

Highlights of your Health Care Coverage

Alaska Public Broadcasting Health Trust
 Group Number: 4003399

Effective Date: 01/01/2023

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		2023 HERITAGE PLUS HSA AGG \$2,000/20%/ \$3,500 W/ESSENTIALS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$2,000 PCY/\$4,000 PCY	Shared with In-Network	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/40% Participating	Hospital and Professional; 60%	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$3,500 PCY/\$7,000 Family PCY	\$7,000 Individual PCY / \$14,000 Family PCY	
Office Visit Cost Share	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital and Professional; 60%	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital and Professional; 60%	
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full	
PROFESSIONAL CARE			
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
APP-BASED VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	

MEDICAL PLAN		2023 HERITAGE PLUS HSA AGG \$2,000/20%/\$3,500 W/ESSENTIALS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
Telemedicine - Outpatient Rehab (Virtual Care Only) (Not Covered)	Not Covered	Not Covered	
Telemedicine - Speech Therapy for Children (Virtual Care Only) (Not Covered)	Not Covered	Not Covered	
Chronic Condition Management (Excluded)	Not Covered	Not Covered	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Out of Network Deductible, then Hospital and Professional; 60%	
Other Professional Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Diagnostic Mammography	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
FACILITY CARE OPTIONS			
Inpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Inpatient Professional Services	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Outpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital and Professional; 60%	
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital and Professional; 60%	
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL CARE COORDINATION AND TRAVEL SERVICES			
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service	
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel	
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Transplants (Unlimited; \$75,000 donor)	Covered as any other service	Not Covered	
Transplant Travel & Lodging (\$7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%	
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: \$35/day; Ferry Transportation \$50 per person each way; Lodging \$50/day per person)	\$2,000 PCY/\$4,000 PCY Deductible, then 0%	\$2,000 PCY/\$4,000 PCY Deductible, then 0%	
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service	
EMERGENCY CARE			
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Urgent Care Center	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60%	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional; 60%	
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional; 60%	
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional; 60%	
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional; 60%	
PHARMACY			

MEDICAL PLAN		2023 HERITAGE PLUS HSA AGG \$2,000/20%/\$3,500 W/ESSENTIALS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers	
Enhanced Preventive Drug List (PV Core)	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
Prescription Drugs - Retail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)	Retail: After Deductible is met \$15/\$30/\$50/30%; Coinsurance is waived.	Retail: After Deductible is met \$15/\$30/\$50/30%; Coinsurance is waived.	
Prescription Drugs - Mail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)	Mail: After deductible is met \$37.50/\$75/\$50/30%; Coinsurance is waived.	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
OTHER SERVICES			
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional; 60%	
SUPPLEMENTAL BENEFITS			
Routine Vision Exam (1 PCY)	Covered in Full	Covered in Full	
Vision Hardware (\$200 PCY)	Covered in Full	Covered In Full	
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered In Full	
Routine Hearing Exam (Not Covered)	Not Covered	Not Covered	
Hearing Hardware (Not Covered)	Not Covered	Not Covered	
ANNUAL PLAN MAXIMUM			
Annual Plan Maximum	Unlimited	Unlimited	

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.

Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premiera 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.

Highlights of your Dental Coverage

Alaska Public Broadcasting Health Trust

Group Number: 4003399

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DENTAL PLAN	2023 DENTAL OPTIMA	
	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

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DENTAL PLAN	2023 DENTAL OPTIMA	
	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
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 and Crowns (1 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 (1 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%

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DENTAL PLAN	2023 DENTAL OPTIMA	
	IN-NETWORK	OUT-OF-NETWORK
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years for surgical implants, implant abutments, and/or implant prosthetics)	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	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

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.

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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, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence 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>.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY: 711)。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Samoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totonu, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 800-508-4722 (TTY: 711).

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 (TTY: 711) まで、お電話にてご連絡ください。

PAKDAAR: Nu sartaem ti llocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.

037379 (07-01-2021)