- Not all medications can be filled via mail order
- Specialty medications must be filled at the approved Premera Blue Cross Blue Shield of Alaska specialty pharmacy.
- Ask your doctor if it is appropriate to use a generic drug rather than a brand name
- Compare pharmacies for the best price
- Prescription Management may apply; such as prior authorization, step therapy, and quantity limits



Preventive Care

Preventive services help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases.

- Preventive services include exams, shots, lab tests, and screenings
- Routine visits will only be covered under preventive care when using an in-network provider
- Full list: healthcare.gov/what-are-my-preventive-care-benefits

Health Savings Account (HSA)

If you elect the **HP HSA AGG 2000 Essentials** HDHP (a qualified high-deductible plan) and you are not enrolled in disqualifying coverage elsewhere (e.g., a general-purpose FSA or another health plan that isn't HSA-compatible), you are eligible to contribute to a Health Savings Account through a financial institution of your choice. You can set aside tax-free money from each paycheck now and save funds to cover qualified healthcare expenses that come up later.

How does an HSA work?

Activate your account through your HSA Vendor. Use your HSA debit card to pay for qualifying expenses.

To view eligible purchases with your HSA account, please visit hsastore.com.

Limitations

- Can not be enrolled in Medicare or Tricare
- Can not be claimed as a dependent on someone's tax return
- Can not be receiving Veterans Affairs (VA) benefits, or within the past 3 months (unless for a service-related disability)
- Can not be contributing towards a Healthcare FSA, nor can you be covered under a spouse's FSA
- Cannot be enrolled in non-qualified HDHP coverage under a spouse's employer's plan.

Advantages

- Balance rolls over each year
- Contributions are tax-free
- Account belongs to you; any money in the account is yours – no vesting

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

Distributions

- Money must be in the account to spend
- Funds can be used for you and your tax dependents' eligible expenses
- 20% tax penalty applied if you are under age 65 and use the funds for non-eligible expenses
- At age 65, monies can be used for non-eligible health expenses with no penalty; normal income tax will apply
  - You can also pay for Medicare Part B premiums with your HSA funds

Enrollment Tiers	2027 Maximum Contribution Allowed
Employee Only	$4,500
Employee + Dependent(s)	$9,000
Employee 55+	Additional $1,000 per year as catch-up

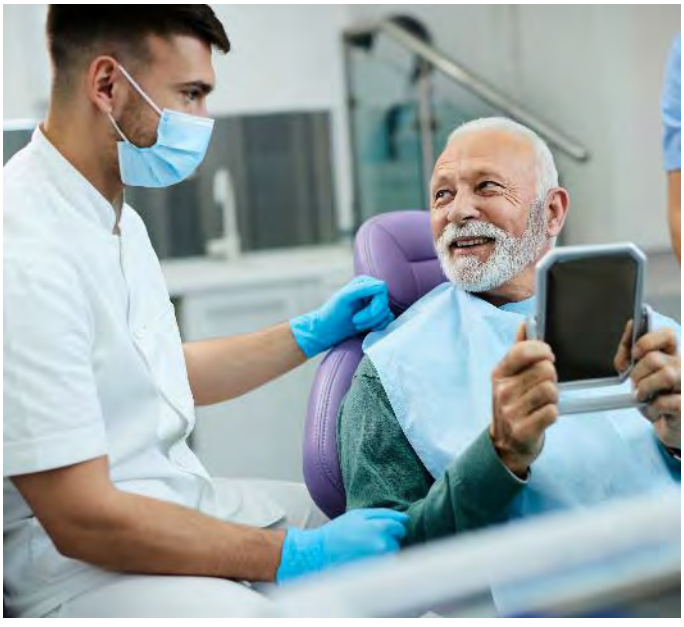
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Dental

Dental insurance is offered through **Premera Blue Cross Blue Shield of Alaska**. Your choice of dentists can determine the cost savings you receive.

You will pay less for in-network services. For out-of-network providers, **Premera Blue Cross Blue Shield of Alaska** will pay claims based on reasonable and customary (R&C) charges. You are responsible for paying the balance of the bill.

Please refer to plan summary for out-of-network benefits, subject to balance billing, and limitations.



DENTAL OPTIMA 1500 ENHANCED	In-Network
Benefit Maximum Per Person	
Calendar Year Annual Max	$1,500
Deductible (applies only to Basic & Major Services)	
Individual	$50
Family	$150
Benefit	**You Pay**
Preventive Services	0%
Basic Services	20%
Major Services	50%
Orthodontia	Not Covered

Life and AD&D Insurance

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

Basic Life/AD&D

A Basic Life insurance policy is provided to you at no cost through **Symetra**. You are automatically enrolled in this benefit. This coverage includes an Accidental Death and Dismemberment (AD&D) provision, at the same coverage amount, in the event of accidental death and other conditions. Please refer to the benefit summary for details. 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.

What is Life Insurance?

- A lump sum payment distributed to beneficiaries upon death of the insured or insureds
- Reassurance that your loved ones would be financially secure if you passed away unexpectedly
- Ability to assist with funeral costs – the average funeral cost is $10,000



Reminder! Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.

Discounts & Savings

Welcome to your discount marketplace provided at no cost by APBHT!

BenefitHub

A platform with exclusive discounts in **every category** you can think of!

- $0 Cost to you
- Find exclusive discounts on all the brands you love
- Find big savings at any time, wherever you are
- Access thousands of discounts and Cash Back offers on travel, electronics, events, and more, whether you're at home or on the road





How to Access

1. Download the app through Google Play Store/Apple App Store by searching BenefitHub

2. Complete your registration by entering your email address, choosing **"APBHT"** from the organization drop down menu and then entering your password.
Company Domain: APBHT.benefithub.com

GET IT ON Google Play | Download on the App Store

For questions regarding your registration, please call **866.664.4621** or email customercare@benefithub.com

Cost of Coverage – 2027 Premiums

The following tables show the **monthly** amounts for each line of coverage.

Health Plan 01/01/2027 (Active Employees)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical *	$1,009.54	$2,497.44	$2,122.70	$3,292.43
Dental *	$53.26	$108.99	$113.06	$174.67
Administration Fee	$18.00	$18.00	$18.00	$18.00
Total	$1,080.80	$2,624.43	$2,253.76	$3,485.10
Life	$0.225 / $1,000			
AD&D	$0.030 / $1,000			
COBRA Services	$1.00	$1.00	$1.00	$1.00
COBRA Services Annual Set-up Fee	$150 annual fee, divided equally among participants at the beginning of year			

***** *Employer is required to pay at least 75% of Employee Only Coverage. Please check with your station manager for your 2027 Employer Contribution Rate.*

Health Plan 01/01/2027 (COBRA Rates)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical and Dental	$1,084.06	$2,658.56	$2,280.47	$3,536.44
Medical Only	$1,029.73	$2,547.39	$2,165.15	$3,358.28
Dental Only	$54.33	$111.17	$115.32	$178.16

Cost of Coverage – 2026 Premiums

The following tables show the **monthly** amounts for each line of coverage.

Health Plan 01/01/2026 (Active Employees)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical *	$934.76	$2,312.44	$1,965.46	$3,048.55
Dental *	$52.22	$106.86	$110.85	$171.26
Administration Fee	$17.50	$17.50	$17.50	$17.50
Total	$1,004.48	$2,436.80	$2,093.81	$3,237.31

***** *Employer is required to pay at least 75% of Employee Only Coverage.*

Health Plan 01/01/2026 (COBRA Rates)	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Medical and Dental	$1,006.72	$2,467.69	$2,117.84	$3,284.21
Medical Only	$953.46	$2,358.69	$2,004.77	$3,109.52
Dental Only	$53.26	$109.00	$113.07	$174.69

Locate a Provider

Utilizing in-network providers ensures that you receive the highest level of coverage while also reducing your overall out-of-pocket cost. Follow the steps outlined below to locate an in-network provider near you.

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Medical Plan

To search for in-network medical providers log in to your portal or visit:

Website: **premera.com/visitor/find-a-doctor**

Network: AK Heritage Plus



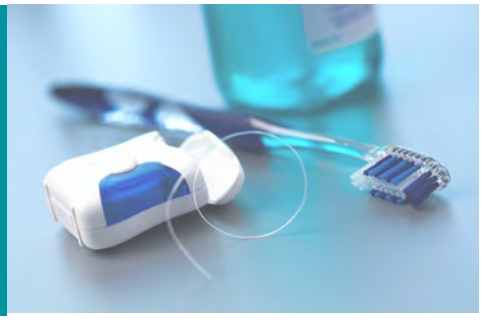
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Dental Plan

To search for in-network dental providers log in to your portal or visit:

Website: **premera.com/visitor/find-a-doctor**

Network: Dental Choice



Contact Information

BENEFIT	PARTNER	WEBSITE / PHONE
Medical **Prescription** **Dental** **Vision**	Premera Blue Cross Blue Shield of Alaska	premera.com 800-508-4722
Basic Life/AD&D	Symetra	Symetra.com 800-796-3872

APB HEALTH TRUST

Benefits Effective January 1, 2027 – December 31, 2027

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Employee Notices

TO	Employees Eligible for Group Health Benefits under the Alaska Public Broadcasting Health Trust's Health & Welfare Benefit Plan
DATE	January 1, 2027
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's Health & Welfare Benefit Plan. These rights and obligations are described in more detail in the enclosed notices.

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General Notice of COBRA Continuation Coverage Rights 13
HIPAA Privacy Policy for the Fully Insured Health Plan 17

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 | Administrative Manager

135 Cordova Street | Anchorage, AK 99501

907-215-3600 | 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, which are available by contacting human resources.

Notice of HIPAA Special Enrollment Rights Under HIPAA and CHIPRA

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 resulting from 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 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 | Administrative Manager

907-215-3600 | kim@coastalaska.org

ACA Reporting Notice

To reduce waste and promote efficiency, Alaska Public Broadcasting Health Trust's Health & Welfare Benefit Plan is taking advantage of a new law that allows us to make your IRS Form 1095-C or Form 1095-B available to you only upon request. We are required to file this form with the IRS to show whether we offered you healthcare coverage in one or more months of the prior calendar year. If you recall, in the past, this form was mailed to you in the first quarter of the year. However, pursuant to the new law, we will not be mailing the forms this year.

While we are no longer automatically mailing the form to you, you can request a copy of your form at any time. If you are interested in obtaining a copy of your form, you may contact:

Kim Pigg | Administrative Manager

907-215-3600 | kim@coastalaska.org

We will provide the form to you within thirty (30) days of your request.

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

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?

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:

Premera BCBS HP HSA AGG $2,000/20%/$3,500 Essentials

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

Kim Pigg | Administrative Manager

907-215-3600 | kim@coastalaska.org

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 percent 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.

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. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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 copayment, coinsurance, or 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" means providers and facilities that haven't signed a contract with your health plan to provide services. 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 plan's deductible 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 May 2026, 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 May 2026, the following 17 states had enacted limited Balance Billing Protections: Alabama, Arizona, Arkansas, 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 types of 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're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "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 in-network deductible and out-of-pocket limit.

If you think 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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depend on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% (2026, indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% (2026, indexed annually) of the employee's household income.[1, 2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-25-25.pdf for 2026.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by Healthcare.gov and either- submit a new application or update an existing application on Healthcare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit Healthcare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Kim Pigg | Administrative Manager

907-215-3600 | kim@coastalaska.org

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

CREDITABLE COVERAGE –

Premera BCBS HP HSA AGG $2,000/20%/$3,500 Essentials

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's 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	November 15, 2026
Name of Entity/Sender:	Alaska Public Broadcasting Health Trust
Contact - Position/Office:	Kim Pigg, Administrative Manager
Address:	135 Cordova Street Anchorage, AK 99501
Phone Number:	907-215-3600

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid	MONTANA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://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, 2026, 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 5/31/2029)

General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). 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 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 must 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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, Administrative Manager

907-215-3600 | 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, Administrative Manager

907-215-3600 | 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.

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 https://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's Health & Welfare Benefit Plan

Kim Pigg, Administrative Manager

907-215-3600 | kim@coastalaska.org

https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

HIPAA Privacy Policy for the Fully Insured Health Plan

The Alaska Public Broadcasting Health Trust's Health & Welfare Benefit Plan ("Group Health Plan") is a fully insured group health plan sponsored by Premera BCBS HP HSA AGG $2,000/20%/$3,500 Essentials (the "Plan Sponsor"). The Group Health Plan provides benefits solely through an insurance contract with a health insurance issuer or health maintenance organization (the "Insurer"). Neither the Plan Sponsor nor any member of its workforce creates, receives, maintains, or transmits protected health information, as defined below ("PHI"), on behalf of the Group Health Plan (also referred to as "Hands-Off PHI").

The Group Health Plan and the Plan Sponsor intend to comply with the requirements of 45 CFR §164.530(k) so that the Group Health Plan is not subject to most of HIPAA's privacy requirements. The Insurer, however, is subject to HIPAA's privacy rules.

No Access to Protected Health Information (PHI) Except for Summary Health Information for Limited Purposes and Enrollment/Disenrollment Information

Neither the Group Health Plan nor the Plan Sponsor (or any member of the Plan Sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 CFR §160.103 except for the following:

- summary health information, as defined by HIPAA's privacy rules, for purposes of (a) obtaining premium bids or (b) modifying, amending, or terminating the Group Health Plan;
- enrollment and disenrollment information concerning the Group Health Plan which does not include any substantial clinical information; or
- PHI disclosed to the Group Health Plan and/or Plan Sponsor under a signed authorization that meets the requirements of the HIPAA privacy rules.

Insurer for Group Health Plan Will Provide Privacy Notice

The insurer for the Group Health Plan will provide the Group Health Plan's Notice of Privacy Practices and will satisfy the other requirements under HIPAA's privacy rules related to Notice of Privacy Practices, including Notices of Availability of the Privacy Practices. The Notice of Privacy Practices, among other things, will notify participants of the potential disclosure of the summary health information and enrollment and disenrollment information to the Group Health Plan and the Plan Sponsor.

Breach Notification Requirements

The Plan will comply with the requirements of the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Plan or one of its business associates discovers a breach of unsecured PHI.

No Intimidating or Retaliatory Acts

The Group Health Plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against an individual for:

- exercising their rights under the HIPAA rules;
- participating in any process provided for by the HIPAA rules, including the filing of a complaint;
- testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under the HIPAA regulations; or
- opposing any act or practice that is illegal under HIPAA, if such individuals have a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of the HIPAA regulations.

No Waiver

The Group Health Plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility for benefits.

Other Matters

No third-party rights (including but not limited to rights of Group Health Plan participants, beneficiaries, or covered dependents) are intended to be created by this Policy. The Group Health Plan reserves the right to amend or change this Policy at any time (and even retroactively) without notice. This Policy does not address privacy or other requirements under state law or federal laws other than HIPAA.

Glossary

Plan Summaries/SBCs

Enrollment Forms



Open enrollment: Glossary of terms

Understanding the language of benefits

Benefits can be complex. Which is why it's important for you to educate yourself on how they work and what you need to know to not only choose the right plans during enrollment, but use them cost effectively throughout the year.

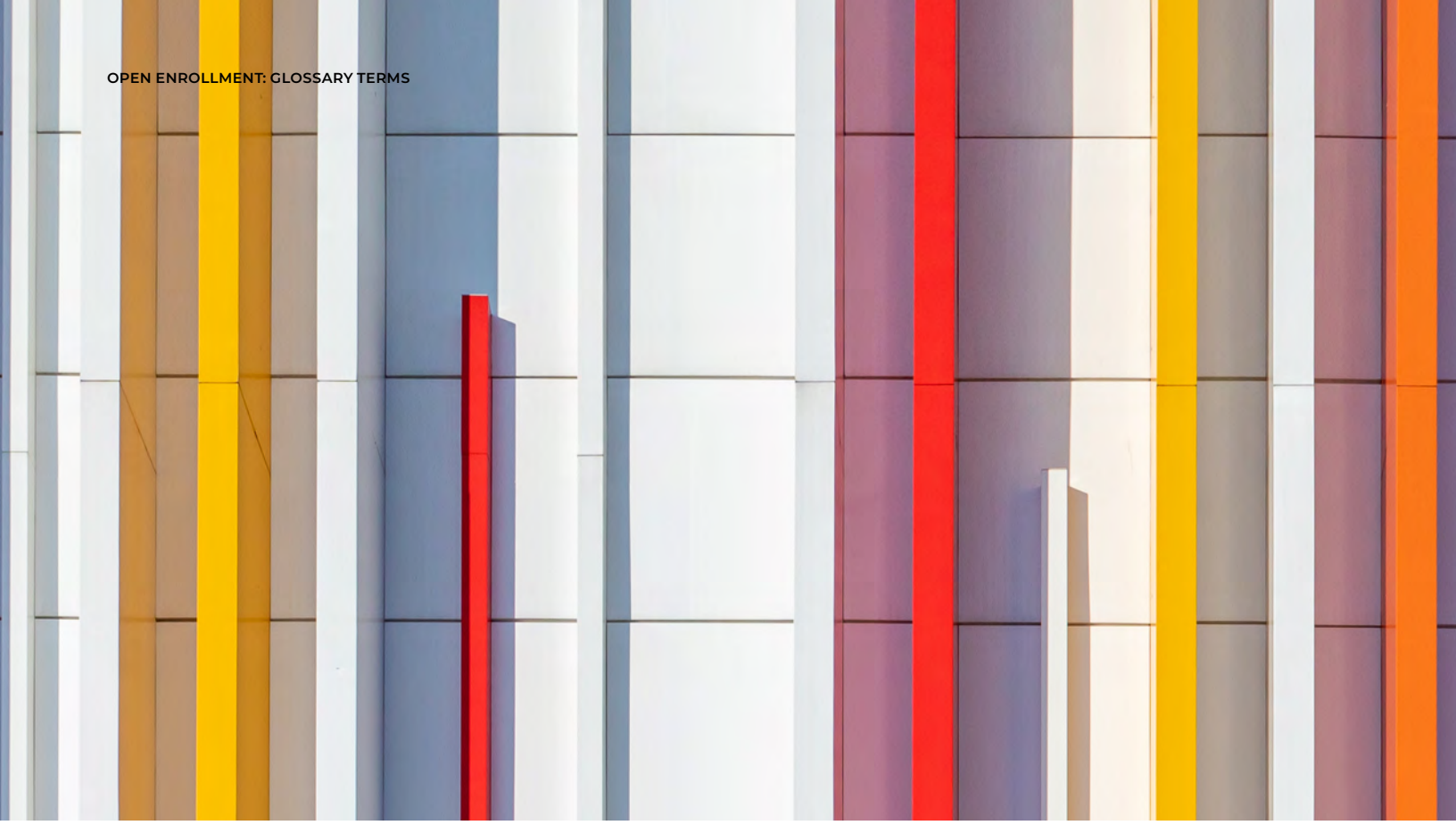
To be successful, you'll need to understand the language of benefits. This glossary of the most commonly used terms will help. It highlights the basic concepts and definitions you'll need to know to get the most from your health plans, spending accounts, life and disability insurance and more. As you review your employer's benefits information, we recommend keeping it handy so you can make the best decisions when the time comes to elect your benefits and access healthcare services.

Allowed amount	This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."
Appeal	A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).
Balance billing	When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Claim	A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.
Coinsurance	Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)
Complications of pregnancy	Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.
Copayment	A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.
Cost sharing	Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out- of-pocket costs you and your spouse and/ or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.
Cost-sharing reduction	Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

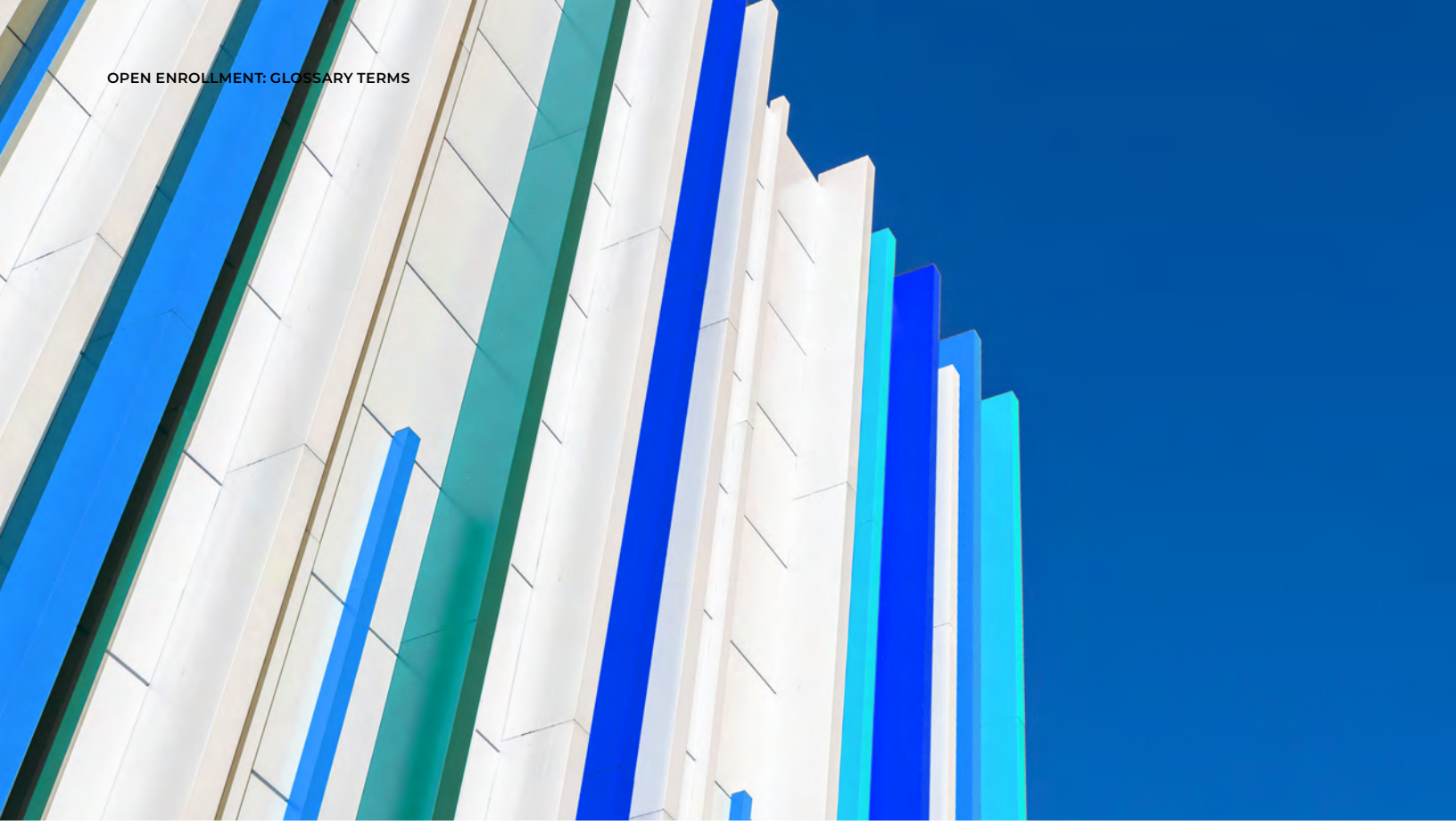


Deductible	An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)
Diagnostic test	Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.
Durable Medical Equipment (DME)	Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen Health Insurance equipment, wheelchairs, and crutches.
Emergency medical condition	An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.
Emergency medical transportation	Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.
Emergency room care / Emergency services	Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.
Excluded services	Health care services that your plan doesn't pay for or cover.
Formulary	A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.
Grievance	A complaint that you communicate to your health insurer or plan.



Habilitation services	Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
Health insurance	A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."
Home health care	Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.
Hospice services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospitalization	Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.
Hospital outpatient care	Care in a hospital that usually doesn't require an overnight stay.

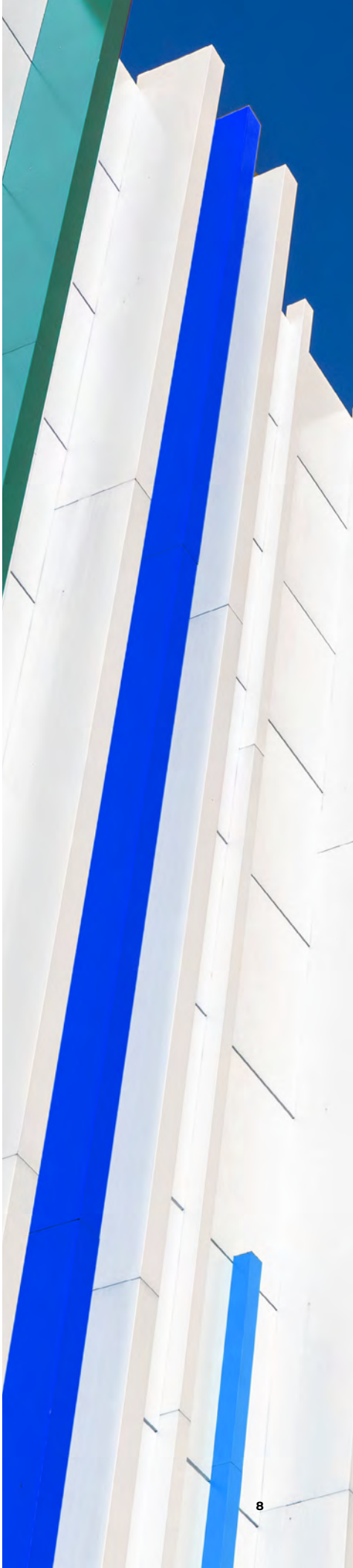
In-network coinsurance	Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.
In-network copayment	A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.
Marketplace	A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.
Maximum Out-of-pocket limit	Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.
Medically necessary	Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.
Minimum essential coverage	Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.
Minimum value standard	A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.
Network	The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.
Network provider (Preferred provider)	A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."
Orthotics and prosthetics	Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.



Out-of-network coinsurance	Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.
Out-of-network copayment	A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.
Out-of-network provider (Non-preferred provider)	A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."
Out-of-pocket limit	The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
Physician services	Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.
Plan	Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

Preauthorization	A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.
Premium	The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.
Premium tax credits	Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.
Prescription drug coverage	Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each “tier” of covered prescription drugs.
Prescription drugs	Drugs and medications that by law require a prescription.
Preventive care (Preventive service)	Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.
Primary care physician	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.
Primary care provider	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.
Provider	An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.
Reconstructive surgery	Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral	A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.
Rehabilitation services	Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.
Screening	A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.
Skilled nursing care	Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.
Specialist	A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Specialty drug	A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.
UCR (Usual, Customary and Reasonable)	The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.
Urgent care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



Premera Blue Cross Blue Shield of Alaska : F3T HSA Qualified Plus Aggregate NGF

Coverage for: Individual or Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-508-4722 (TTY: 711) or visit us at www.premera.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-508-4722 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Calendar year aggregate deductible. $2,000 Individual / $4,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Does not apply to Preventive care, services listed below as "No charge"	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $3,500 Individual / $7,000 Family, Out-of-network: $7,000 Individual / $14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.premera.com or call 1-800-508-4722 for a list of network providers.	You pay the least if you use a provider in the Preferred network. You pay more if you use a provider in the Participating network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	60% coinsurance	None
	Specialist visit	20% coinsurance	60% coinsurance	None
	Preventive care/screening/ immunization	No charge	60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Prior authorization is required for some outpatient imaging tests. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.premera.com/documents/052149_2027.pdf	Preferred generic drugs	$15 copay/prescription (retail), $37.50 copay/prescription (mail)	$15 copay/prescription (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail)-Retail pharmacies: One copay for each 30 day supply. No charge for specific preventive drugs. Prior authorization required for some drugs. Medical deductible applies
	Preferred brand drugs	$30 copay/prescription (retail), $75 copay/prescription (mail)	$30 copay/prescription (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail)-Retail pharmacies: One copay for each 30 day supply. Prior authorization required for some drugs. Medical deductible applies
	Preferred specialty drugs	$50 copay/prescription	Not covered	Covers up to a 30 day supply.Prior authorization is required for some drugs. Medical deductible applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred generic drugs Non-preferred brand drugs Non-preferred specialty drugs	Non-pref generic: 30% coinsurance Non-pref. brand: 30% coinsurance Non-pref. specialty: 30% coinsurance	Non-pref generic: 30% coinsurance (retail), not covered (mail) Non-pref. brand: 30% coinsurance (retail), not covered (mail) Non-pref. specialty: Not covered	Non-pref. generic and non-pref. brand: Covers up to a 90 day supply (retail and mail). Non-pref. specialty drugs: Covers up to a 30 day supply. Prior authorization is required for some drugs. Medical deductible applies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center: 10% coinsurance All Other: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Prior authorization is required for some services. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	Ambulatory Surgery Center: 10% coinsurance All Other: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Hospital-based: 20% coinsurance Freestanding center: 60% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Physician/surgeon fees	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	60% coinsurance	None
	Inpatient services	20% coinsurance	60% coinsurance	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
If you are pregnant	Office visits	No charge	60% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	Birth Center: 10% coinsurance All Other: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	
	Childbirth/delivery facility services	Birth Center: 10% coinsurance All Other: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Limited to 130 visits per calendar year.
	Rehabilitation services	Outpatient: 20% coinsurance Inpatient: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Limited to 45 outpatient professional visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Habilitation services	Outpatient: 20% coinsurance Inpatient: 20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Limited to 45 outpatient professional visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Skilled nursing care	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Limited to 60 days per calendar year. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Durable medical equipment	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Prior authorization is required for purchase of some durable medical equipment. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence.
	Hospice services	20% coinsurance for Preferred/40% coinsurance for Participating	60% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	Limited to one exam per calendar year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses: Limited to one pair per calendar year. Frames and lenses. Limited to one pair per calendar year (under age 19).
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Cosmetic surgery	• Infertility treatment	• Weight loss programs
• Dental care (Adult)	• Long-term care	

Other Covered Services (Limitations may apply to these services. **This isn't a complete list.** Please see your plan document.)		
• Acupuncture	• Foot care	• Non-emergency care when traveling outside the U.S.
• Chiropractic care or other spinal manipulations		• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. For church plans and all other plans, call 907-269-7900 or 1-800-467-8725 for the state insurance department, or the insurer at 1-800-508-4722 or TTY: 711. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-508-4722 or TTY: 711, or the state insurance department at 907-269-7900 or 1-800-467-8725, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-508-4722.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-508-4722.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-508-4722.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-508-4722.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The **plan's** overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,560

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The **plan's** overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The **plan's** overall deductible	$2,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,910

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Notice of availability and nondiscrimination 800-508-4722 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala'au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍ່ວິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍ່ວິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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 Ave 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.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Dental Coverage

Alaska Public Broadcasting Health Trust

Group Number: 4003399

Effective Date: 01/01/2027

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN	2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual Deductible	$50	Shared with In Network
Family Deductible	$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$1,500 PCY applies to basic and major services	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full

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DENTAL PLAN	2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays & Crowns (Replacement once per tooth, every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (Replacement once every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		
Implant Crowns (Replacement once per tooth, every 5 calendar years)	Deductible, then 50%	Deductible, then 50%

Highlights of your Dental Coverage

Alaska Public Broadcasting Health Trust

Group Number: 4003399

Effective Date: 01/01/2027

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DENTAL PLAN	2027 DENTAL OPTIMA 0%/20%/50%/$1,500/ENHANCED + ANNUAL MAX WAIVER	
	IN-NETWORK	**OUT-OF-NETWORK**
Implant Bridge and Denture (Replacement once every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

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Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala'au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
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Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
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Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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037398 (07-05-2024)

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

P.O. Box 91059
Seattle, WA 98111-9159

Waiver of Coverage

1. EMPLOYEE INFORMATION

Group/employer name		Group number	
Alaska Public Broadcasting Health Trust		4003399	
Employee name	**Employee date of birth**	**Gender**	**Number of hours worked per week**
		☐ Male ☐ Female	

2. WAIVER CONFIRMATION

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

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

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

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

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

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

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

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

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

3. EVIDENCE OF OTHER GROUP COVERAGE

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

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

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

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

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

4. EMPLOYEE SIGNATURE

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

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

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

X	Date

An Independent Licensee of the Blue Cross Blue Shield Association

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) - Station	Employee Date of Termination OR Employee Date of Hire
4003399	Alaska Public Broadcast Health Trust		/ /

Enrollment Reason	If COBRA, indicate number of months eligible for coverage:	Date of enrollment details	Plan end date OR Plan start date
	☐ 18 months ☐ 29 months ☐ 36 months	☐ Same as hire date ☐ Other 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

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-016756-00

Employer/Policyholder Name _____

Street Address _____ City _____ State _____ Zip Code _____

Employee Occupation/Job Title _____ Employee Date of Employment _____

Effective Date of Coverage _____ ☐ Full Time Employee ☐ Part Time Employee

$_____/ ☐ HR ☐ WK ☐ MO ☐ YR Basic Earnings _____ Class Number (if applicable) _____

I. EMPLOYEE/ENROLLEE INFORMATION

Name _____ Sex M F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____ Marital Status _____

II. BENEFITS (Please check if you wish to enroll)

Please contact your HR representative with any questions

	Yes	No	Indicate the benefit amount
Employee Life	X		
Employee AD&D	X		

III. BENEFICIARY DESIGNATION

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.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ ☐					
☐ Primary ☐ Contingent					

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature: _____ Date Signed: _____

SYMETRA
RETIREMENT | BENEFITS | LIFE

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

CHANGE OF BENEFICIARY DESIGNATION

Please attach to original enrollment form

POLICY # _____

EMPLOYER/POLICYHOLDER NAME _____

EMPLOYEE INFORMATION

NAME **PHONE NUMBER**

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

PRIMARY BENEFICIARY(IES):

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

CONTINGENT BENEFICIARY(IES):

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

NAME **DATE OF BIRTH**

ADDRESS

RELATIONSHIP **BENEFIT PERCENT**

DEFINITIONS

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

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

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

EMPLOYEE SIGNATURE **DATE SIGNED**

Symetra® is a registered service mark of Symetra Life Insurance Company.

ALASKA PUBLIC BROADCASTING HEALTH TRUST

TO: Participant in Alaska Public Broadcasting Health Trust Plan

FROM: Kim Pigg, Administrative Manager

DATE: November 16, 2026

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 www.akpb.org then click on health tab.

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.