All Alaska Longshore Health & Welfare Trust

The All Alaska Longshore Health & Welfare Plan has adopted temporary COVID-19 Plan Changes effective February 11, 2020. READ BELOW FOR BENEFIT UPDATES ON TESTING AND PRESCRIPTION.

UPDATES ON WEBSITE – The All Alaska Longshore Benefits website is regularly being updated with information on COVID-19. Also, you are able to obtain all forms from the documents page, and information about your contributions, eligibility, dependents and claims by logging in. If you have never before used the website, you may contact the Trust Office for your login credentials.

Interim COVID-19 Benefit for the Self-Funded Retiree Health Plan

The Board of Trustees of the All Alaska Longshore Health & Welfare Trust ("Trust") approved an interim COVID-19 Benefit, as summarized below. The benefit improves coverage for testing and related provider visits needed for the test. This enhanced coverage is effective February 11, 2020 and is scheduled until the crisis abates. You will be notified when the COVID-19 Benefit Period ends.

Testing

Self-Funded retirees who are Medicare eligible will have COVID-19 testing covered by Medicare. For non-Medicare Participants, the coverage changes are as follows:

- All member cost sharing (deductibles, copays, coinsurance) will be waived for the interim COVID-19 Benefit with no pre-approval necessary. The COVID-19 Benefit includes the following, if medically necessary: provider ordered medically approved COVID-19 testing; provider visit for the test, associated lab testing and radiology services in a hospital, emergency or urgent care setting, or medical office; follow-up tests and provider visits for tests. All other treatments and services, including hospitalization costs and prescriptions, continue to be subject to the usual benefit limitations and costs shares.

Prescriptions

- Effective immediately, allow participants to obtain a one-time refill of their covered prescription medications (except opioids) prior to the expiration of the waiting period between refills. To obtain an emergency override, participants must contact their pharmacist or Express Scripts to obtain an override with an explanation they are ill or quarantined due to COVID-19.

Telemedicine Visits

Medicare has broadened access to telemedicine services so that participants may receive a wider range of services from the doctors without having to travel to a healthcare facility. For non-Medicare Participants, the coverage changes for telemedicine are as follows:

- Effective March 23, 2020, if you seek medical care remotely via phone and/or video directly with a provider, claims will be paid similarly to an in-person office visit with usual limitations and cost shares subject to the terms and conditions set forth in the Summary Plan Description.

COVID-19 Symptoms

The COVID-19 virus is not fully understood at this time. The Centers for Disease Control and Prevention (CDC) states that coronavirus symptoms may appear in as few as two days, or as long as 14 after exposure. Symptoms can vary by person, usually starting with a fever, followed by a dry cough. Some individuals may have some or none of the symptoms. In some cases, the symptoms may progress to severe acute respiratory infections.

Trust members who may have been exposed to COVID-19 or who have symptoms, such as coughing or a fever, are encouraged to contact their healthcare provider. But, before going into a doctor's office or emergency room, call ahead and tell the facility about the symptoms and any recent travel.

Prevention

The CDC guidelines have indicated the same behaviors that will help prevent the spread of cold and flu will also help prevent COVID-19. These behaviors include:

- Avoid close contact with sick people.
- Stay home when you are sick. Respect others by minimizing exposure.
- Cover your mouth and nose when coughing or sneezing.
- Clean your hands. Wash with soap and water frequently or use alcohol-based hand sanitizer.
- Avoid touching your eyes, nose and mouth.
- Get plenty of sleep, eat nutritious food, drink plenty of fluids and get regular exercise.

Questions?

If you have questions about this new benefit, please go to www.alaskalongshorebenefits.org for complete information about Plan benefits, eligibility, dependents and claims. Updates on the response to COVID-19 will be made onto the announcement section of the website.

All Alaska Longshore Health & Welfare Trust

November 1, 2018

SUMMARY OF MATERIAL MODIFICATION

AMENDMENT TO THE PPO PLAN
AND SUMMARY PLAN DESCRIPTION
FOR ALL ALASKA LONGSHORE SELF-FUNDED
RETIREE HEALTH PLAN

(January 2013)

PLEASE KEEP THIS DOCUMENT WITH YOUR BENEFIT BOOKLET

Vision Benefit

Effective January 1, 2019, the vision benefit limit will be increased from 80% of the cost of a vision exam and hardware up to $150 per year to 80% of the cost of a vision exam and hardware up to $300 per year. All other limitations and requirements are subject to the same terms and conditions as described in the January 2013 Summary Plan Description.

If you have any questions about this notice, please contact the Trust Administrative Office at 1-(800) 547-4457 or email ibu@benesys.com.

PMB #116 · 5331 SW Macadam Avenue Suite 258, · Portland, OR 97239
(503) 224-0048 (800) 547-4457 Fax (503) 228-0149
www.AlaskaLongshorebenefits.org

September 2016

Summary of Material Modification
Please keep this notice with your benefit book

The Board of Trustees has made modifications to the All Alaska Longshore Self-Funded Retiree Health and Welfare Summary Plan Description (SPD), Plan booklet which was effective January 1, 2013. The following identifies changes to the Trust's Transportation Benefit, Medicare Part B reimbursement and the addition of dental and vision benefits that were effective July 1, 2015.

The information described below replaces or changes certain information in your Summary Plan Description (SPD). You should review this information and keep this notice of Summary of Material Modifications with your SPD. If you have a spouse or dependents(s) enrolled, you should review this information with them as well.

Pages 7 & 8 of the SPD are replaced with the following:

TRANSPORTATION BENEFIT

Effective July 1, 2015, transportation (travel reimbursement) benefits will be provided to eligible retirees and dependents based on the following provisions.

Benefit Amount

The Plan will reimburse you up to an amount equal to the round trip coach airfare between Dutch Harbor, Alaska and Portland, Oregon. Additionally, the Plan will reimburse you for incidental travel expenses up to $100 per day, up to a $500 maximum, to pay for car rental, lodging, food, etc.

- When you travel by common carrier, such as by air, rail, or steamship line, the Trust will reimburse you for the fare (but no more than the cost of traveling by plane between Dutch Harbor and Portland and back).

- When you travel by car, you will be reimbursed for gas and oil expenses (but no more than the cost of traveling by plane between Dutch Harbor and Portland and back).

- The patient and an authorized escort will each receive their own separate per diem reimbursement.

In the case of medical need, you may be reimbursed for the cost of travel that is higher than the cost of traveling from Dutch Harbor to Portland and back. In

these cases, you must provide evidence of the need to the Trustees, and you must receive approval from the Trustees before you travel.

When applying for your benefit, please be sure to submit receipts for all expenses to be reimbursed because the Trust will only reimburse for actual expenses incurred.

Necessary Escorts

If your doctor certifies that an escort is necessary, travel benefits and related incidental expenses will be paid to the escort (subject to the limitations described above). Possible reasons for having an escort would be if the patient is too young or too sick to travel alone. The doctor need only prescribe that an escort is necessary. The choice of the escort is left to you.

Benefit Requirements

Your or your dependent's attending doctor in Alaska must certify that the necessary care is not available in your home community, and the certification/referral must show the out-of-area licensed doctor, dentist or medical facility that will be providing the service. You or your dependent must be placed under care as soon as possible after arriving at the designated location.

Transportation Benefit Limitations and Exclusions

The transportation benefit will not pay for the following charges:

- Travel necessitated by pregnancy, unless you receive approval to travel from the Trustees before you travel.

- Travel to obtain eye examination for glasses.

The following replaces page 20 of the SPD.

MEDICARE PLAN BENEFITS

Benefits If Eligible For Medicare

The following summarizes the benefits available for a retiree or a surviving spouse upon attaining Medicare eligibility:

Medicare Part A

- Effective 1/1/2013, the plan pays up to $1,184 of Medicare's Part A Deductible. The amount of $1,184 is indexed to increase each year as the amount of Medicare's Part A deductible increases.
- Effective 1/1/2013, the plan pays up to $296 per day for 61st - 90th day of hospitalization. The amount of $296 is indexed to increase each year as the amount of Medicare's copayment for hospitalization increases.
- Effective 1/1/2013, the plan pays up to $592 per day from 91st until Medicare Lifetime Reserve is exhausted. The amount of $592 is indexed to increase each year as the amount of Medicare's copayment for hospitalization increases.
- Plan pays all costs after Medicare Lifetime Reserve is exhausted.

Medicare Part B

- The Plan pays up to $100 of Medicare's Part B Deductible. The amount of $100 is indexed to increase each year as the amount of Medicare's Part B deductible increases.
- Plan pays 20% of the Reasonable and Customary Charges for Medicare's Part B covered expenses.
- Home Health Care, subject to 80% of yearly maximum of $1,000 for home health care.
- Plan pays all costs after Medicare Lifetime Reserve is exhausted.

IN ORDER TO OBTAIN THE MOST COMPREHENSIVE COVERAGE,
YOU MUST ENROLL FOR BOTH PARTS A & B OF MEDICARE.

The Plan will reimburse you up to $110 per month per household of your Medicare Part B premium. This is in the form of a monthly check or you may ask for automatic deposit to your bank account. You can obtain the form for automatic deposit online at www.alaskalongshore.aibpa.com or by calling (800) 547-4457.

Dental and Vision Benefits

The Plan provides dental and vision benefits for eligible retirees and their spouses effective July 1, 2015. The covered dental and vision services for participants in the Self-funded Retiree Plan will match the benefits available under the Inlandboatmen's Union of the Pacific National Health Benefit Trust for other plan participants.

A full summary of the available dental and vision benefits is available by contacting the Administration Office. A copy of the IBU Summary Plan Description is also available on-line at http://www.ibu.aibpa.com.

Dental Benefits

In general, the Plan pays 85% of Reasonable and Customary Charges for prophylaxis (dental cleanings), 80% of Reasonable and Customary Charges for preventative and basic services, and 50% of Reasonable and Customary Charges for other dental services. There is no Deductible, but there is a calendar year maximum benefit payment of $2,000 per Covered Individual except the calendar year maximum benefit payment does not apply to Covered Individuals under age eighteen (18).

If you are contemplating dental work in excess of $300, you are encouraged to submit a pre-treatment estimate of the work to be performed. After a dental examination, have your Dentist send a copy of the treatment plan, including the cost of treatment, to the Trust Office. The Trust Office will estimate the benefits available and inform your Dentist.

Vision Benefits

In general, the IBU Plan pays 80% of Reasonable and Customary Charges for covered vision services. There is no Deductible. There is a calendar year maximum benefit payment of $150 per Covered Individual except the calendar year maximum benefit payment does not apply to Covered Individuals under age eighteen (18).

Exclusions Applicable to Dental and Vision Benefits

The Plan has a range of limitations and exclusions that are applicable to covered dental and vision services. Dental and Vision benefits provided to the self-funded retirees under this Plan are also subject to these same exclusions or limitations. A complete listing of such provisions is available in the current IBU Health Plan Summary Plan Description, which is available by contacting the Administration Office or online.

Throughout the Summary Plan Description, all references to “A&I Benefit Plan Administrators, Inc.” or “A&I” are changed to “BeneSys, Inc.”. There is no change to the address, telephone numbers or website.

If you have questions about the information included in this Summary of Material Modifications or otherwise have questions in connection with this Health Plan, please contact the Trust Administrative Office.

Sincerely,

All Alaska Health and Welfare Trust

All Alaska Longshore Health & Welfare Trust

June 2014

SUMMARY OF MATERIAL MODIFICATIONS
SELF FUNDED RETIREES
EFFECTIVE MAY 8, 2014

Dear Plan Participant:

The Board of Trustees of the All Alaska Longshore Health & Welfare Trust met on May 8, 2014. The Board is pleased to announce a benefit Improvement as described below. Please keep a copy of this document with the January 1, 2013, benefit booklet previously mailed to you last summer.

BENEFIT ENHANCEMENT

Effective May 8, 2014, the Trust has increased the life insurance benefit for the self funded retirees from $7000 to $17,000. (This does not pertain to surviving spouses.)

- Do you have a current beneficiary form on file? If you do not have a valid form on file, the Trust will pay in the following order:

  Spouse, children, parents, siblings, your Estate.

Retiree Medicare Part B Reimbursement

The following section is to clarify the Medicare Part B reimbursement listed on page 20 of your benefit booklet. This shall now state; "The Plan will reimburse the retiree or surviving spouse up to $100 per month for your Medicare Part B premium. This is in the form of a monthly check or you may ask for auto deposit into your bank account."

Should you have any questions after reviewing the book, please contact the Trust Office at either 1-800-547-4457 or 503-224-0048 extension 1922.

Sincerely,
The Trust Office

All Alaska Longshore
Self Funded Retiree Health Plan

Summary Plan Description

January 1, 2013

The only party authorized by the Board of Trustees to answer questions about your health and welfare plan is the Trust Administrative Office, A&I Benefit Plan Administrators, or the Board of Trustees (as a whole group, not individually). No participating employer, labor organization, or any individual employed by any of these organizations has the authority to answer questions about this health and welfare plan.

Table of Contents

INTRODUCTION

ALASKA LONGSHORE RETIREE HEALTH PLAN

For Retired Employees & Dependents Formerly Covered by the Pacific Northwest-Alaska Health Benefits Trust

IMPORTANT NOTICE

Purpose of the Plan

This Plan was established by the Trustees to specifically cover only

- Certain retirees and Dependents who had previously been covered by the Pacific Northwest Alaska Health Benefits Trust; and

- Such other retirees and Dependents who will retire under the established eligibility rules of the Pacific Northwest Alaska Health Benefits Trust before June 30, 1999.

Benefit Coverage

The benefits outlined in this summary plan description are the only benefits provided to covered retirees and Dependents.

Any other benefits previously covering such participants shall no longer be in effect.

Funding of the Plan

This Plan has been specifically funded only to the extent that monies have been allocated by the collective bargaining parties.

Such coverage shall continue only so long as the collective bargaining parties make necessary funding provisions. The Board of Trustees further retains the full and exclusive authority, in its discretion, to determine the extent to which these funds shall be available for this or alternate coverage, and shall also determine how such coverages shall be paid for.

Furthermore, the Board of Trustees reserves the right, upon proper notification, to modify, amend, or terminate this Plan as required.

ALASKA LONGSHORE HEALTH & WELFARE TRUST

BOARD OF TRUSTEES

Employee Trustees

Alan Coté
Peter Danelski
Patrick Day
Chuck Wendt

Employer Trustees

Marion Davis
Jeff Bentz
Gene Makarin
Jim Taro

Trust Administrative Office

A&I Benefit Plan Administrators, Inc.
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
(503) 224-0048 or (800) 547-4457

Legal Counsel

Bruce McKenzie, Esq.
McKenzie, Rothwell Barlow & Coughran, P.S.

Consultant

Milliman

Only the Trust Administrative Office, A&I Benefit Plan Administrators, 1220 S.W. Morrison Street, Suite #300, Portland, Oregon, represents the Trustees in administering the Plan and giving information relating to the amount of benefits, eligibility, and other provisions of the Plan. No union employee, including union officers and business agents, no employer or employer representative, no representative of any other organization, except the Trust Administrative Office is authorized to give information, interpret the Plan, or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

ELIGIBILITY RULES

As mentioned previously, the group of people referred to under the section (above) entitled “Purpose of this Plan”, shall be the only persons covered under this Plan.

Coverage is provided to retirees if they meet the following:

- Apply for and are receiving both parts A&B of Medicare, when eligible.

Coverage is provided for Dependents if they meet the following:

- The surviving spouse of a deceased pensioner will remain eligible for coverage until his or her death, or remarriage.

- The dependent children of a deceased pensioner will remain eligible for coverage as long as they qualify as a Dependent (see Coverage for Dependent Children below).

Retirees and their spouses who have both parts A & B of Medicare, Medicare will always be primary prior to the All Alaska Longshore Health & Welfare Retiree Plan.

Your benefits under this Plan and those of your spouse will terminate if this plan is terminated.

Please note that the termination of your benefits and those of your spouse for the reasons listed above will also result in termination of your Dependent children’s coverage, if any.

COVERAGE FOR DEPENDENT CHILDREN

Effective January 1, 2011, pursuant to the Patient Protection and Affordable Care Act, eligible children are your natural born or legally adopted children and children placed with you for adoption who are under 26 years of age, irrespective of whether the child lives with you, is married or a student, or is financially dependent on you for support, except that children who are eligible to enroll in a health plan offered by their employer or in a similar health plan offered to their spouse are not eligible to enroll in this Plan.

Children who reach age 26 may be entitled to continue coverage if they are developmentally disabled or physically handicapped, unmarried, chiefly dependent on you for support and incapable of self-sustaining employment. You must provide proof of the child’s disability or handicap no later than thirty-one (31) days after the child reaches age 26.

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a covered Employee who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to dependent coverage under this

Plan. A participant of the Plan may obtain a copy of the procedures governing QMCSO's from the Trust Administrative Office without charge.

CONTINUATION COVERAGE - COBRA

The Plan provides spouse and/or eligible Dependents of retired participants the opportunity to continue their coverage, under the plan, beyond the date that their coverage would otherwise terminate. This complies with the Consolidated Omnibus Budget Reconciliation Act (COBRA) enacted by Congress in 1986.

The following section describes the qualifying events that must occur in order for a spouse or eligible Dependent to exercise their right under this provision. It will also explain the obligations of those spouse/Dependents who elect to continue their coverage through COBRA. Please review this important provision with your spouse or eligible Dependent(s), if applicable.

Qualifying Events

Spouse/Dependent Children

The Retiree's spouse or Dependent children of a participant of this Retiree Plan may elect continuation health coverage for up to a maximum of thirty-six (36) months if there is loss of Plan coverage due to the following qualifying events:

- Death of the Retiree
- Divorce or legal separation

(In the case of the death of the retiree, Plan coverage continues, provided the spouse does not remarry.)

If the spouse remarries within 36 months after the retiree's death, however, the Dependent child may elect continuation coverage for up to 36 months after the retiree's death.

Dependent Children

Dependent children of a participant in the All Alaska Longshore Health & Welfare Retiree Plan may also elect continuation health coverage for up to a maximum of thirty-six (36) months if there is a loss of coverage because they cease to be "eligible Dependents" under the Plan.

Continuation Coverage Obligations

It is the responsibility of any eligible spouse or any eligible Dependent children to inform the Trust Administrative Office of a death of a retiree, divorce, legal separation or child losing Dependent status.

It is ***imperative*** that the Trust Administrative Office be notified within 60 days after the date plan coverage ceases or the date of the specific qualifying event, whichever is later, as this is the only way to initiate continuation coverage.

When information is received concerning the occurrence of the qualifying event the Trust Administrative Office will send to the person(s) affected a Notice of Continuation Coverage rights. This Notice will provide information on the cost of continuation coverage. If you desire to elect continuation coverage, you are required to file a COBRA election form with the Trust Administrative Office within sixty (60) days from the date he/she would lose health coverage or 60 days from the date of notification from the Trust Administrative Office whichever is later, to elect COBRA Coverage. Once coverage has been elected, he/she has 45 days in which to make the first payment. This payment must be for all prior months starting on the first day of the first month that qualified you for COBRA Coverage. Failure to elect COBRA Coverage or make the payments within that period will cause group health coverage to end as it normally would under the terms of the Plan.

The Trust is required to offer continuation coverage that is identical to that provided under your Plan to retirees, spouses, Dependent children and surviving spouses. Note that coverage under your Plan changes when you become eligible (even though not enrolled) for Medicare; continuation coverage (and, if appropriate the premium charged for continuation coverage) will correspondingly change upon attaining eligibility for Medicare.

The continuation coverage periods described above are the maximum available coverage periods. Continuation coverage terminates before the maximum coverage period expires for any of the following reasons:

- The self-payment for your continuation coverage is not paid in a timely manner.
- You become covered under another group health plan.
- Your Plan terminates.
- For any other reason that would terminate Plan coverage for a retiree, spouse, Dependent child, or surviving spouse who is not receiving continuation coverage.

Making Monthly Payments

You do not have to show that you are insurable to choose COBRA continuation coverage; however, you are responsible for self-payments for your coverage. You will have a grace period of 30 days to pay the self-payment.

The Board of Trustees has adopted procedures for continuation coverage based on its interpretation of the law as it is known at this time. The Board reserves the right to make any changes it deems appropriate or as required by law.

If you have any questions about COBRA coverage, please contact the Trust Administrative Office. Also, ***if you have changed marital status or if you or your spouse have changed addresses, please notify the Trust Administrative Office:***

A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205
(503) 224-0048 or (800) 547-4457

TRANSPORTATION BENEFIT

Effective December 1, 2011, transportation (travel reimbursement) benefits will be provided to eligible retirees and their eligible dependents.

Benefit Amount

The Plan will reimburse you up to an amount equal to the round trip coach airfare between Dutch Harbor, Alaska and Portland, Oregon. Additionally, the Plan will reimburse you for a per diem of $50 per day, up to a $250 maximum, to pay for car rental, lodging, food, etc.

- When you travel by common carrier, such as by air, rail, or steamship line, the Trust will reimburse you for the fare (but no more than the cost of traveling by plane between Dutch Harbor and Portland and back).

- When you travel by car, you will be reimbursed for gas and oil expenses (but no more than the cost of traveling by plane between Dutch Harbor and Portland and back).

- The patient and an authorized escort will each receive their own separate per diem reimbursement.

In the case of medical need, you may be reimbursed for the cost of travel that is higher than the cost of traveling from Dutch Harbor to Portland and back. In these cases, you must provide evidence of the need to the Trustees, and you must receive approval from the Trustees before you travel.

When applying for your benefit, please be sure to submit receipts for all expenses to be reimbursed.

Necessary Escorts

If your doctor certifies that an escort is necessary, travel benefits and a per diem allowance will be paid to the escort. Possible reasons for having an escort would be if the patient is too young or too sick to travel alone. The doctor need only prescribe that an escort is necessary. The choice of the escort is left to you.

Benefit Requirements

Your or your dependent's attending doctor in Alaska must certify that the necessary care is not available in your home community, and the certification/referral must show the out-of-area licensed doctor, dentist or medical facility that will be providing the service. You or your dependent must be placed under care as soon as possible after arriving at the designated location.

Transportation Benefit Limitations and Exclusions

The transportation benefit will not pay for the following charges:

- Travel necessitated by pregnancy, unless you receive approval to travel from the Trustees before you travel.

- Travel to obtain eye examination for glasses.

LIFE INSURANCE

For Retirees Only

The Plan provides a life insurance benefit for you. Effective January 1, 2013, the life insurance benefit is $7000.00. The benefit is for the retiree only.

Beneficiary

Life insurance benefits will be paid to the person (or persons) you named in your beneficiary designation. You may name or change beneficiaries at any time. You do not need the consent of a named beneficiary to change beneficiaries.

The beneficiary designations will be kept on file at the Trust Administrative Office (A&I) and they will take effect on the date the Trust Administrative Office receives the designation.

If the beneficiary(ies) you name dies before you, or if you do not designate a beneficiary, the benefit will be paid, in the following order, to:

- Your spouse;
- Your children;
- Your parents;
- Your brothers and sisters;
- Your Estate

SUPPLEMENTAL PLAN

The Supplemental Plan is a vital part of your Plan, which allows you to reimburse yourself for health care expenses that are not covered by insurance.

Eligibility

To be eligible for the $5,000 Supplemental Plan benefit, you must be either the retiree or a surviving spouse.

How the Supplemental Plan Works

January 1 of each year the Plan will establish a Supplemental Plan Account in your name and deposit up to a maximum of $5,000 in the account.

1. The money in your Supplemental Account will be used to reimburse you for out-of-pocket health care expenses. (See the list below for the types of expenses eligible for reimbursement.) Whenever a medical claim is processed by the Plan on your behalf or on behalf of your enrolled dependent and there is a balance due to the provider after payment by Medicare and the Plan, a check will automatically be issued to you for the out-of-pocket amount as long as there are sufficient funds in your Supplemental Account.

2. As you are reimbursed for out-of-pocket expenses, the amount you are reimbursed is deducted from your Supplemental Account until you have used up the $5,000.

3. The following January 1, if you have eligibility, the Plan will deposit up to $5,000 into your Supplemental Plan Account again. Since you may not use the entire $5,000 in a year, the Plan will deposit whatever amount is necessary so that your January 1 Supplemental Plan Account balance once again equals $5,000. You have 30 days after the Supplemental Plan Accounts are funded (January 31st) to submit claims for the prior period.

4. All manual claims must be submitted within 12 months of the date of service.

How to Claim Money from Your Supplemental Account

Anytime a claim is processed a check will automatically be issued from your supplement account for the covered portion of the claim that is the “participant’s responsibility”, including co-pays, deductibles and coinsurance.

For prescription co-payments and certain medical, dental and vision expenses that are not covered by the Plan, you must complete a **Reimbursement Form** and send the completed form, along with a copy of the itemized bill, co-payment receipt and the Explanation of Benefits (EOB) from Medicare and the Alaska Longshore Self-Funded Retiree Health Plan to the Trust Administrative Office for reimbursement.

Do not use the Reimbursement Form for medical co-pays, deductibles or coinsurance. These out-of-pocket items are handled automatically when your claims are processed by the Trust Administrative Office.

The Supplemental Account **cannot be used for reimbursement of prescription drug purchases made without the use of your Express Scripts Prescription ID card.** Your prescriptions are paid for/reimbursed by your Pharmacy Benefit Manager, **Express Scripts**. You may request reimbursement for your prescription co-pays using the Reimbursement Form as described above.

Payment from your Supplemental Account can occur only if there are funds in the account at the time the claim is filed. If there are no funds in your Supplemental Account at the time the claim is filed, and subsequent funds are deposited into your Supplemental Account, these new funds cannot be used to pay claims that were previously submitted and denied due to lack of funds.

All Supplemental Account funds are made payable to the participating retiree or surviving spouse and it is the responsibility of the participating retiree or surviving spouse to disburse these funds to any providers. The Trust Office cannot issue checks from the Supplemental Account to anyone other than the participant.

You must be covered by the Plan during the month that services are rendered in order to use your Supplemental Account.

Eligible Expenses

You may use the Supplemental Account to reimburse any services covered under the medical or prescription drug plan (retail and mail order), including:

- Deductible;
- Coinsurance;
- Co-pays;
- Amounts over the Reasonable and Customary Charges;
- Amounts over specific plan limits.

You may use the Supplemental Plan account to reimburse any services covered under the medical, dental and vision expenses, not covered by the plan, such as:

- Hearing aids;
- Orthopedic shoes or other supportive devices;
- Weight loss treatment;
- Eye refractions or the fitting or cost of eyeglasses;
- Services not covered by Medicare;
- Dental care.

If you have other medical coverage that is secondary to Medicare, use a claim form to submit balances to be paid by your Plan and include copies of your EOB's from Medicare and your secondary insurance.

Do not use the Supplemental claim form to submit medical bills that need to be processed as medical claims.

Please note that you cannot be enrolled in more than one prescription drug plan. Please notify the Trust Administrative Office immediately if you are.

Claim forms are available online at www.alaskalongshore.aibpa.com, or by calling the Trust Administrator Office at (800) 547-4457.

CLAIM FILING AND CLAIM REVIEW

How to File a Medical Claim

The Trust wishes to provide the fastest possible claims service. By following the steps shown below when filing a claim, prompt service will be assured.

- Obtain itemized hospital or doctor bills, listing all services and treatments you have received. Also obtain the Medicare Explanation of Benefits (EOB) if you are on Medicare.

- Bills must be submitted within 90 days after claims expense is incurred. Failure to furnish notice or proof within 90 days will not necessarily invalidate or reduce any claim if it can be shown that notice or proof of incurred claims expense was given as soon as reasonably possible. Failure to furnish notice of proof within one (1) year will invalidate any claim.

- Forward your itemized bills and Medicare Explanation of Benefits, if any, to:

A&I Benefit Plan Administrators
1220 SW Morrison, Suite 300
Portland, OR 97205
(503) 224-0048 or (800) 547-4457

PLEASE BE SURE TO INCLUDE THE PARTICIPANT'S (RETIREE'S) SOCIAL SECURITY NUMBER OR GROUP AND ID NUMBER ON ALL BILLS.

- Obtain and complete a claim form only to report changes in address or other insurance.

If your claim is incomplete for any reason, processing of your claim may be suspended until complete information is provided, subject to the rules described below.

Direct Payments

Any benefits payable to a provider or for covered health and accident services which you have assigned will be paid to the hospital or the provider of the services. If you have not assigned the benefits, the Plan will pay you.

Any other benefits will be paid to you except that benefits unpaid at your death may be paid, at the Plan's option to:

- Your beneficiary; or
- Your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than $1,000, the Plan may pay up to $1,000 to any relative of yours who the Plan finds is entitled to the benefit.

Any payment made in good faith will fully discharge the Plan to the extent of payment.

Claim Review Procedure

Procedures to be followed: The procedures specified in this article shall be the sole and exclusive procedures available to a participating retiree, beneficiary, or any other person, who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees.

No legal or equitable action for benefits under the Plan shall be brought unless and until the claimant has exhausted the claim procedure set forth below.

Claims should be filed with the Plan Administrator. The Administrator should be contacted for questions regarding claims. Details are set forth previously in this booklet. Properly filed claims will be processed in accordance with the following:

Post-Service Claims. Any properly filed claim for benefits that is not a "pre-service" or "urgent care" claim as defined below is processed as a post-service claim. A post-service claim ordinarily is processed within 30 days of receipt. This may be extended for an additional 15 days if the Trust Administrative Office determines that the extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the circumstances requiring the extension within the initial 30-day period. If the extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be given at least 45 days from receipt of the notice to provide the required information.

Pre-Service Claims. "Pre-service claims" are claims that the Plan requires to be approved in advance. A pre-service claim is ordinarily processed within 15 days of receipt. This period may be extended for an additional 15 days if the Trust Administrative Office determines that the extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the extension within the initial 15-day period. If the extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of the extension will describe the required information and the claimant will be given at least 45 days from receipt of the notice to provide the required information.

Urgent Care Claims. "Urgent care claims" are claims for medical care or treatment in which a delay in resolving the claim could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or which, in the opinion of a physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the

care or treatment that is the subject of the claim. Urgent care claims are ordinarily processed within 72 hours of when they are received unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, in which case the Plan Administrator, (the Trust Administrative Office) has 24 hours to notify the claimant of the specific information necessary to complete the claim. If additional information is requested, the claimant has 48 hours to provide it. If the requested information is not provided within the 48 hours, the Trust Administrative Office will make its determination based on the information that is available.

Notice of Denial

If a claim is denied, the claimant will receive written notice of the denial, which will include the following information:

- The reason for the denial.
- Reference to the Plan provision relied on.
- A description of any additional material needed for the claim, with an explanation of why it is necessary.
- Reference to any internal rule, guideline or protocol used n denying the claim, with a statement that a copy is available without charge upon request.
- If the denial is based on the service or supply in question being not medically necessary or experimental or a similar exclusion, an explanation of the scientific or clinical judgment on which the denial was based or a statement that such explanation will be provided without charge upon request.
- An explanation of the Plan's appeal procedures, including the applicable time limits.

Appeal Procedure

Where a claim has been denied or partially denied, you may appeal the denial and have a review before the Appeals Review Committee. To appeal a denied claim, you must submit a written request for review within 180 days after you receive written notice that your claim has been denied. Your request must be sent to: The All Alaska Health & Welfare Trust, c/o A&I Benefit Plan Administrators, Inc., 1220 SW Morrison Ave Suite 300, Portland, Oregon 97205.

Your request for review must set forth all the grounds upon which it is based, together with any supporting facts and any other matters which you feel should be considered. You may review any pertinent documents of the Trust in preparing your request for review.

Your request for review will be referred by the Trust's administrative agent to the Appeals Review Committee, which is a committee of the Board of Trustees consisting of not fewer than two Trustees. If the appeal involves a "post-service claim", you may request a hearing before the Appeals Review Committee at which you are entitled to be

present, with a representative of your choice. The hearing will be conducted in accordance with the Trust's Hearing Procedures, a copy of which may be obtained from the administrative office. After consideration of the appeal, the Appeals Review Committee will issue a written decision affirming, modifying or setting aside the original decision on your appeal. If the Appeals Review Committee is unable to render a decision, the question will be referred to the full Board of Trustees for decision. The decision on review will be issued within the time limits described below. The decision will be in writing and will include specific reasons for the decision.

Post-Service Claims In the case of a post-service claim, the Committee will issue its decision within sixty (60) days of the date the appeal was received unless the claimant agrees to a different schedule.

Pre-Service Claims In the case of a pre-service claim, the Committee will issue its decision within thirty (30) days of the date the appeal was received, unless the claimant agrees to a different schedule.

Urgent Care Claims In the case of an urgent care claim, the Committee will issue its decision within seventy-two (72) hours of the time the appeal was received.

A Claimant is required to use all of the procedures set forth above before resorting to any court, tribunal or agency.

NON-MEDICARE PLAN BENEFITS

IF NOT ELIGIBLE FOR MEDICARE

The following summarizes the benefits available for retirees and/or spouse and eligible Dependents, if applicable, who are **NOT** eligible for Medicare.

MAJOR MEDICAL PLAN BENEFITS

• Deductible	$200 per person per year
• Percentage Payable	80% after Deductible
• Maximum Payment-Annually	$2 million (2013) No Maximum (after 2013)

Deductible

The Deductible is $200 per person of eligible expenses in any calendar year.

Expenses used to satisfy the Deductible in the last 90 days of the calendar year may be used to satisfy the Deductible for the next calendar year.

Percentage Payable

After the Deductible is satisfied, the Plan pays 80% of a provider's discounted charges for the remainder of the calendar year up to the Trust's Reasonable and Customary Charges.

Maximum Payment

For any accident or sickness or any combination of them, the maximum payment under the Non-Medicare Plan is $2 million per person per year for all benefits paid (unlimited after 2013).

Covered Services

The following charges are covered by the Plan and paid according to the Plan provisions described in this Plan.

- Hospital charges incurred while an inpatient for:
    - Room and board up to semi-private room charge;
    - Other Hospital services and supplies used while confined in the Hospital.
- Medical services and supplies furnished by the Hospital;

- Treatment received on the day of surgery; and

- Pre-admission tests;

- Skilled Nursing Facility charges to a maximum of 70 days if:

    - Confinement begins within 14 days from the last day of Hospital confinement for which Hospital room benefits are paid for three days or more;

    - For the purpose of receiving care for the condition which caused the Hospital confinement; and

    - Is under the supervision of a physician.

Skilled Nursing Facility benefits described above will be restored for each new period of confinement. A new period of confinement will commence:

- At least 60 days after an eligible person was last confined in a Skilled Nursing Facility; and

- Satisfies the above provisions;

- Charges made by a physician for medical services, surgery, assistant surgery, and anesthesia;

- Charges made by a registered physical therapist or a registered graduate nurse (RN) for private duty nursing services rendered solely for you or your Dependents;

- Charges for local professional ambulance service, and, if the covered injury of sickness requires special and unique Hospital treatment, transportation within the United States or Canada to the nearest Hospital equipped to furnish the treatment not available in a local Hospital, by professional ambulance, railroad or commercial airlines on a regularly scheduled flight;

- Charges for the following additional services and supplies: diagnostic x-ray and laboratory service; oxygen and the rental of equipment for its administration; blood or blood plasma and its administration; radiation and chemotherapy; casts, splints, braces, trusses and crutches; rental (up to the purchase price) of a Hospital type bed, wheelchair or iron lung; artificial limbs and eyes to replace natural limbs and eyes lost while covered under this Plan.

- Charges for treatment by a physician, dentist or dental surgeon of accidental injuries to natural teeth within six months after the accident. The Plan also covers jaw surgery by a physician when medically necessary, subject to all plan exclusions. The Plan does not cover treatment of periodontal or periapical disease or any condition (other than a tumor) involving teeth, surrounding tissue structure.

- Drugs and medicines furnished by a Hospital are paid as Hospital charges.

- Prescription Drugs. The summary of benefits for prescription coverage is outlined on page 22.

Outpatient Mental or Nervous Disorders

After the Deductible is satisfied, the Plan pays 80% of the provider's charges up to the Trust's Reasonable and Customary Charges for covered services.

Chemical Dependency Treatment

The Plan will provide coverage for chemical dependency treatment rendered in or out of a Hospital or treatment center. Medical Necessity must be shown for inpatient care. No benefits for outpatient care by an alcoholism counselor not affiliated with a qualified facility will be considered.

MEDICARE PLAN BENEFITS

BENEFITS IF ELIGIBLE FOR MEDICARE

The following summarizes the benefits available for a retiree and/or spouse upon attaining Medicare age.

Medicare Part A Benefits

- Effective 1/1/2013, the plan pays up to $1,184 of Medicare's Part A Deductible.
- Effective 1/1/2013, the plan pays up to $296 per day for 61st - 90th day of hospitalization.
- Effective 1/1/2013, the plan pays up to $592 per day from 91st until Medicare Lifetime Reserve is exhausted.
- Plan pays all costs after Medicare Lifetime Reserve is exhausted.

Medicare Part B Benefits

- Effective 2/1/2012, the Plan pays up to $100 of Medicare's Part B Deductible.
- Plan pays 20% of the Reasonable and Customary Charges for Medicare Part B covered expenses.
- Home Health Care, subject to 80% to yearly maximum of $1,000 for home health care.

IN ORDER TO OBTAIN THE MOST COMPREHENSIVE COVERAGE, YOU MUST ENROLL FOR BOTH PARTS A & B OF MEDICARE.

Plan will reimburse you up to $100 per month for your Medicare Part B premium. This is in the form of a monthly check or you may ask for auto deposit to your bank account. You can obtain the form for auto deposit online at www.alaskalongshore.aibpa.com or by calling (800) 547-4457.

GENERAL EXCLUSIONS AND LIMITATIONS

Provisions Applicable To All Benefits

The Plan will NOT pay for:

1. Any injury or sickness for which the person on whom the claim is presented has received or is entitled to receive compensation for that particular injury or sickness under any workers' compensation, occupational disease law or similar law, whether or not you elect such coverage or meet the claim filing deadline.

2. Hospitalization, medical or surgical treatment provided by or paid for by the U.S. Government or any instrumentality thereof, except as otherwise required by law.

3. Any loss caused by war or any act of war.

4. Loss incurred while engaged in military, naval or air service.

5. Any expense which is in excess of the Reasonable and Customary Charges.

6. Any expense or service provided by a person who ordinarily resides in your home or is a relative or member of your family.

7. Any expense or charge for any services or supplies not recommended by a legally qualified physician or surgeon, or not medically necessary in treating an accidental bodily injury or sickness.

8. Any expense or charge which an eligible person does not have to pay.

9. Any expense or charge for custodial care.

10. Any loss, expense or charge which results from cosmetic or reconstructive surgery, except:

    - For injuries received while you or a covered Dependent is eligible under the Plan;

    - For repair of congenital defects of newborn children;

    - For repair of defects resulting from surgery for which benefits are paid under this Plan; or
    - For the initial reconstruction of a breast after a mastectomy.

11. Any loss, expense or charge which results from weight control or any treatment of obesity not caused by an organic condition.

12. Any expense or charge for orthopedic shoes or other supportive devices for the feet, whether or not they are considered medically necessary.

13. Any loss, expense or charge for sex transformations.

14. Any treatment related to sexual dysfunction not caused by organic conditions.

15. Any expense or charge for services or supplies which are:

    - Not provided in accord with generally accepted professional medical standards; or
    - For experimental or investigational treatment. Services are considered experimental or investigational if:
        - They require, but have not received, approval of the U.S. Food and Drug Administration; or
        - They have not been the subject of a favorable study published in the peer review medical literature. Peer review medical literature means a U.S. scientific publication which requires that manuscripts be submitted to acknowledged experts inside an outside the editorial office before publication for their considered opinions or recommendations regarding publication of the manuscript; or
        - They are determined by the Board of Trustees, after consultations with medical advisors, to be in research status and not accepted as a proper course of treatment.

16. Maternity expenses for Dependent children.

17. Tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or diseases of the gingival tissue except as provided under “covered services.”

18. Eye refractions or the fitting or cost of eyeglasses or hearing aids.

19. Nursing expense except as provided under “covered services.”

20. Services not covered by Medicare.

PRESCRIPTION DRUG COVERAGE

Prescription Drug Benefit Schedule for Retirees and Dependents on the Medicare and Non-Medicare Plans

The All Alaska Longshore Health and Welfare Trust has chosen Express Scripts to manage your prescription drug benefit. Only prescriptions purchased at Express Scripts network pharmacies are covered by the Plan, unless you live in an area where a network pharmacy is not available. You must present your Express Scripts member ID card number to the network pharmacy in order to receive coverage.

Effective with prescriptions purchased on or after June 1, 2006, the copayments are as follows:

Retail (30-day supply)

$0 for generic drugs
$20 for brand name drugs
$0 for brand name drugs when no equivalent generic is available

Mail Order (90-day supply)

$0 for generic drugs
$40 for brand name drugs
$0 for brand name drugs when no equivalent generic is available

If you live in an area where a network pharmacy is not available (beyond 20 miles), purchase your medication and send your completed claim form to Express Scripts for reimbursement (mailing address provided on form). You will be reimbursed the actual cost of the medication less the appropriate copayment. All benefit consideration based on cost in US funds. You can obtain claim forms from Express Scripts, as well as find the nearest network pharmacy, by calling **(800) 451-6245**.

If you need medication on an ongoing basis, such as to treat asthma or diabetes, we require you to use the mail order service provided by Express Scripts for convenient and discreet home service delivery. Simply obtain a 90-day prescription from your doctor and complete the Express Scripts mail order form and mail both to Express Scripts (mailing address provided on form). You can obtain the mail order form from Express Scripts by calling **(800) 451-6245**.

Medicare Part D and Creditable Coverage

Effective **January 1, 2006**, prescription drug coverage from Medicare (Medicare Part D) is available to everyone eligible for Medicare benefits (age 65 or older)**.** All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare for a monthly premium. Your existing prescription drug coverage has been

determined by the Trustees to be *better* than coverage under a Medicare Part D prescription drug plan, and accordingly is considered "creditable coverage" (as good or better than standard Medicare Part D coverage).

Because your existing prescription drug coverage under the All Alaska Longshore Health and Welfare Trust is better than the standard Medicare prescription drug coverage, you should not enroll in a Medicare Part D prescription drug plan and can keep your current coverage under this Trust. Your prescription drug benefits from this Trust will not change as a result of Medicare Part D.

Medicare will subsidize the Trust for offering prescription drug coverage as good or better than the standard Medicare Part D prescription drug plan. If you do enroll in a Medicare prescription drug plan, however, the following will occur:

- You will receive unnecessary dual coverage for prescription drugs from the Medicare prescription drug plan.
- You will pay a monthly Medicare Part D premium for prescription drug coverage that may be inferior to your current benefits.
- The Trust will <u>not</u> receive the Medicare or federal subsidy to maintain or improve your prescription drug or other Trust benefits.

As long as you maintain your retiree status as provided by the rules of the Trust, your prescription drug coverage will continue. <u>If you decide to terminate your prescription drug coverage under this Trust in favor of a Medicare prescription drug plan, please note that you cannot be reinstated</u>.

As noted earlier, your prescription drug coverage qualifies as "creditable coverage". Therefore, in the event you lose coverage under this Trust and wish to enroll in a Medicare prescription drug plan, you will not have to pay a higher premium under the Medicare prescription drug plan (certain conditions apply). For more information, please contact the Trust Fund Office at (503) 224-0048, or write to the All Alaska Longshore Health and Welfare Fund at 1220 SW Morrison, Suite #300, Portland, OR 97205.

<u>Covered Prescription Drugs</u>

The prescription drug program covers the following:

1. Prescription drugs which are those medicinal substances that require, by law, a prescription that authorizes the dispensing of such substances from a pharmacist to a patient. These prescriptions can only be filled by a licensed pharmacist.

2. Non injectable legend drugs. Exceptions: See exclusion listed below.

3. Insulin.

4. Pre-natal vitamins for use by pregnant participating employees and spouses.

5. Diabetic supplies including disposable insulin syringes and needles, disposable blood/urine, glucose/acetone testing agents (eg. Chemstrips, Diastix Strips and Test Tape), lancets and lancet devices, alcohol swabs and glucose elevating agents, not to include adhesive tape, cotton balls, antiseptics or other common first aid supplies).

6. Compound medication of which at least one ingredient is a legend drug.

Exclusions - Prescription Drug Program

1. Oral contraceptives and contraceptive devices.

2. Vitamins, minerals, nutritional or dietary supplements, calcium supplements, except pre-natal vitamins taken during pregnancy. Pre-natal vitamins only covered for participating pregnant employees and spouses, not covered for Dependent children that are pregnant.

3. Drugs or medicines procured or procurable without a physician's written prescription, including over-the-counter drugs.

4. Injectable band syringes (other than insulin syringes).

5. Drugs whose purpose is to measure or enhance fertility or treat infertility.

6. Drugs prescribed for dermatological or cosmetic purposes or to promote hair growth, (i.e., Rogaine, Retin A for patients over age 29, Minoxidil).

7. Therapeutic services.

8. Medications for immunizations.

9. Smoking deterrents or treatments.

10. Drugs dispensed by a Hospital, nursing home, clinic, ambulatory surgical center, doctor or other institution.

11. Drugs obtained after coverage has terminated.

12. Drugs prescribed for weight loss or treatment of obesity.

13. Drugs labeled "caution - limited by Federal Law to investigations use" or experimental drugs.

14. Growth Hormone.

15. Injectable drugs (except glucagon and insulin).

16. Levonorgestrel (Norplant).

17. Over-the-counter drugs.

18. Prescription drugs with equivalent products also available as over-the-counter drugs (e.g. Hydrocortisone, Ibuprofen, Diphenhydramine, etc.).

19. Legend diagnostic, testing and imaging supplies.

20. Legend homeopathic drugs

IDENTIFICATION CARD

This Non-Medicare Hospital and physician identification card provides important information for both you and medical providers, such as who to call for questions, and where claims should be mailed. It also lets the providers know that you are a member of the All Alaska Longshore Health and Welfare Retiree Plan.

- Please be sure to fill out the card, and include the **participant's (retiree's**) name (not a family member's name) and the **participant's Social Security Number.**

- Carry your ID card with you at all times. Present it any time you seek medical care.

- If you did not receive, or if you lost your card, please call the Trust Administrative Office at (800) 547-4457 or (503) 224-0048 to request a card.

COORDINATION OF BENEFITS (COB)

In coordinating medical benefits, one plan is determined to have primary responsibility of your medical benefits. The primary program is responsible for paying all its benefits first. Other programs will provide reduced benefits so that total payments made under your combined coverages will not exceed 100% of covered expenses.

The primary program is determined by the following order:

- The program that does not have a COB provision.

- The program covering the person as an active employee.

- The program covering the person as the subscriber.

- The program covering the person as a Dependent.

- If the person is a Dependent child and the natural parents are married and reside together:

- The program covering the parent whose month and day of birth falls earlier in the year.

However, if one of the parents' program does not have this "birthday" rule, then the program covering the father is primary.

- If the parents of the Dependent child are separated or divorced;

- The program of the custodial parent;

- The program of the custodial step-parent;

- The program of the non-custodial parent;

- The program of the non-custodial step-parent;

However, if the court decrees financial responsibility for the Dependent child's health care, the program of the parent with that responsibility is the primary program.

- The program covering the person as a retired or laid-off employee, or Dependent of such person.

- If the above order does not establish the primary program, then the program that has covered the person for the longest period of time is the primary program.

- If none of the above rules determines the order of benefits, the benefits of the plan which covered an employee longer are determined before those of the plan which covered that person for the shorter time.

This provision does not apply to any individual insurance policy or contract an eligible person may have.

SUBROGATION

Third Party Liability

The payment of medical and prescription drug benefits are subject to subrogation under this Plan.

A Covered Individual, upon accepting payment of benefits, agrees to do whatever is necessary to fully secure and protect, and nothing to prejudice, the Plan's rights to subrogation. This provision applies when a Covered Individual incurs Covered Charges which (1) total at least $1000 and (2) result from an Illness or injury for which he or she might have a right of recovery from a third party or his or her own insurance company.

If the Covered Individual received payment for such Covered Charges from a third party or his or her own insurance company, the Plan will be reimbursed by the Covered Individual for all medical and prescription drug benefits paid. Such reimbursement will not exceed (1) the amount recovered by the Covered Individual from the third party or his own insurance company or (2) the amount the Plan paid for the medical benefits. The amount the Plan will be reimbursed may be reduced by a reasonable fee retained by the attorney who assisted in obtaining reimbursement.

After the Covered Individual enters into a settlement agreement or obtain satisfaction of a judgment against the third party that caused the Illness or injury, the Plan will provide no further benefits to the Covered Individual for any Illness or injury caused by the third party that was subject to the settlement agreement.

Recovering Payment

If you bring an action or claim against another person, you must also seek recovery of the benefits paid under this plan. The Plan asserts the right to recover benefits directly from the other person, or from you.

Upon making a claim for benefits from the Plan, you will be required to agree to reimburse the Trust for the full amount of its payments of Plan benefits, less the attorney's fees stated above, up to the full amount that you receive from the third party by judgment or settlement.

Return of Overpayment

If the Board of Trustees or the Trust Administrative Office mistakenly pays a claim for the Covered Individual for which he or she is not entitled or, if the Board of Trustees or the Trust Administrative Office makes a payment to a person who is not entitled, the Board of Trustees has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider of services. The Board of Trustees' right to recovery includes the right to deduct the amount paid by mistake from future benefits of the participating employee or from any Dependent of the participating employee even if the mistaken payment was not made on that family member's behalf.

DEFINITIONS

Board of Trustees or Trustees – Means the person designated in the Trust Agreement together with their successors designated and appointed in accordance with the terms of the Trust Agreement.

Collective Bargaining Agreement – Any agreement in effect between the Contributing Employer and International Longshoremen and Warehousemen Union and any other Collective Bargaining Agreement that provides for the provision of benefits under the Plan. The relevant provisions in the Collective Bargaining Agreement determine the rate at which Contributing Employers contribute to the Plan and on whose behalf contributions are made.

Contributing Employer – an employer who is obligated to make health and welfare contributions to the Plan on behalf of participating employees based on a Collective Bargaining Agreement with the International Longshoremen and Warehousemen Union or Joinder agreement with the Plan.

Covered Charges – charges covered under this Plan.

Covered Person – A Covered Person is any employee or Dependent covered by the Plan.

Dependent(s) – see definition on page 3.

Deductible – the Deductible is the first $200 of covered charges for which the retiree is responsible, per covered person, per calendar year. Any covered charges incurred during the last three months of the calendar year and applied to the Deductible will apply toward the Deductible of the next calendar year.

Health Care Provider(s) – Duly licensed within their geographic area:

- Medical Doctor (MD)
- Doctor of Osteopathy (DO)
- Chiropractic Physician (DC)
- Doctor of Podiatry Medicine (DPM)
- Clinical Psychologist (PhD)
- Licensed Naturopath (ND)
- Licensed Acupuncturist (LAC)
- Clinical social worker or other mental health practitioner.
- Nurse Midwife, who is licensed by the state.
- Registered Physical or Occupational Therapist, who is licensed by the state as a Physical Therapist of Occupational Therapist.
- Speech Therapist; someone who (1) has a master's degree in speech pathology; (2) has completed an internship; and, (3) is licensed by the state in which he or she performs his or her services, if that states requires licensing.

- Legally qualified Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education; and works for a clinic or for a physician who is an MD or DO.
- Nurse Practitioner (Certified)

Hospital – a facility legally operating as a Hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians; and
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses;
- In no event will a "Hospital" be:
  - An institution or facility which is run mainly as a rest, nursing, or convalescent home; residential treatment center; or health resort.
  - An institution or facility to provide hospice care for terminally ill patients.
  - An institution or facility for the care of the elderly.
  - An institution or facility for the treatment of chemical dependency or tuberculosis.

Illness – means a disorder or disease of the body or mind; or an accidental bodily injury or pregnancy. All Illnesses due to the same cause, or to a related cause, will be deemed to be one Illness.

Medical Necessity – those covered services and supplies which are determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of an Illness, accidental injury, or condition harmful or threatening to the covered person's life or health, unless provided for preventative services when specified as covered under this plan.
- Appropriate and consistent with the diagnosis as specified in accordance with authoritative medical or scientific literature.
- Not primarily for the convenience of the patient, the patient's family, the patient's physician, or another provider.
- The least costly of the alternative supplies or levels of service which can safely be provided to the patient.
- Not primarily for research or date accumulation.
- The fact that the covered services were furnished, prescribed, or approved by a physician or other provider does not in itself mean that the services were medically necessary.

Medicare – medical benefits provided by Title XVIII of the Federal Social Security Act.

Plan – Means the All Alaska Longshore Health & Welfare Trust

Plan Year – shall be determined by claims incurred for services rendered January 1 through December 31 of a calendar year.

Reasonable and Customary Charges – charges which do not exceed the fee usually charged by the individual or institution and which are similar to charges made by other providers with similar training and experience in the same geographical areas for comparable services and supplies. As to any particular service or supply, the term "geographic area" means a county or such representative cross section of persons, groups, or other entities rendering or furnishing such services or supplies.

Skilled Nursing Facility – a facility qualified as such under Medicare.

Trust Administrative Office – A & I Benefit Plan Administrators, Inc., 1220 S.W. Morrison Street, Suite 300, Portland, OR 97205-2222.

GENERAL PLAN INFORMATION

A. NAME OF PLAN

All Alaska Longshore Health & Welfare Retiree Plan

B. NAME, ADDRESS AND TELEPHONE NUMBER OF THE BOARD OF TRUSTEES

This Plan is sponsored by a joint labor-management Board of Trustees, the name and address of which is:

Board of Trustees

All Alaska Longshore Health & Welfare Trust
c/o A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, Oregon 97205
(503) 224-0048 or (800) 547-4457

C. IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Plan sponsor by the Internal Revenue Service is No. 91-6070467. The Plan Number is 501.

D. TYPE OF PLAN

This Plan can be described as a health benefit plan which provides Hospital, surgical, medical and prescription drug benefits for retired employees and their Dependents.

E. TYPE OF ADMINISTRATION

This Plan is sponsored by the Board of Trustees with the assistance of a Contract Administrator, Consultant, Legal Counsel, auditor and Investment Manager.

F. NAME, ADDRESS, AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR

The Plan is administered pursuant to a contract with the A&I Benefit Plan Administrators, Inc., a contract administrator, whose address is:

A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, Oregon 97205
(503) 224-0048 or (800) 547-4457

G. NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

The Board of Trustees has designated its Administrator as Agent for purposes of accepting legal process on the behalf of the Trust. The name of the contract Administrator is:

A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, Oregon 97205
(503) 224-0048 or (800) 547-4457

Service of legal process may be made upon a Plan Trustee or the Trust Administrative Office.

H. NAMES, TITLES AND ADDRESSES OF JOINT BOARD OF TRUSTEES:

Employer Trustees

Marion Davis
Horizon Lines
1717 Tidewater Rd.
Anchorage, AK 99501

Jeff Bentz
North Star Terminal & Stevedore Co.
PO Box 102019
Anchorage, AK 99510

Jim Taro
Southeast Stevedore
PO Box 8080
Ketchikan, AK 99901

Eugene Makarin
American President Lines
3443 W Marginal Way S.W.
Seattle, WA 98106
Dutch Harbor, AK 99692

Employee Trustees

Patrick Day
PO Box 788
Valdez, AK 99686

Alan Coté
IBU National
1711 W Nickerson St #D
Seattle, WA 98119

Pete Danelski
P.O. Box 2333
Kodiak, AK 99615

Chuck Wendt
ILWU
P.O. Box 1367
Seward, AK 99664

I. DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENT

This Plan is maintained pursuant to the terms of labor agreements between certain Participating Employers and the International Longshoremen and Warehousemen Union who have been accepted by the Board of Trustees. These Agreements provide that employer parties thereto will make the required contributions to this Trust for the purposes of enabling the employees and retirees who are working or have worked under the Collective Bargaining Agreement to participate in the health plan. The contribution rates are specified in the labor agreement. A copy of the labor agreement regarding contributions to this Trust can be obtained from the Union Office or from the Trust Administrative Office for a reasonable charge.

J. ELIGIBILITY, TERMINATION OF ELIGIBILITY, AND BENEFITS

Retirees are entitled to participate in this Plan if they worked under a Labor Agreement described previously and if they had coverage under the Pacific Northwest Alaska Health Benefits Trust-Longshore.

The eligibility rules that determine which Employees and beneficiaries are entitled to benefits has previously been set forth in this summary plan description.

K. CIRCUMSTANCES WHICH MAY RESULT IN INELIGIBILITY OR DENIAL OF BENEFITS

A retiree who is eligible for benefits may become ineligible as a result of the following circumstances:

1. The exhaustion of the annual maximum of benefits payable.

A spouse of an employee who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

1. The ineligibility of the Retiree.
2. The death of the retiree without the spouse taking continuation coverage.
3. The divorce or legal separation from the retiree without the spouse taking continuation coverage.

Beneficiaries who are Dependents of a retiree may become ineligible if (a) they are no longer a Dependent or (b) they have attained a disqualifying age, unless they elect to take continuation coverage.

A retiree or Dependent who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

1. The failure of the Retiree or Dependent to file a claim for benefits within twelve (12) months of the date he incurred the expense for which benefits are payable. See filing requirements set forth earlier in this summary.

2. The failure of the Retiree or Dependent to file a complete and truthful benefit application.

3. Where the Retiree or Dependent has other group insurance coverage or a claim against a third person, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two plans.

The Trust Agreement governing the all Alaska Longshore Health Trust also provides as follows:

1. This Trust Agreement may be terminated at any time, by action of the Trustees, provided that, if the signatory parties hereto are other than the Trustees, any such actions shall require the written approval of the signatory parties (or their successors).

2. In any event, this Trust Agreement shall be automatically terminated upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the trust fund, provided that for purposes of this provision a collective bargaining agreement or special agreement shall not be deemed to have expired in a strike or lockout situation, unless said strike or lockout continues for more than six (6) months.

3. Upon the termination of this Trust Agreement the Trustees shall wind up the affairs of the trust fund. Where the termination occurs as a result of a merger, as authorized by Article VIII, Section 28, any and all monies and assets remaining in the trust fund, after payment of expenses, shall be transferred to the trust fund with which the merger has been negotiated. With respect to any other termination, any and all monies and assets remaining in the trust fund, after the payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted unless some other disposition is required in regulations of the Secretary of Labor.

4. In no event shall any of the remaining monies or assets be paid to or be recoverable by any participating employers, employer association, or labor organization.

L. SOURCE OF CONTRIBUTIONS

This Plan is funded through Employer contributions, the amount of which is specified in the Collective Bargaining Agreements.

M. PARTICIPATING EMPLOYERS

A complete list of Employers participating in the Plan may be obtained by participants and beneficiaries on written request to the Board of Trustees and is available for examination by participants and beneficiaries during regular office hours at the Administrative Office.

N. ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS

The Employer contributions are received and held in trust by the Board of Trustees. Claims are paid directly from the assets of the trust fund.

O. END OF PLAN YEAR

This Plan is on a January through December year basis. The end of the Plan Year is December 31st.

LEGISLATION AFFECTING HEALTH CARE BENEFITS

Newborns And Mothers' Health Protection Act

Note: Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with child birth for the other 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 newborns' 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 may not, under Federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress passed the "Women's Health and Cancer Rights Act of 1998." Under this law, health plans must provide the following coverage after a mastectomy, as determined in consultation with the attending physician and patient:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance;
- prostheses (artificial replacement); and
- service for physical complications resulting from the mastectomy.

This new coverage will be subject to the same deductibles and co-payments that apply to mastectomies under the Plan's current terms.

The law also requires that written notice of this coverage be provided to participants annually.

If you have any questions about this new law, please contact the Administrative Office.

Patient Protection and Affordable Care Act - Grandfathered Status Notification

The All Alaska Longshore Health & Welfare Trustees believe this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing.

However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to a grandfathered health plan.

Substantiation showing grandfathered status may be found on the All Alaska Longshore website at: www.alaskalongshore.aibpa.com.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561

MAINE – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473

SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

Creditable Coverage Disclosure Notice for Medicare Part D

Do Not Enroll in Medicare Part D If You Plan on Staying in the IBU Medical Plan

Re: Important Information 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 through your Medical Plan with All Alaska Longshore Health & Welfare Trust, the prescription drug coverage available for Medicare-eligible beneficiaries. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- In 2006 Medicare prescription drug coverage became available to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage.

- The Trust has determined that the prescription drug coverage offered under the Alaska Longshore Medical Plan is, on average for all plan participants, expected to pay out at least as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

- Read this notice carefully - it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Keep this notice. If you enroll in one of the Medicare Prescription Drug Plans approved by Medicare, you may be required to give a copy of this Creditable Coverage Notice when you enroll in a Medicare Prescription Drug Plan to show that you are not required to pay a higher premium.

All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium. The Medicare prescription drug program is a voluntary program and is also referred to as Medicare Part D.

Because your existing coverage is on average better than the standard Medicare prescription drug coverage, you can keep your current coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

People eligible for Medicare can enroll in a Medicare prescription drug plan from when they first become eligible for Medicare and each year from October 15 through December 7th. However, because **you have existing prescription drug coverage that, on average is better than Medicare coverage**, you can choose to join a Medicare prescription plan at a later time.
You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you drop your coverage through the All Alaska Medical Plan and enroll in a Medicare prescription drug plan, you and your dependents will not be able to re-enroll in the All Alaska Medical Plan. Your current All Alaska medical coverage pays for other health expenses in addition to prescription drugs. You will NOT be eligible to receive any of your current medical benefits, including prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage for the All Alaska Medical Plan and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month that you did not have that coverage. 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 to join a Medicare drug plan.

To Obtain More Information
You may refer to your Summary Plan Description for current prescription drug coverage information. For further information about your current prescription drug coverage or for more information about this notice please contact the Administration Office at the numbers listed at the bottom of this page.

More detailed information about your options and Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also obtain more information about Medicare prescription drug plans from the following places:

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

Extra help paying for Medicare prescription drug coverage is available for individuals with limited income and resources. Information about this assistance is available from the Social Security Administration. For more information, visit www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You may receive this notice at other times in the future such as before the next enrollment period for Medicare prescription drug coverage or if your current prescription coverage changes. You also may request a copy of this notice from the Administration Office by submitting a written request to the address below.

HIPAA Privacy And Security Information And Notice

These provisions were made as an amendment to the Plan and are now included in the Summary Plan Description. These provisions are effective as of April 14, 2004 and are intended to meet the requirements of 45 CFR § 164.504(f), which requires plan documents of group health plans such as the Plan to be amended to restrict certain uses and disclosures of Protected Health Information by the Board of Trustees as plan sponsor before such Protected Health Information may be disclosed to the Trustees. This amendment shall be construed and administered in accordance with all applicable laws and regulations. If the terms or conditions of any plan conflict with this Amendment, the terms of the amendment shall control.

Definition (Protected Health Information)

"Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in any electronic media as set forth in 45 C.F.R § 160.103. Where this section references Protected Health Information it includes electronic Protected Health Information.

> **Protected Health Information** "Protected Health Information" ("PHI") has the same meaning as in 45 CFR § 164.501.

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Trust, and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

1. Effective April 20, 2006, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic Protected Health Information that the Board of Trustees' creates, receives, maintains, or transmits on behalf of the Plan as set forth in 45 C.F.R § 160, 162, and 164.

2. To make or obtain payment for care received by Covered Persons.

3. To facilitate treatment that involves the provision, coordination or management of health care or related services.

4. To conduct health care operations to facilitate the administration of the benefit plan maintained by the Trust and as necessary to provide coverage and services to Covered Persons.

5. In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.

6. If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.

7. To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.

8. For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.

9. To prevent or lessen a serious and imminent threat to a Covered Person's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.

10. For specified government functions as described in 45 CFR Part 164.

11. To the extent necessary to comply with laws related to workers compensation or similar programs.

Trustee Certification

The Trust will only disclose PHI to a Trustee upon receipt of a certification that this Amendment has been adopted and the Board of Trustees agrees to the following:

1. Prohibition on Unauthorized Use or Disclosure of PHI
   The Trustees will not use or disclose any PHI received from the Trust, except as permitted in this Amendment or required by law.

2. Subcontractors and Agents

   The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Trust agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees. Effective April 21, 2005, ensure that any agents or subcontractor the Board of Trustees provides participants' electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information.

3. Permitted Purposes

   The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any employee benefit plan other than the plans maintained by the Trust.

4. Reporting

   The Trustees will report to the Trust any known impermissible or improper use or disclosure of PHI not authorized by this Amendment of which they become aware. Effective April 20, 2006, report to the Health Trust any security incident, as defined in 45 C.F.R § 164.304, that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic Protected Health Information of which it becomes aware, within a reasonable time after becoming aware. Report to the Health Trust and PPO Plan any other security incident on an aggregate basis every year, or more frequently upon the Plan's written request.

5. Disclosure to Government Agencies

   The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Trust available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Trust's compliance with HIPAA.

6. Return or Destruction of Health Information

   When PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Trust or destroy all PHI that the Trustees received from or on behalf of the Trust. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Trustee Certification As To Covered Persons' Rights

The Board of Trustees also certifies that it will observe the following with respect to Covered Persons and their PHI:

1. The Trustees will make PHI available to the Trust to permit Covered Persons to inspect and copy their PHI contained in a designated record set in accordance with 45 CFR § 164.524.

2. The Trustees will make a Covered Person's PHI available to the Trust to permit Covered Persons to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate such amendments in accordance with 45 CFR § 164.526.

3. The Trustees will make a Covered Person's PHI available to permit the Trust to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

Adequate Separation

The Trustees represent that adequate separation exists between the Trust and the Trustees so that PHI will be used only for plan administration. Each Trustee will certify as to the employees, or other persons under his or her control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

The Trustees certify that anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

Notice Of Privacy Practices

This Notice describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully. This Notice is applicable to the All Alaska Longshore Health & Welfare Trust Fund (hereinafter the "Plan"). If you have medical and prescription drug coverage through an insured plan such as PCS, that plan has its own Privacy Practices to protect your health information.

Policy Of The Health Plans Regarding Your Health Information

The health plans understand that health information about you is personal. The health plans are committed to protecting health information about you. This notice will tell you about the ways in which the health plans may use and disclose health information about you. This notice also describes the Plans obligations and your rights regarding the use and disclosure of health information. Your doctor or health care provider may have different policies or notices regarding their use and disclosure of your health information created in the doctor's office or clinic.

The health plans are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy policies regarding your health information; and
- Follow the terms of the notice that currently is in effect.

How The Health Plans May Use And Disclose Health Information About You

The following categories describe different ways the health plans may use and disclose your health information. For each category of use or disclosure, we will explain what we mean and present examples. Not every use or disclosure in a category will be listed. However, all of the ways the health plans are permitted to use and disclose your health information will fall within one of these categories.

To Make or Obtain Payment. The health plans may use and disclose health information about you to determine eligibility for benefits, to facilitate payment for the treatment and service you receive from health care providers, to determine benefit responsibility under one of the health plans or to coordinate health plan coverage. For example, the health plans may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or medically necessary or to determine whether the health plans will cover the treatment. The health plans may also share health information with a stop loss insurance carrier or a utilization review or precertification service provider. Likewise, the health plans may

share health information with another entity to assist with the adjudication of health claims or with another health plan to coordinate benefit payments.

To Facilitate Treatment. The health plans may use and disclose your health information to facilitate treatment or services by providers, including coordination or management of health insurance carrier-related services. For example, the health plans may disclose health information about you with physicians who are treating you.

To Coordinate Health Care Operations. The health plans may use and disclose your health information to facilitate the administration of the health plans. These uses and disclosures are necessary to run the health plans. For example, health care operations include such activities as:

- Quality assessment and improvement activities;
- Activities designed to improve health or reduce health care costs;
- Clinical guideline and protocol development, case management and care coordination;
- Contacting health care providers and participants with information about treatment alternatives and other related functions;
- Health care professional competence or qualification review and performance evaluation;
- Accreditation, certification, licensing and credentialing activities;
- Underwriting, including stop-loss underwriting, premium rating and related functions to create, renew or replace health insurance or health benefits;
- Review and auditing, including compliance reviews, medical reviews, legal services, fraud and abuse detection and compliance programs;
- Business planning and development, including cost management and planning related to analyses and formulary development; and
- Business management and general administration activities of the health plans, including customer service and resolution of appeals and grievances.

When Required by Law. The health plans will disclose health information about you when required to do so by federal, state or local law. For example, the health plans may disclose health information when required by a court order in a lawsuit such as a malpractice case.

Additional Situations

To Avert a Serious Threat to Health or Safety. The health plans may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, will only be made to someone able to help prevent the threat. For example, the health plans may disclose health information about you in a proceeding regarding the licensure of a physician.

Military and Veterans. If you are a member of the armed forces, the health plans may release health information about you as required by military command authorities. The Health Plans may also release health information about foreign military personnel to the appropriate foreign military authority.

For Treatment Alternatives. The health plans may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The health plans may use and disclose your health information to provide information on health-related benefits and services that may be of interest to you.

For Disclosure to the Board of Trustees. The health plans may disclose your health information to another health plan maintained by the Trust or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the health plans. In addition, the health plans may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate one or more of the health plans. The health plans may also disclose to the Board of Trustees information whether you are participating in one of the health plans.

A Family Member or Close Personal Friend Involved in Your Health Care. The health plans may make your health information known to a family member or close personal friend. Disclosure of your health information will be determined based on how involved the person is in your health care or payment of your health care claims. For example, the health plans would normally provide information to a family member confirming eligibility for health coverage or if a claim was paid but not the specific treatment or diagnosis provided or the reason the provider was consulted. The health plans may release health information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your health information, the health plans through its third party administrator may use its professional judgment to determine whether the disclosure is in your best interest. **If you do not want your health information disclosed to a family member or close personal friend as outlined in this section, you must notify the Health Plans as described in the Right to Request Restrictions section.**

Personal Representative. The health plans will disclose your health information to an individual who has been designated as your personal representative and has qualified for such designation in accordance with relevant state law. However, before the health plans will disclose health information to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification, such as a power of attorney.

Even if you designate a personal representative, federal law permits the health plans to elect not to treat the person as your personal representative if the health plans have a reasonable belief that: (1) you have been, or may be, subject to domestic violence, abuse or neglect by such person; (2) treating such a person as your personal representative could endanger you; or (3) the health plans determine, in their professional judgment, that it is not in your best interest to treat the person as your personal representative.

Business Associates. Business Associates perform various functions and services on behalf of the health plans. For example, the Third-Party Administrator, A&I Benefit Plan Administrators, Inc., will be handling many of the functions in connection with the operation of the health plans. To perform these functions, or provide the services, the health plans' Business Associates may receive, create, maintain, use or disclose your health information, but only after agreeing, in writing, to appropriate safeguards concerning your health information.

Other Covered Entities. The health plans may use or disclose your health information to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the health plans may disclose your health information to a health care provider when needed by the provider to render treatment to you or the health plans may disclose health information to another covered entity to conduct health care operations in the area of quality assurance.

To Conduct Health Oversight Activities. The health plans may disclose your health information to a health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. However, the health plans may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

Legal Proceedings. The health plans may disclose your health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or an administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, discovery request or other lawful process once the Health Plans have met the administrative requirements of the Health Insurance Portability and Accountability Act of 1996 (hereinafter the "HIPAA Privacy Rule"). For example, the health plans may disclose your health information in response

to a subpoena for such information, but only after the health plans meet certain conditions required by the HIPAA Privacy Rule.

Law Enforcement. Under certain conditions, the health plans may disclose your health information to law enforcement officials. Some of the reasons for such a disclosure include, but are not limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness or missing person; and (3) it is necessary to provide evidence of a crime that occurred.

National Security and Intelligence. In certain circumstances, federal regulations require the health plans to disclose your health information to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

Abuse or Neglect. The health plans may disclose your health information to a governmental entity that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the health plans may disclose to a governmental entity authorized to receive such information your health information if the health plans believe that you have been a victim of abuse, neglect or domestic violence.

Research. The health plans may disclose your health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of your health information; and (2) approved the research.

Inmates. If you are an inmate of a correctional institution, the health plans may disclose your health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Coroners, Medical Examiners, Funeral Directors and Organ Donation. The health plans may disclose health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The health plans may also disclose, as authorized by law, information to funeral directors so they may carry out their duties. Further, the health plans may disclose health information to organizations that handle organ, eye or tissue donation and transplantation.

Workers' Compensation. The health plans may release your health information to the extent necessary to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Health Plans are required to disclose your health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the health plans' compliance with the HIPAA Privacy Rule.

Authorization To Use Or Disclose Health Information

Other than as stated above, the health plans will not disclose your health information without your written authorization. If you authorize the health plans to use or disclose your health information, you may revoke that authorization in writing at any time.

Minimum Necessary Disclosure Of Health Information

The amount of health information the health plans will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

Potential Impact Of State Laws

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the health plans will be required to operate. For example, where such laws have been enacted, the health plans will follow more stringent state privacy laws that relate to uses and disclosures of health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

Your Rights With Respect To Your Health Information

You have the following rights regarding your health information that the health plans maintain:

Right to Request Restrictions. You have the right to request restrictions or limitations on the health information the health plans use or disclose about you for treatment, payment or health care operations. You have the right to request a limit on the Health Plans' disclosure of your health information to someone involved in your care or the payment for your care. However, the health plans are not required to agree to your request. If the health plans do agree to the restriction, the health plans will comply with the restriction unless the information is needed to provide emergency medical treatment.

To request restrictions, you must make your request in writing to the organization listed as the contact person. Any restrictions that may have been provided to the administrator for the health plans before April 14, 2004 must be renewed in writing. In your request, you must tell the health plans:

- What information you want to limit;
- Whether you want to limit the health plans' use, disclosure or both; and
- To whom you want the limits to apply, for example, non-disclosure to your spouse.

Right to Receive Confidential Communications. You have the right to request that the Health Plans communicate with you about health matters in a manner other than by mail or at an alternative location if you feel the disclosure of your health information could endanger you. For example, you may ask that the health plans communicate with you only at a certain post office box, telephone number or by e-mail.

To request confidential communications, you must make your request in writing to the organization listed under contact person. The health plans will not ask you the reason for the request. The health plans will attempt to honor all reasonable requests. Your written request must specify how or where you wish to receive confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the organization listed under the contact person. If you request a copy of your health information, the health plans may charge a reasonable fee for copying, assembling and postage.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the health plans amend their records. The request may be made as long as the health information is maintained by the health plans.

A request for an amendment of health information records must be made in writing to the organization listed under the contact person. The health plans may deny the request if it does not include a reason to support the amendment. The request may also be denied if your health information records were not created by the health plans, if the health information you are requesting to amend is not part of the health plans' records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the health plans determine that records containing your health information are accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your health information when the disclosure was made for any purpose other than treatment, payment, health care operations or when disclosures are not in accordance with the health plans' Notice of Privacy Practices and applicable law. An accounting of disclosures is not required for disclosures made pursuant to a signed authorization by you or your personal representative. Most disclosures of your health information will be for purposes of treatment, payment or health care operations and, therefore, will not be subject to your right to an accounting.

The request for an accounting must be made in writing to the organization listed under contact person. The accounting request should specify the time period for which you are requesting the accounting but may not start earlier than April 14, 2004. Accounting requests may not be made for periods of time going back more than six (6) years. The health plans will provide the first accounting you request during any 12-month period

without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The health plans will inform you of the fee in advance.

Right to a Paper Copy of this Notice. You have the right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. To receive a paper copy, please contact the organization listed below.

Duties Of The Health Plans

The health plans are required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this notice. The health plans are required to abide by the terms of this Notice, which may be amended from time to time. The health plans reserve the right to change the terms of this notice and to make the new Notice provisions effective for all health information that they maintain. If the health plans change their policies and procedures, the health plans will revise the notice and will provide a copy of the revised notice to you within sixty (60) days of the change.

Complaints

You have the right to express complaints to the health plans and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the health plans should be made in writing to the organization listed below. The health plans encourage you to express any concerns you may have regarding the privacy of your health information. All complaints should be in writing. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Plan has designated the Health Trust's client service representative to answer all issues regarding this Notice and your privacy rights. You may contact this person at:

Client Service Representative
All Alaska Longshore Welfare Trust
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205
(503) 224-0048 or (800) 547-4457

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE CLIENT SERVICE REPRESENTATIVE AT THE ADDRESS AND TELEPHONE NUMBER LISTED ABOVE.

ERISA Statement Of Rights

As a participant in the All Alaska Health & Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

1. Examine without charge, at the Trust Administrative Office, and at other specified locations (such as worksites and union halls), all Plan documents, including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor (such as detailed annual reports and summary plan description.);

2. Obtain copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, upon written request to the Trust Administrative Office. The Trust Administrative Office may make a reasonable charge for copies;

3. Receive a summary of the Plan's annual financial report. The Trust Administrative Office is required by law to furnish each participant with a copy of this Summary Annual Report.

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposed duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called *fiduciaries* of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Health benefit of exercising your rights under ERISA.

If your claim for a health benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedule.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suite in a federal court. In such a case, the court may require the Trust Administrative Office to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Administrative Office. If you have a claim for benefits which is denied or ignored, in whole or in part, you may have the right to a hearing before the Trustees at which you may present your position and any

supporting evidence. You also have the right to be represented by an attorney or any other representative of your choosing. If you are dissatisfied with the Trustees' determination, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about this Plan, you should contact the Trust Administrative Office at the address listed above. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.