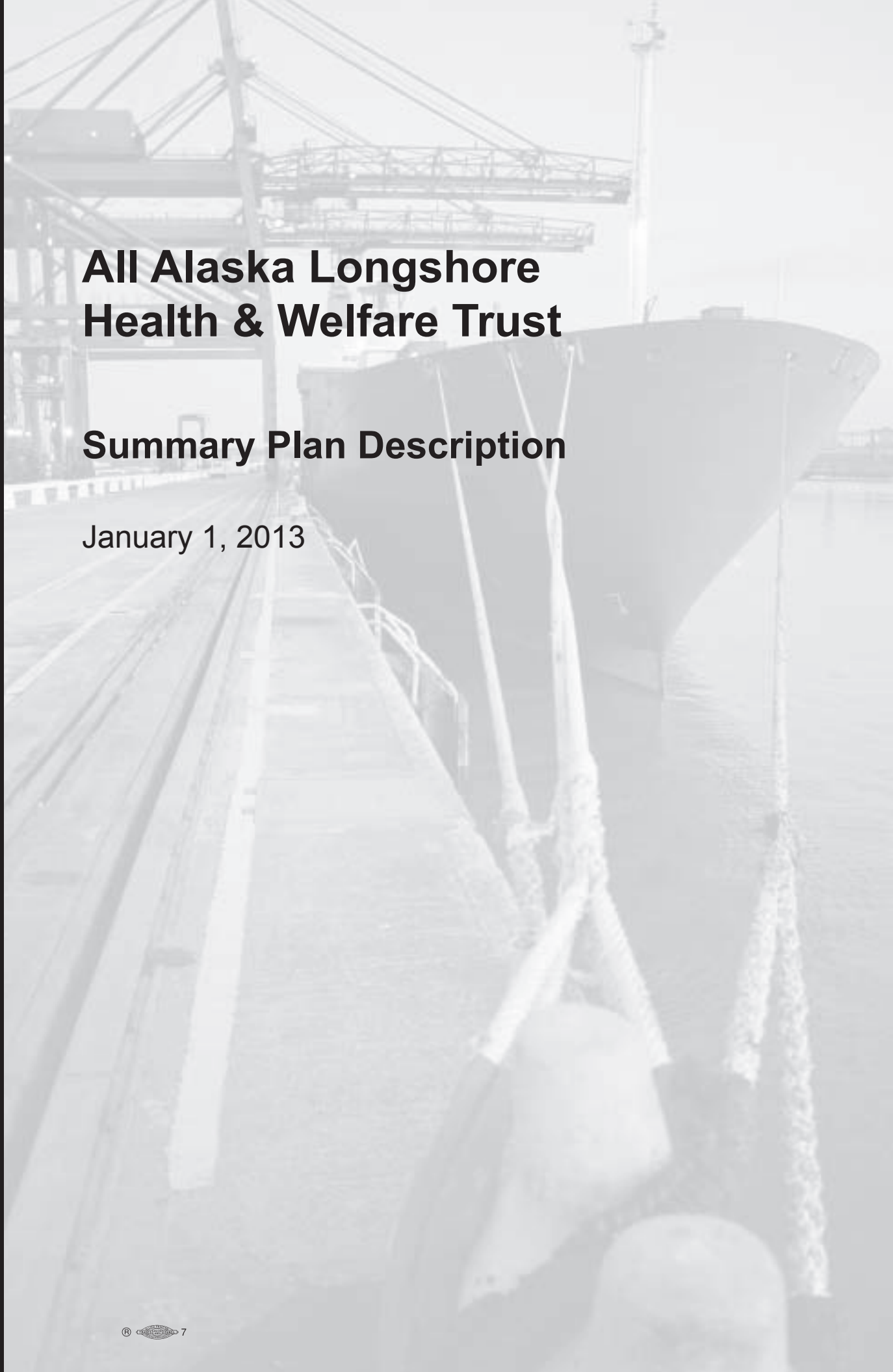

All Alaska Longshore Health & Welfare Trust

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.

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TRUSTEES LETTER

To All Alaska Longshoremen:

We have provided this booklet to you and your family to explain your All Alaska Longshore Health & Welfare Trust benefits. Please read the booklet carefully. There are certain deadlines that you must meet to be eligible for benefits and to make self-payments that are explained in this booklet. This booklet provides a brief description of the benefits available to you and your dependents. The Inlandboatmen's Union of the Pacific Health Trust benefit booklet describes the medical, dental, prescription drug, additional life insurance and time loss benefits available to you and your dependents. This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974, as amended (commonly known as ERISA). This Plan complies with the Employee Retirement Income Security Act of 1974 and other applicable laws, regulations and amendments. Any omissions or oversights will be resolved according to these laws and regulations.

This booklet has been written to describe the benefits and provisions of the program as simply as possible. Only the Collective Bargaining Agreement and/or insurance contracts described, in detail, your rights and the provisions of the Plan.

Your Plan is administered by a joint labor-management Board of Trustees. As Trustees, we have the sole and absolute discretionary authority to amend, modify or terminate the Plan, or any of the benefits it provides, at any time for any reason. We also have the sole and absolute authority to determine eligibility and the amount of benefits paid by the Plan, to interpret the terms of the Plan, resolve inconsistencies and omissions, and to rule on benefit exclusions.

If you have any further questions after reading through this book, please contact the Trust Administrative Office, A&I Benefit Plan Administrators, at (503) 224-0048 or (800) 547-4457.

Sincerely,
The Board of Trustees
All Alaska Longshore Health & Welfare Trust

ALASKA LONGSHORE HEALTH & WELFARE TRUST
BOARD OF TRUSTEES

Employee Trustees	Employer Trustees
Alan Coté	Marion Davis
Peter Danelski	Jeff Bentz
Patrick Day	Gene Makarin
Chuck Wendt	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

Registered Longshoremen

You are required to work a minimum of 800 hours during a calendar year (January - December) to be eligible for Plan coverage fully paid by the Plan for July 1 through June 30 period beginning the following year.

For Example:

If you work 800 or more hours during 2012, you are eligible for coverage from July 1, 2013 through June 30, 2014.

Worked 800 Hours During the Eligibility Period	*Waiting Period*	*Coverage Period*
January 1 - December 31, 2012	*January 1 –June 30, 2013*	*July 1, 2013 – June 30, 2014*

If during the eligibility period you do not accumulate enough hours to be eligible for coverage, you may self-pay the Plan for the difference between the hours you worked and the 800-hour requirement. If you are eligible to self-pay, during May, before the July through June coverage period, you will receive a bill for coverage. You may pay in one lump sum payment or 12 equal payments in the form of an auto-pay deduction from a checking or savings account. You must send to the Trust Administrative Office the entire year's payment or the Auto-pay Form by the deadline on the bill. If you miss the deadline, you will not be covered during that July through June period.

You may earn the hours to meet the 800-hour requirement at your homeport or as a visitor or traveler at another port.

Disability Credits for Registered Active Longshoremen

If you are a registered active employee (meaning a registered longshoreman who is currently covered by the Plan in a major port or a minor port), and a disabling Illness or injury prevents you from meeting the hours requirement for the next year's Plan eligibility, you may be credited with additional hours during the period of a certified disability.

Credited With At Least 25% Of Hours Required

If you are unable to meet the hour requirement for eligibility, but you worked or were credited with at least 25% of the hours required, you will be credited with additional hours during the review period as follows:

The total number of credited hours is the result of multiplying the number of weeks of certified disability by the average number of hours per week worked and credited to you during the review period. This average is determined by dividing the total number of hours worked and

credited during the review period by the number of weeks in the review period, excluding the period of disability.

Credited With Less Than 25% Of Hours Required

If you were eligible immediately before the annual review date (in June, for July 1 coverage), but, because of a continuous disability in the review period, you were unable to work any hours, or you worked or were credited with less than 25% of the hours required, you may be credited with enough hours to establish eligibility at the annual review.

If your disability is due partly or wholly to a job-connected Illness or injury for which you are receiving industrial compensation (medical care or benefit payments) you will be credited with enough hours to give you coverage for a maximum of five years in a row while the disability continues.

If the disability is not due to a job-connected Illness or injury and you are not receiving industrial compensation, you may be credited with enough hours to give you coverage for a maximum of three years in a row while the disability continues.

Applying for Disability Credits

Each year, you must submit evidence to the Trustees that proves you are disabled for the period you are claiming and that establishes whether or not your disability is a job-connected Illness or injury for which you received industrial compensation. The evidence must be submitted to either the Joint Port Labor Relations Committee of your port or directly to the Trustees of the Plan. The Trustees determine whether to grant the disability credits based on the evidence you have submitted.

Leave of Absence Credits

During an authorized leave of absence, registered longshoremen will receive credit toward the hour requirement for coverage. An authorized leave of absence is a period during which you have been granted permission by the Joint Port Labor Relations Committee to be absent from work or from availability to work.

Leave of absence credits are computed the same way as disability credits for registered active employees who have worked or been credited with at least 25% of the hours required (described above).

Steadymen

If you are classified as a "steadyman" under your Collective Bargaining Agreement, your initial coverage will begin on the first of the month following the sixth month for which employer contributions have been made on your behalf, provided that contributions have been made for at least 800 hours. Once you have attained initial eligibility under this rule, your eligibility for future coverage will be determined under the same rules that apply to registered longshoremen. If you attain initial eligibility as a steadyman and your employment as a steadyman is later terminated, your eligibility for coverage will terminate on the last day of the sixth month

following the termination of your employment unless you have qualified for continued coverage under the rules that apply to registered longshoremen.

Casual Employees

A casual employee is an eligible employee who is not a registered longshoreman or steadyman. If you are a casual employee, you are eligible for coverage from July 1 to June 30 if, as of the July 1 your coverage starts:

- You are not jointly registered, either fully or partially; and
- You worked at least 1,600 hours in employment requiring a Plan contribution during the previous calendar year; and
- You are regularly available for Longshore employment during your eligibility period.

Each December your eligibility will be reviewed. If your port's Joint Labor Relations Committee determines that you are not regularly available for work, your coverage ends that December 31. If this happens, your eligibility cannot be reestablished until the July 1 following a calendar year in which you are employed at least 1,600 hours.

Self-payment for Coverage

If during the eligibility period you do not accumulate enough hours to be eligible for coverage, you may self-pay the Plan for the difference between the hours you worked and the hour requirement for your classification (long term casual or casual). If you are eligible to self-pay, during May, before the July through June coverage period, you will receive a bill for coverage. You may pay in one lump-sum payment or 12 equal payments in the form of an auto-pay deduction from a checking or savings account. You must send to the Trust Administrative Office the entire year's payment or the Auto-pay form by the deadline on the bill. If you miss the deadline, you will not be covered during that July through June period.

Spouse and Dependent Children of Active Employees

If you are an eligible, active employee (a registered longshoreman or a casual or casual ID employee currently participating in the Plan), the Plan will provide medical, prescription drug, dental, vision and transportation benefits to your:

- Legal spouse. Your spouse is not eligible if you are legally separated. In the event of your death, your surviving spouse is eligible as long as he or she is not remarried.
- Dependent children, as defined below, and who are:
  - Under age 26; or
  - Age 19 or older and who are incapacitated by physical or mental disability, who were incapacitated when they turned age 19 and who are unable to maintain self-sustaining employment.

- A biological child of either or both you or your spouse;

- A legally adopted child of either or both you or your spouse;

- A child placed for adoption with you for the purpose of legal adoption, in accordance with state law. Placed for adoption means you have assumed and you retain the legal obligation for primary support of the child in anticipation of adoption of that child. If the placement is interrupted and the adoption is not finalized, coverage will end. The Plan reserves the right to request a refund of benefits already paid for the child;

- The unborn child of a deceased or retired employee;

- A foster child;

- A child for whom you have been named legal guardian, have physical custody of, and for whom you provide a major amount of support;

- 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.

Coverage For Adult 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.

Special Enrollment Rights

If you marry or add a child to your family, coverage for the new family member will be effective as follows:

- Spouses and his or her child(ren) - coverage will be effective the date of marriage;

- Child(ren) - coverage will be retroactive to birth, adoption or placement for adoption.

You have up to 30 days after the new family member(s) joins your family to notify the Trust Administrative Office.

Other Enrollment Situations

For a child covered under a QMCSO, you (or the custodial parent) should enroll the child within 31 days of the order; coverage will be effective the date of the order or the date the order specifies. If the child is not enrolled within 31 days of the order, the child's coverage will be effective the first day of the month after the child is enrolled.

If you are adding coverage for a foster child or a child for whom you have been named legal guardian, coverage for that child will be effective the first day of the month following enrollment.

Survivor Eligibility

If you die while you are eligible for coverage as an active employee, your surviving spouse and/or child(ren) can continue health coverage (medical, prescription drug, dental and vision) from the Plan, as follows:

Spouses:

- If the member dies before meeting the eligibility requirements for receiving a pension from the All Alaska Longshore Pension Trust, coverage will be provided for the spouse for four years after the member's death or until the spouse remarries, whichever occurs first.

- If the member dies after meeting the eligibility requirements for receiving a pension from the All Alaska Longshore Pension Trust and the eligibility requirements for enrollment in the All Alaska Longshore retiree health plan, coverage will be provided for the spouse until his or her death or remarriage, whichever occurs first, provided the member was married to the spouse on the date he first became eligible to receive a pension from the All Alaska Longshore Pension Trust. If the member was not married to the spouse on the date he first became eligible to receive a pension from the All Alaska Longshore Pension Trust, coverage will be provided for four years after his death or until the spouse remarries, whichever occurs first.

Surviving children:

- Your surviving children will be covered for as long as they meet the definition of a Dependent child on page 5.

Retirees and Their Dependents

You and your spouse and dependents will be covered for medical, prescription drug, dental, vision and transportation benefits if you meet all of the following qualifications:

- You are retired and drawing a pension benefit from the All Alaska Longshore Pension Trust;

- You apply for and maintain Medicare Parts A and B when eligible;
- You had 10 years (120 months) of coverage under active status;
- You were covered in 12 of the 24 months immediately before applying for retirement.

For the purpose of counting months for eligibility, both disability waivers and self-payments are included.

Survivor Eligibility

If you die while receiving a pension from the All Alaska Longshore Pension Plan, your surviving spouse remains eligible for coverage until death or remarriage, provided that you were married to the spouse on the effective date of your retirement. Your spouse must maintain Medicare Part B coverage to maintain coverage under the Plan. Your Dependent children are covered as long as they meet the eligibility requirements for Dependent children described in the Spouse and Dependent Children of Active Employees sections of this booklet, provided that the children were your dependents on the effective date of your retirement. If you marry or acquire a new Dependent after the effective date of your retirement, their coverage will terminate upon your death, subject to their right to self-pay for COBRA continuation coverage as described in the COBRA Coverage sections of this booklet.

Retiree Health Coverage Not Guaranteed

The Board of Trustees provides retiree coverage to you and your spouse or dependents as long as money is currently available to pay the cost of the coverage. The Board of Trustees retains full authority to determine the extent to which money is available for retiree coverage and to determine the payments for retiree coverage. Coverage for retirees and their dependents is not guaranteed to continue indefinitely. It may be terminated or modified at any time by the Board of Trustees.

LOSS OF ELIGIBILITY

Active Employees

Plan benefits coverage for you and your dependents will end when any of the following events happen:

- The effective date of the annual review, if you have not met the hours requirement (or made the required self-payment);
- The last day of the month in which you stop working in the industry;
- The last day of the month in which you lose your registration as a longshoreman;
- The last day of the month in which you begin an authorized leave of absence for military service.

If you are a casual employee, your coverage will end the last day of the month in which you are not regularly available for Longshore employment.

Notwithstanding the above, if you retire during a period in which you have coverage as an active employee and you do not qualify for coverage as a retiree, you will continue to be eligible for active coverage for the remainder of that coverage period and any additional coverage period for which you had qualified prior to your retirement.

Dependent Spouses

Your spouse will lose coverage for medical, prescription drug, dental, vision and transportation benefits on the last day of the month if any of the following events happen:

- Legal separation and/or your divorce is finalized;
- You cancel your spouse's coverage;
- You lose eligibility for coverage;
- Your spouse dies.

Dependent Children

Your Dependent child will lose coverage for medical, prescription drug, dental, vision and transportation benefits on the last day of the month any of the following events happen:

- You cancel your Dependent's coverage;
- You lose eligibility for coverage;
- Dependent reaches the age limit described in the Eligibility section;
- Your Dependent dies.

Surviving Spouses

Your surviving spouse will lose coverage for medical, prescription drug, dental, vision and transportation benefits on the last day of the month any of the following events happen:

- Four years following your death unless you qualified for both pension and health retiree benefits at the time of your death.
- Your surviving spouse remarries;
- Your surviving spouse fails to maintain enrollment in Medicare Part B (if eligible for Medicare);
- Your surviving spouse dies.

Retirees

You or your surviving spouse will lose coverage for medical, prescription drug, dental, vision and transportation benefits on the last day of the month if any of the following events happen:

- You or your spouse dies;
- You or your spouse fails to maintain Medicare Part B coverage (if eligible for Medicare).

Notwithstanding the above, if you retire during a period in which you have coverage as an active employee and you do not qualify for coverage as a retiree, you will continue to be eligible for active coverage for the remainder of that coverage period and any additional coverage period for which you had qualified prior to your retirement.

REESTABLISHING ELIGIBILITY FOR COVERAGE

Disability

If you are an active employee and you exhaust the five-year or three-year maximum period for disability credits (described in the Disability Credits for Active Registered Employees sections), you can become covered again only if you start working enough hours to meet the eligibility requirements.

Medicare Eligibility

If you lose Plan eligibility because you have not maintained Medicare Part B coverage, you will be reinstated in the Plan when you enroll in Medicare Part B.

Family and Medical Leave Act

Your employer may be subject to the Family and Medical Leave Act (FMLA). If your employer is subject to the FMLA and you take FMLA leave, your health coverage may continue as though you are an active employee. If, you are making partial self-payments to maintain your coverage, (because you didn't work 800 hours), you must continue your partial contribution. If you do not intend to return to work after your leave, your coverage will end when you notify your employer and/or the union that you are not returning to work. (At that time, you will be eligible to continue coverage for up to 18 months under COBRA.) If you believe you are entitled to FMLA leave, you should check with your employer or the Trust Administrative Office.

Certificate of Creditable Coverage

Some health care plans do not cover medical conditions you had before becoming covered under that plan for up to the first 18 months of coverage. These are called "preexisting conditions exclusions."

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health care plans to reduce the length of time your preexisting conditions are excluded from coverage by the amount of time you were covered by the previous health plan(s).

If your coverage under this Plan ends, and you become covered under another health care plan that does not cover preexisting conditions, and you have 12 months of coverage under this Plan, your new employer cannot exclude your preexisting conditions. If you have less than 12 months coverage under this Trust, you will receive month-for-month credit against the preexisting conditions waiting period for each month covered under this Trust.

The new health care plan can, however, exclude your condition for up to 18 months in the following situations:

- If you don't enroll at your first opportunity; or
- If you had a lapse in coverage lasting 63 days or longer.

When your coverage under the Plan ends, the Trust Administrative Office will mail you a Certificate of Creditable Coverage. This certificate will show that you were covered under the Plan's medical benefit program and the length of time you were covered. You should receive the certificate automatically. If, for some reason you do not receive it, contact the Trust Administrative Office.

Continued Coverage While on Military Leave

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you take a military leave, whether for active duty or for training, you are entitled to continue medical coverage for up to 18 months, as long as you give the Trust Administrative Office advance notice (with certain exceptions) of the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the employee self-pay rate.

If you take a military leave but your coverage under the Plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon reemployment under the Plan when determining whether an exclusion or waiting period applies upon your reinstatement into the Plan.

The Veterans Benefits Improvement Act of 2004, 38 U.S.C. § 4317, increased the maximum period of coverage for participants and dependents when a participant is absent from employment, by reason of service in the uniformed services, from 18 months to 24 months. This extension shall apply to elections made on or after December 10, 2004.

The Plan Participant is responsible for notifying the Trust Administrative Office in writing of voluntary or involuntary duty with a United States uniformed service within 60 days of being called to service.

COBRA COVERAGE

COBRA coverage is available to eligible employees, retirees and Dependents who satisfy a qualifying event.

Federal law requires this Plan to offer you, your spouse and dependents covered by the Plan, the opportunity for a temporary extension of health benefits, called "COBRA coverage." Coverage is provided at group rates in certain instances where coverage would otherwise end. This section will inform you, your covered spouse and dependents of your rights and obligations under COBRA coverage provisions.

Your spouse and dependents also have separate, individual COBRA rights. This means that if you or your dependents become eligible for COBRA coverage and you do not elect COBRA coverage, your spouse and/or Dependent children may elect (and pay for) COBRA coverage on their own.

Qualifying Events - Eligibility for COBRA Coverage

The reasons you can become eligible for coverage are called "qualifying events."

Employees

If you are an employee covered by this Plan, you have the right to choose COBRA coverage for yourself, your spouse or your Dependent, if you lose your coverage under this Plan because the termination of your employment or your hours are reduced so that you are no longer eligible for coverage.

Spouses

If you are the spouse of an employee covered by this Plan, you have the right to choose COBRA for yourself and your dependents if you would otherwise lose coverage under this Plan for any of the following reasons or "'qualifying events":

- The death of the employee;
- The termination of the employee's employment or reduction in the employee's hours of employment;
- Divorce or legal separation from the employee; or
- The employee enrolls in Medicare.

Dependents

If you are a Dependent child of an employee covered by this Plan, you have the right to choose COBRA if you lose coverage under this Plan for any of the following reasons:

- The death of the employee;
- The termination of the employee's employment or reduction in the participating employee's hours of employment;
- Dissolution of the employee's marriage or legal separation;
- The employee becomes enrolled in Medicare; or
- You are no longer a Dependent under the Plan. (See the Eligibility sections.)

Duration of COBRA Coverage

The length of time you are allowed to continue coverage under COBRA depends on whether you are an employee or Dependent and which "qualifying event" caused your coverage to end.

COBRA Qualifying Event	Maximum Duration of COBRA Coverage	Who Can Continue Coverage through COBRA
Your employment terminates	18 months	• You • Your spouse • Your children Your spouse and children have a separate right to elect COBRA
Your working hours are reduced resulting in loss of coverage	18 months	• You • Your spouse • Your children Your spouse and children have a separate right to elect COBRA
You, your spouse or child is disabled within the first 60 days after your coverage ended because of termination of employment or reduced hours	29 months (18 months plus an additional 11 months if the disability is established within required time limits)	• You • Your spouse • Your children
Your covered spouse and child lose coverage because of your coverage under Medicare, your death or your divorce	36 months	• Your spouse • Your children Each has a separate right to elect COBRA
Your child no longer qualifies as an eligible dependent	36 months	The child who loses eligibility

Extended COBRA Coverage for Disabled Participants

If you or a family member becomes disabled, you may be able to continue your COBRA coverage for up to 29 months (instead of 18 months), following loss of coverage as a result of termination of employment or reduction of hours if certain conditions are met. To qualify for this additional period of coverage, you must become disabled within 60 days of the date your coverage as an active employee ended, receive a Social Security Disability Award during the first 18 months of continuation coverage, and provide the Trust Administrative Office with a copy of your Disability Award within 60 days of receiving it. Extended COBRA coverage is available to the whole family, no matter which family member has the disability.

Extended COBRA Coverage for a Second Qualifying Event

"Multiple qualifying events" is a qualifying event followed by one or more qualifying events. In this case, your spouse or child, with proper notice to the Trust Administrative Office of the second qualifying event, can extend COBRA coverage for up to 36 months from the date the original COBRA coverage began.

If your dependent wants to extend coverage as a result of a second qualifying event, he or she must notify the Trust Administrative Office within 60 days of the second qualifying event; otherwise, he or she will not be permitted to extend coverage.

For Example:

If you and your family enroll for COBRA coverage because of your termination of employment, you can extend coverage for up to 18 months. If, during that 18-month period, you and your spouse divorce, your spouse and dependents may extend their coverage under COBRA for an additional 18 months for a total of 36 months of coverage. However, to do this they must notify the Trust Administrative Office of the divorce and the intent to extend coverage within 60 days of the divorce. If your spouse and/or dependents do not notify the Trust Administrative Office within 60 days of the divorce, they lose their right for the additional 18-month extension.

COBRA Benefits Choices

Right to Separate Elections

You, your spouse and each Dependent child covered by the Plan have the right to make a separate election and determine whether to have COBRA coverage. When you choose COBRA coverage, coverage for your spouse and dependents continues automatically unless your spouse and/or dependents decline coverage independently. If you choose not to elect COBRA coverage, your spouse and eligible dependents may still choose COBRA coverage. Anyone electing COBRA coverage must pay the required self-payment.

Right to Elect Full or Partial Coverage

You, your spouse and each Dependent covered by the Plan also have the right to elect COBRA coverage for medical and prescription drug benefits only, or for medical, prescription drug, dental and vision benefits. COBRA covers health care benefits only. No transportation, life

insurance or time loss benefits are continued through the COBRA coverage provisions. If you have money in your supplemental accounts, you can continue to seek reimbursement for health care expenses from that account until June 30 (when the Plan Year ends). However, no deposits will be made to the supplemental accounts.

How to Apply - Time Limits and Notification Requirements

You, your spouse and dependents are responsible for notifying the Trust Administrative Office in writing of a divorce, legal separation, Medicare enrollment, or of a child losing Dependent status under the Plan within 60 days of the event. Your employer is responsible for notifying the Trust Administrative Office of your death, termination of employment or reduction in hours.

When the Trust Administrative Office is notified that one of these events has occurred, they will notify you, your spouse or Dependent that each of you have the right to choose COBRA coverage. You or your spouse and/or Dependent has 60 days from the date you 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 you have elected coverage, you have 45 days to make the first payment. This payment must include all previous month's premiums, starting from the first day of the first month that you qualified for COBRA coverage, so that there is no lapse in coverage.

For Example:

If you and your spouse divorce effective March 5 and you receive your COBRA notice on March 15, you must complete the COBRA Application and return it to the Trust Administrative Office by May 14. Payment for April, May and June must arrive at the Trust Administrative Office no later than June 25 (and July's premium is due July 1). If you miss the deadline, you lose your right to COBRA coverage.

COBRA Payment Amounts

The monthly cost for COBRA coverage is 102% of the cost the Plan must pay for the coverage. If you are eligible for the 11 additional months of coverage because of your disability, the cost of the COBRA coverage is 150% of the cost of the Plan for the 11-month period (this applies to the entire family).

You are notified of the cost of COBRA coverage at the time the Trust Administrative Office informs you of your right to elect COBRA coverage. The monthly cost for COBRA continuation is subject to change once per year.

When making COBRA self-payments, no time loss benefits or disability waivers are provided. Therefore, non-months of disability waivers are earned because of eligibility resulting from a COBRA payment.

Making Monthly Payments

You are responsible for monthly self-payments for your COBRA coverage. After your initial payment, payments are due on the first day of the month for which you are purchasing coverage.

You will have a 30-day grace period to pay the self-payment. If your payment is not received at the Trust Administrative Office by the 30th day of the month, your COBRA coverage will end. Once COBRA coverage ends, it cannot be reinstated.

Coverage for New Family Members

If, while you are covered under COBRA, you obtain a new spouse and/or Dependent, you can enroll your new family member under your coverage in the same manner as an active employee. Your new family member will be covered under COBRA for the remainder of the period you are eligible for coverage.

Termination of COBRA Coverage

Your COBRA self-payment coverage will end before the maximum duration if any of these events happen:

- You do not pay premiums by the end of the grace period;
- You become eligible for another group health care plan, unless you have a preexisting medical condition that the other plan limits or excludes from coverage, or the preexisting condition limitation period has not been satisfied;
- You become entitled to Medicare;
- Social Security determines you are no longer disabled and you have extended your coverage beyond 18 months on the basis of your disability;
- You provide written notice to the Trust Administrative Office that you want to terminate coverage;
- The Plan terminates.

Questions?

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

A & I Benefit Plan Administrators, Inc.
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Phone: (503) 224-0048 or outside Portland: 1-800-547-4457
Email: Alaskalongshore@aibpa.com

MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, LIFE INSURANCE AND TIME LOSS BENEFITS

Medical, prescription drug, dental, vision, additional life insurance and time loss benefits are provided through the Inlandboatmen's Union of the Pacific Health Trust Plan. These benefits are described in the separate plan booklet for that plan. You may obtain a copy of the IBU PPO Plan booklet online at www.alaskalongshore.aibpa.com or www.ibu.aibpa.com or by contacting the Trust Administrative Office at 1-800-547-4457, extension #1922. **Please note that certain provisions of the IBU PPO Plan booklet do NOT apply to All Alaska Longshore Health Trust Participants. For eligibility when coverage begins, COBRA, Coverage for Retired Employees, Supplemental Plan accounts and Retiree Medical Plan, refer to this All Alaska Longshore Health & Welfare Trust SPD only**.

The PPO Network is the Premera Blue Cross/Blue Shield Network. For All Alaska Longshore Health Trust participants who reside in an area that is defined as underserved by the Premera Network, when a PPO provider is not available to you, the in-network level of benefits will be provided.

TRANSPORTATION BENEFIT

For eligible employees, retirees, and 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 Plan 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.

SUPPLEMENTAL PLAN

For eligible employees, retirees and dependents.

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.

Casuals shall not be eligible to accrue supplemental welfare accounts.

How the Supplemental Plan Works

When your coverage under the Plan starts, the Plan establishes a Supplemental Plan account in your name and deposits up to a maximum of $5,000 in the account.

You use the money in your Supplemental Plan account to reimburse yourself for out-of-pocket health care claims. (See the list below for the types of expenses eligible for reimbursement.)

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

The following July 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 July 1 Supplemental Plan account balance equals $5,000. You have 30 days after the Supplemental Plan Accounts are funded (July 31st) to submit claims for the prior period.

For Example:

Your family incurs $1,000 in dental expenses. If you are eligible, the IBU Plan will pay for 50%, or $500, of the expenses. Assuming your Supplemental Plan account had a balance of $500 and your spouse had no group insurance, you could submit a claim to the Plan and be reimbursed for $500 from your Supplemental Plan account.

Eligible Expenses

You can be reimbursed for the following expenses, which are not covered by this Trust or another group insurance plan:

- Services covered under the medical, prescription drug plan (retail and mail order), dental, vision, including:
  - Deductible;
  - Coinsurance;
  - Co-pays;
  - Amounts over the Reasonable and Customary Charges;
  - Orthodontic or vision expenses in excess of the maximum benefit covered by insurance;
  - Diabetic classes;
  - Smoking cessation clinics and smoking cessation aids, such as Nicoderm;
  - Hearing aids and routine hearing exams;
  - Dental sealant, prescription fluoride and fluoride treatments for a Covered Person over 19 years of age;
  - Services from an acupuncturist;
  - Naturopathic physician visits;
  - Additional pairs of casted orthotics (first paid per year paid under regular plan benefits);
  - Weight loss treatment with a Physician referral (food products not covered);
  - PKU testing; and
  - Flu shots for all family members.

Payment of Claims

The Plan has three payment methods: an automatic reimbursement method called the Early Supplemental Plan, the Monthly Recap Letter method, and a procedure for submitting prescription drug claims for reimbursement.

Automatic Reimbursement/Early Supplemental Plan

Under the Early Supplemental Plan, whenever you submit a covered claim to the Trust Administrative Office for payment, any reimbursement from the Supplemental Plan will automatically be sent to you at the time your claim is paid.

Monthly Recap Letter

If you have submitted medical, dental or vision claims for a service covered by the Plan, once a month you will receive a letter summarizing the dollar amount of your claims that have been processed. The letter will show how much you have submitted, the amount paid by the Plan and the amount that you owe out-of-pocket (which is the amount eligible to be paid from your Supplemental Account.) You then have to indicate on the letter how much of the out-of-pocket expense you want reimbursed from your Supplemental Account, sign the letter and return it to the Trust Administrative Office by the due date indicated on your letter. If you return your signed letter on time, the Plan will issue a check from the Supplemental Plan following receipt of your claim. If you don't return the letter, you will not receive the reimbursement.

Reimbursement for Prescription Drug Claims

You may have out-of-pocket prescription drug expenses (such as copayments) reimbursed through the Supplemental Plan. To receive reimbursement, submit the Reimbursement Form with the receipt from your pharmacy showing the co-payment amount or the explanation of benefits worksheet showing the prescription charge and benefit paid and the participant balance.

Annual Enrollment

Once a year, during the annual enrollment period, you can enroll in the Early Supplemental Plan or dis-enroll by changing to the Monthly Recap Letter method of reimbursement. During the enrollment period, the Plan will send you a letter asking you to choose whether to enroll in the Early Supplemental Plan or be reimbursed using the Monthly Recap Letter method. You make the choice for the entire year by choosing your option, then signing and returning the letter. You can change reimbursement methods only during the annual enrollment period.

Covered by Two Plans

If you are covered by another plan in addition to the Plan, you have two weeks after receiving the explanation of benefits from the other plan to submit your signed letter to the Plan for Supplemental Plan payment. You must include a copy of the other health plan’s explanation of benefits with your signed letter. A check will be issued following receipt of your claim.

LIFE INSURANCE - STANDARD INSURANCE COMPANY

For Active Employees Only

The Plan provides a life insurance benefit for you. The first life insurance benefit is fully insured through Standard Insurance Company and it has a face value of $10,000.

This life insurance benefit is fully insured and underwritten under a separate contract with Standard Life Insurance Company. Contact the Trust Administrative Office for more specific details and a copy of the contract. The highlights of your coverage are described below.

Summary of Benefits

Life Insurance Benefits for Active Employees:

Age	Life Insurance Amount
Life benefits to age 69	$10,000
Life benefits age 70 to 74	$5,000
Life benefits age 75 and over	$3,500

The change in life insurance amount takes effect the first day of the month after your birthday, or, if your birthday is on the first of the month, that day.

If you die while covered under this policy, your beneficiary will receive the life insurance amount that corresponds to your age when you die. Your beneficiary will have to submit a Standard Insurance Company claim form and proof of your death, to receive the benefit.

If the life insurance amount is $10,000, Standard Insurance Company will deposit that amount into a Standard Insurance Company "Secure Access" account, which is an interest-bearing checking account, with your beneficiary named as the owner. When Standard Insurance Company opens the account, your beneficiary will receive a Confirmation Certification explaining the terms and conditions of the account.

If your life insurance amount is less than $10,000, or your beneficiary chooses not to have a Secure Access account, Standard Insurance Company may pay the benefit in installments, over a period agreed upon by your beneficiary and Standard.

For Spouses and Dependent Children

Life insurance is also provided for spouses and Dependent children of active employees who meet the eligibility requirements set forth on page 3. Eligible Dependent children are those described on pages 5 and 6 except for foster children.

The face value of the life insurance for spouses and Dependent children is $10,000 unless the spouse is age 65 or older, in which case the amount of the benefit will be:

Age	Benefit Amount
65 - 69	$6,500
70 - 74	$5,000
75 or over	$3,500

Life insurance coverage for spouses and Dependent children will end on the earliest of:

- Five months after the death of the employee;
- The date the employee's life insurance coverage ends;
- The date the policy is terminated.
- For a spouse, the date of the spouse's divorce from the employee; or
- For a Dependent child, the date the child ceases to be a Dependent as described on pages 5 and 6, or any required proof of dependent status is not provided when requested.

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.

Eligibility

You will not be covered under the life insurance portion of the Plan if you are a full-time member of the armed forces of any country.

Becoming Covered Again After Insurance Ends

If you stopped being covered under the Plan, then come back to work under the Plan again, whether or not you can be covered again under this policy depends on the following circumstances:

- If you let your life insurance lapse, you will become covered for life insurance as though you are a new employee.

- If you have had your life insurance converted to an individual policy, Standard Insurance Company will decide whether or not you can be covered under the Plan policy again. To make the decision about whether you can be covered, you will be required to:

  - Complete and sign a health and medical history form provided by Standard;

  - Sign Standard Insurance Company's form authorizing Standard Insurance Company to obtain information about your health;

  - Provide any additional information reasonably required about your insurability to Standard Insurance Company;

  - You must provide this information at your own expense.

Converting Group Life Insurance to Individual Coverage

If you leave your employment for any reason, you can convert your basic life insurance to an individual policy. You must apply for this option and pay for the first month's premium within the 31-day grace period immediately following the end of your coverage. In most cases, your conversion policy amount will be the same amount of basic life benefit you received while actively employed under the Plan policy. If the Plan policy is terminated, the amount of life insurance you can convert may be lower. Converted policies do not have any of the extra benefits provided under group policies, such as continued life insurance during a disability.
If you have further questions about converting your policy, contact the Trust Administrative Office.

Continued Life Insurance During Disability

If you become totally disabled, you may be able to continue your life insurance during your disability. If you apply for continued insurance, and meet the qualifications listed below, you may continue your life insurance:

- You must be totally disabled, meaning you are unable, as a result of sickness, accidental bodily injury or pregnancy, to perform the material duties of any occupation for which you are or become reasonably capable of performing by your education, training or experience;

- You must be less than 60 years of age when the disability starts;

- You must provide written proof of your disability within 12 months after the end of the waiting period.

If your application for continued life insurance is approved, you must submit proof of your disability at your own expense. Standard Insurance Company will require this proof at

reasonable intervals. After you have been disabled for two years, Standard Insurance Company will not require the proof of disability more than once a year.

Independent Examination

Standard has the right to have you examined, by a physician or vocational specialist of their choice and at their expense, while you are receiving continued life insurance.

Amount of Continued Life Insurance

You will have the same coverage amount that you would have as an active employee, and your coverage will reduce when you reach ages 70 and 75.

When Continued Life Insurance Ends

Your continued life insurance ends:

- The date you are no longer totally disabled;
- 90 days after the date Standard Insurance Company mails you a request for proof of continued total disability, unless you provide the proof;
- The date you do not submit to an examination when required by Standard Insurance Company;
- The date you convert your life insurance, as described under Converting Group Life Insurance to Individual Coverage.

If you die during the first six months of your permanent disability, Standard Insurance Company will pay the life insurance benefit according to the master policy schedule of benefits, as long as premium payments have been made by the Plan.

Claims Review and Appeal Procedures under the Life Insurance Benefit

If you die, your beneficiary(ies) should contact the Trust Administrative Office and they can provide you with the claim forms, help you complete the forms and answer any questions.

Standard Insurance Company will not pay the life insurance benefit unless you provide satisfactory written proof of the death. Standard Insurance Company has the right to conduct an independent investigation of any claim and the right to have an autopsy performed (at Standard's expense), except where prohibited by law.

If your beneficiary's claim is denied, he or she has the right to appeal the decision.

If he or she does not receive a written decision on the claim within 90 days after the claim is received, he or she will have an immediate right to request a review under the review procedure (below), as if the claim had been denied.

Notice of the Denial

After a claim is denied or partially denied, you (your beneficiary) will be notified in writing and given an opportunity for review by the Trustees. The written denial will give:

- Specific reasons for the denial;
- A reference to the specific provision on which the denial is based;
- A description of any additional material or information necessary for you to receive the benefits and the reason why the information is needed;
- A notice of your right to a review of the denial; and
- An explanation of Standard Insurance Company's claim review procedure.

Review Procedure

Within 60 days after you (your beneficiary) receive a written notice that your claim was denied (180 days after receiving notice of a denial of a claim for Waiver of Premium), you or your representative may request that Standard Insurance Company reconsider your claim. You must ask for review in writing:

- The written request for review must explain why you are requesting a review and include any supporting facts and any other matters that you feel should be considered;
- You may review any pertinent documents to prepare your request for review.

Standard Insurance Company will review your claim promptly after receiving your request for review. You will receive written notice of Standard Insurance Company's decision within 60 days after they receive your request for review (45 days with respect to Waiver of Premium), or 120 days if special circumstances require an extension. The written decision you receive will include the reasons for the decision and reference to the policy provision on which the decision is based.

Legal Action

You cannot take legal action until 60 days after proof of loss has been provided to Standard Insurance Company. No legal action can be taken three years after the time written proof of loss is required.

Assignment

Your beneficiary may not assign life insurance benefits to another.

For Retirees Only

The Plan provides a life insurance benefit for you. The life insurance benefit is $2,000. 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.

WEEKLY TIME LOSS BENEFITS

For Active Employees Only

This benefit is to supplement the time loss benefit you receive from the IBU Trust. The eligibility and qualifications for the programs are the same, and if you qualify for that benefit, you qualify for this benefit. Because the same people process the benefits, you do not have to apply for both benefits. When you apply for the IBU Trust time loss benefit, you will receive this benefit as well.

How the Weekly Time Loss Benefit Program Works

If you are prevented from working because of bodily injury or sickness, and you meet the definition of disability (below), contact the Trust Administrative Office for the appropriate forms and payment schedule. The Board of Trustees reserves the right to have you undergo an independent medical exam before deciding if you are eligible for benefits.

Qualifications for Benefit Payment

To qualify for weekly time loss benefits you must:

- Have worked or been available for work at least one day in the 31 days before the first day of your disability (paid vacation and travel time count as time worked);

- Be under the care of a licensed physician who confirms (in writing) that you cannot work;

- Be covered on the day of the disability under the All Alaska Longshore Health & Welfare Trust.

Time loss benefits will not be paid for the same time you are collecting or entitled to: accumulated time off, vacation pay, sick leave, workers' compensation, Longshore & Harbor Workers Act, unearned wages or pension benefits, California Disability Income (or have exhausted your rights to CDI), if you are a resident of Hawaii and eligible for Temporary Disability Income (or you have exhausted your rights to TDI).

Definition of Disability

To be eligible for weekly time loss benefits, you must be completely and continuously disabled and be prevented from performing each and every function pertaining to your employment. You also must be under the direct care of a legally qualified doctor as defined by the Plan.

If you return to full-time active work for a continuous period of at least two weeks, any new disability will be considered a new disability regardless of its cause and is subject to a new waiting period before benefits begin again.

Maximum Weekly Benefit

Once you have met the required period of disability prior to benefit payment, you will receive a benefit of $415.53 per week ($59.36 per day).

When Benefit Payments Start

If Disability Results From:	Benefits Begin:
An accident	On the first day of disability
An Illness (non-occupational)	On the eighth consecutive day of disability
An inpatient hospital confinement	On the first day of disability

A period of disability will start only when you are personally seen and treated by a doctor and you provide the Trust Administrative Office with a Certificate of Disability signed by your doctor.

Recurring Disability

If the same Illness or injury occurs again within a 14-day period after the doctor's certification that you are able to return to work, a new claim will be established, but a new seven-day waiting period will not be required. However, the Plan will pay benefits only if you are under the care of a doctor and you submit a new Certificate of Disability, which has been signed by your doctor, to the Trust Administrative Office.

When Time Loss Benefits End

Weekly benefits are payable until:

- The first day your doctor allows you to return to work, or the day you return to work;
- The end of the maximum 52-week lifetime benefit;
- Your retirement under ILWU Alaska Pension Plan or the All Alaska Longshore Pension Plan, other than a disability pension;
- You are no longer eligible under this All Alaska Longshore Health & Welfare Trust.

Time Loss Benefits and Your Taxes

Time loss payments are subject to federal income tax and, if applicable, state income tax. By January 31st of the following year, the Trust Administrative Office will mail W-2 forms for time loss payments made to participants during any given year.

Processing of Claims

You will be notified of a determination on a claim for weekly disability benefits within 45 days after the receipt of the claim by the Trust Administrative Office. If the Trust Administrative Office determines an extension of time is necessary to complete the review of the time loss claim because of matters beyond its control, the 45 day period may be extended for up to 30 days provided the Trust Administrative Office notifies you of the extension of time for processing the time loss claim during the initial 45 day period. If prior to the end of the first 30 day extension, the Trust Administrative Office determines that a further extension of time is necessary to complete the review of the time loss claim because of matters beyond its control, the 30 day extension period may be extended for up to an additional 30 days provided that the Trust Administrative Office notifies you of the extension of time for processing the time loss claim before the end of the first 30 day extension period. If an extension of time is required by the Trust Administrative Office, you will be notified in writing and the notice shall specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional, if any, needed to resolve the issue(s) and the date a decision is expected.

Claims Appeal Procedures for Time Loss Claims

When a claim for time loss benefits has been denied or partially denied, you may appeal the denial to the Board of Trustees. No legal action can be taken until you have exhausted the claim appeal procedure outlined below.

You or your representative has 180 days following receipt of the denial notice from the Trust Administrative Office to file an appeal with the Board of Trustees. The appeal must be in writing and mailed or delivered as follows:

All Alaska Longshore Health & Welfare Trust
c/o A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Email: Alaskalongshore@aibpa.com

Your written request for review must explain why you are requesting a review and should include any supporting facts and any other matters that you feel should be considered.

You may review any pertinent documents to the Plan to prepare your request for review.

Your written request for review is referred by the Trust Administrative Office to the Appeal Review Committee, which is a committee of the Board of Trustees consisting of at least two Trustees.

The Appeals Review Committee will schedule a hearing on your claim at which you will be entitled to present your position and any supporting evidence. You may be represented at the hearing by an attorney or other representative of your choice (at your own cost and expense). After consideration of the evidence presented at the hearing, the Trustees will issue a written decision agreeing, modifying or setting aside the decision on your appeal. The Trustees have the authority to determine eligibility and any other issues referred to throughout this appeal process.

Decision on Review

The Board of Trustees will decide promptly, not more than 60 days after receiving your review request. If special circumstances require an extension of time, the Plan has 120 days from your initial request to make a decision. The final decision will be in writing and include specific reasons for the decision.

Effective January 1, 2002, pursuant to regulations issued by the United States Department of Labor, a participating employee who applies for weekly disability (time loss) benefits on or after January 1, 2002 and whose application is denied by the Trustees may no longer appeal that denial to arbitration.

GENERAL EXCLUSIONS

Applicable to All Benefits

All benefits described in this booklet are subject to the following general exclusions. The Plan will not pay for:

- Services and supplies received while not eligible for Plan coverage;
- Any fee or charge that is more than the Reasonable and Customary (R&C) Charge;

- Any fee or charge for any services or supplies not recommended by a licensed physician, or other qualified provider when appropriate, or for services or supplies determined not to be Medically Necessary in treating an injury or Illness.

- Any injury or sickness where you are entitled to receive compensation for that particular injury or sickness under any workers' compensation, occupational disease law or other similar law, whether or not you elect such coverage or meet the claim filing deadline;

- Charges for services or supplies that are paid for or otherwise provided under any law of government (including Medicare), except where the payments are provided under a plan specifically established by a government for its own civilian participating employees and their dependents;

- Any loss incurred while serving in the armed forces, or caused by war or any act of war (declared or undeclared);

- Charges incurred while legally confined for participation in criminal activities and charges incurred as a result of participation (other than as a victim) in violent criminal activity;

- Charges for any services given by you, your spouse, or any member of your immediate family;

DEFINITIONS

Board of Trustees or Trustees – Means the persons 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 you 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 – see the definition of Dependent under the Eligibility section.

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 masters 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)

Illness – 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, are considered one Illness.

Medically Necessary – covered services and supplies that are determined to meet all of the following requirements. They must be:

- Essential, consistent, and provided for the diagnosis or the direct care and treatment of an Illness, accidental injury, or condition harmful or threatening to your or your dependent's life or health, unless provided for preventative services when specified as covered under this Plan;
- Appropriate and consistent with the diagnosis according to the authoritative medical or scientific literature;
- Not primarily for you, your family's, physician's or another provider's convenience;
- The least costly of alternative supplies or levels of service that can be provided safely;
- Not primarily for research or data accumulation.

The fact that the services and supplies were furnished, prescribed, or approved by a physician or another provider does not mean that the services were Medically Necessary. The Trustees reserve the right to determine whether services and supplies are Medically Necessary and whether or not the Plan will pay for them.

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

Plan – Means the All Alaska Longshore Health & Welfare Trust.

Plan Year – January 1 through December 31 of a calendar year.

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

Reasonable and Customary Charges (R&C) – the fee usually charged by the individual or institution that are similar to charges made by other providers with similar training and experience in the same geographical areas for comparable services and supplies. The Plan will not pay for a fee that exceeds the R&C. As to any particular service or supply, the term "geographic area" means a county or representative cross-section of persons, groups, or other entities furnishing the same services or supplies. The Plan uses a nationwide service to determine the local R&C charge for a service.

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

FILING CLAIMS FOR BENEFITS

Procedures and Requirements

Claims should be submitted for payment within 90 days.

- For medical, prescription drugs, dental, vision, supplemental, transportation and time-loss benefits, you must submit the claim within one year of the date of service; otherwise, the Plan will not pay the claim.

- For life insurance, your beneficiary must submit the claim within one year and ninety days (450 days) after your death; otherwise the claim will not be paid, unless the beneficiary can prove he or she was incapacitated during that period.

Filing Medical, Prescription Drugs, Dental or Vision Claims

Be sure to present your identification card when receiving treatment.

Get itemized provider bills listing all services and treatments you received, and send them to A&I. Providers should send claims to Premera.
Make sure your name or dependent's correct name and social security number are listed on all bills.

Include the diagnosis and accident information if the claim is due to an injury.

If another benefit plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.

Submit the claim on the correct form. Separate claim forms are used for medical, prescription drugs, dental and vision benefits.

A&I determines the benefits and you will receive an Explanation of Benefits, which tells you what the Plan paid.

After presenting the completed claim form and itemized bill for eligible expenses to A&I, a check is made payable to you on behalf of the Plan.

In the event you assign payment (in writing) to the care provider, the check is made payable to that care provider. (Time loss and life insurance benefits cannot be assigned to another).

Filing Transportation Benefit Claims

Before traveling or receiving medical care, obtain a Transportation Application from the Trust Administrative Office or your Union Regional Office. You may obtain these forms electronically at www.alaskalongshore.aibpa.com.

You must complete the first page of the Transportation Application. Have the referring physician or clinic complete the Referring Doctor's Certification. Take the Statement of Attending Doctor form with you when you travel for completion by the treating doctor or clinic.

Submit the completed forms with **all receipts** necessary to verify the reimbursement you are requesting. Transportation benefit claims are processed once per month at the end of the month.

Filing Supplemental Plan Benefit Claims

See page 19 for a description of automatic reimbursement versus monthly recap letter reimbursement.

Filing Weekly Time Loss Claims

If you are unable to work because of an accident or sickness, you should follow these steps:

- Obtain a time-loss claim form online at www.ibu.aibpa.com, www.alaskalongshore.aibpa.com, from the Trust Administrative Office or your Union Regional Office;

- Complete Part 1 of the claim form, have your physician complete Part 2 providing the dates you were unable to work and have your employer complete Part 3 of the form;

- Submit the completed form to the address at the top of the form.

The Trust Administrative Office can answer questions regarding claims submission and benefits. You may contact the Office at:

A&I Benefit Plan Administrators
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
Phone: (503) 224-0048 Outside Portland: (800) 547-4457
Email: Alaskalongshore@aibpa.com

Filing Life Insurance Claims

Life Insurance claims are decided upon, and paid, by Standard Insurance Company. See the Life Insurance sections for claims filing procedures. Claims must be made on an insurance company claim form, which you can obtain from the Trust Administrative Office.

Medical Examinations

The Plan may require you to be examined by a medical doctor for benefits to be paid.

- The Plan has the right to have you examined, at its own expense, as often as required, whenever your Illness or injury is the basis of a claim.

- The Plan has the right to require an autopsy, if not prohibited by law. A disputed Illness is a basis for this requirement.

CLAIMS REVIEW PROCEDURE

The following procedures will be used for the transportation and supplemental plan benefits. For time loss benefits refer to page 26 and the information provided above. Life insurance benefits are provided through a contract with Standard Insurance Company, which gives Standard the right to decide if benefits will be paid under those contracts. See the Life Insurance sections for the procedures to appeal life insurance claims.

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.

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.

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 in 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 S.W. Morrison Street, Suite 300, Portland, Oregon 97205-2222.

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 Plan 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 Plan's hearing procedures, a

copy of which may be obtained from the Trust 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.

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

CIRCUMSTANCES THAT MAY AFFECT YOUR BENEFITS

Coordination of Benefits

Coordination of Benefits (COB) is the term used to describe when you are covered under another benefit plan, in addition to this Plan and how the two plans work together to pay benefits. When you are covered by more than one plan, the two plans will coordinate payment so that the benefit from the two plans together will equal the benefit that would have been paid by the plan with the highest benefits. All of the benefits of this plan are subject to COB except life insurance and time loss benefits.

The All Alaska Longshore Health & Welfare Trust has adopted the National Association of Insurance Commissioners (NAIC) guidelines for COB. For any issue not addressed by the Plan, we will refer to the NAIC guidelines for clarification.

Coordination of Benefits Definitions

Plan means all of the following, even if they do not have their own coordination provisions:

- Group or blanket disability insurance or health care plans issued by insurers, health care service contractors and health maintenance organizations;

- Labor management trustee plans, labor organization plans, employer organization plans or participating employee benefit organization plans;

- Government plans that provide benefits for their own civilians, participating employees or their dependents;

- Group coverage required or provided by any law, including Medicare. This does not include workers' compensation;

- Group student coverage which is sponsored by a school or other educational institution, and that includes medical benefits for Illness or disease;

- Individual medical plans in Washington State;

- Group or individual (no fault) auto insurance.

Allowable Expense – means the reasonable charge for any necessary health care service or supply when the service or supply is covered, at least in part, under any of the plans involved.
Claim Determination Period – means a calendar year.

Which Plan is Primary (And Pays the Larger Portion of the Claim)

An important part of coordinating benefits is determining the order the plans provide benefits. One plan is responsible for providing benefits first; this is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plan then becomes "secondary," which means they reduce their payment amount so that the total benefits from all plans are not more than the allowable expenses. Coordination of benefits always considers amounts that would be payable under the other plan, whether or not a claim has actually been filed.

Here is the order in which the plans usually determine which plan is primary (but not all plans follow this order).

The plan is primary when:

- A plan that does not provide coordination of benefits;
- A plan that covers an enrollee as other than a Dependent (usually the employee);

The plan is secondary when:

- You are covered by another plan as an employee and this plan as a Dependent.

For Dependent children, the following rules apply:

- When Parents Are Married – The plan of the parent whose birthday falls earlier in the year is primary, if that is in agreement with the coordination of benefits provision of both plans. Otherwise, the rules outlined in the plan that does not have this provision will determine the order of benefits;

  When the Parents Are Not Married – If a court decree makes one parent responsible for paying the child's heath care costs, that parent's plan is primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who does not have custody.

Continuation Coverage (COBRA)

If your (or your dependents) coverage is provided under a right of continuation mandated by federal or state law (COBRA) and you are also covered under another plan, the order of benefit determination is:

- First, the benefits of the plan covering the person as an employee, member or subscriber (or as that person's Dependent);

- Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer or Shorter Length of Coverage

If none of the rules in the prior sections apply to your situation, plan that covered you (or your Dependent) longer is primary.

Coverage as a Laid off or Retired Employee

If the plan you have been covered under the longest, covers you as:

- A laid-off or retired participating employee, or
- The Dependent of a participating employee of a laid-off or retired participating employee;

then the plan you have been covered under for the shorter period will be primary. This applies only when other plans involved have this provision regarding laid-off or retired participating employees.

How the Plans Work Together to Pay Benefits

Any amount of the secondary plan's benefits have been reduced to meet the rules in this section, will be used by the secondary plan to pay allowable expenses not otherwise paid. However, the enrollee must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary plan determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

Right of Recovery/Facility of Payment

The Plan has the right to recover any payments that are greater than those required by the COB provision from one or more of the following: providers of a service, insurance companies, service plans or other organizations.

If a payment that should have been made under this Plan was made by another plan, the Plan also has the right to pay directly to another plan any amount that should have been paid by the Plan.

Our payment will be considered a benefit under this plan and will meet the Plan's obligations to the extent of that payment.

Subrogation

The payment of time loss benefits are subject to subrogation under this Plan. This means that if the Plan pays your claims for benefits for an Illness or injury, then you receive payment from a third party who is held responsible for that same Illness or injury (through legal judgment or settlement), you must repay the Plan for the expenses it paid from your judgment/settlement money.

Third Party Liability

When accepting benefit payments from the Plan, you agree to do whatever is necessary to secure, protect, and do nothing to inhibit the Plan's rights to subrogation. This provision applies when you incur Covered Charges that total at least $1,000 and result from an Illness or injury that you might have a right to recover from a third party or his or her own insurance company.

If you received payment for Covered Charges from a third party or his or her own insurance company, the Plan will be reimbursed by the Covered Person for benefits it has paid. The reimbursement cannot exceed the amount you recovered from the third party or their insurance company or the amount the Plan paid for benefits. The amount the Plan will be reimbursed may be reduced by a reasonable fee retained by the attorney who assisted in getting reimbursement.

After you enter into a settlement agreement or receive a judgment against the third party that caused the Illness or injury, the Plan provides no further benefits to you for any Illness or injury caused by the third party that was part of 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 has the right to recover benefits directly from the other person, or from you.

If you make a claim for benefits from the Plan, you are required to agree to reimburse the Plan for the full amount of its payments of Plan benefits, less any 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 Trust Administrative Office mistakenly pays a claim for you that you weren't entitled to, or, if the Board of Trustees or Trust Administrative Office makes a payment to a person who is not entitled to benefits, the Board of Trustees has the right to recover the payment from the person paid or anyone else who benefited, including a provider of services. The Board of Trustees' right to recover includes the right to deduct the amount paid by mistake from your future benefits or from any of your dependents even if the mistaken payment was not made on that family member's behalf.

Assignment of Benefits/QMCSOs

Generally, you can assign benefits to a third party (typically to the provider of the service). You may not assign your supplemental plan benefit, time loss benefit and your beneficiary(ies) may not assign the proceeds of your life insurance benefit.

The plan is legally required to recognize obligations you are liable for as a result of a Qualified Medical Child Support Order (QMCSOs), which is an order that may require you to enroll your child for health care coverage under the Plan. Contact the Trust Administrative Office for information about the Plan's procedures for QMCSOs.

Right to Receive and Release Necessary Information

By participating in the Plan, you consent to the release of certain medical/health care records to the providers and Plan. Records are released only to the extent necessary to determine if a service is covered, quality assurance, utilization review, disease management, settling your grievance, or any other reason permitted by law. Please be aware that the Plan does not need your consent to release certain information necessary to the operation of the Plan.

ADMINISTRATIVE INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA) as amended.

This Plan complies with the Employee Retirement Income Security Act of 1974 and other applicable laws, regulations and amendments. Any omissions or oversights will be resolved according to these laws and regulations.

Name of Plan

This benefit program is known as the All Alaska Longshore Health & Welfare Trust.

Plan Sponsor

This Plan is sponsored by a joint labor-management Board of Trustees. The name, address and telephone number of the Board is:

Board of Trustees

All Alaska Longshore Health & Welfare Trust
c/o A & I Benefit Plan Administrators, Inc.
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
(503) 224-0048 or Outside Portland: (800) 547-4457

The All Alaska Longshore Health & Welfare Trust is sponsored by the participating ports and employers who have Collective Bargaining Agreements with the unions. The agreements require the employers to make contributions to the trust fund and the contributions are used to

provide eligible employees and their dependents with health and welfare benefits specified in the Collective Bargaining Agreement and contracts. The contribution rate is specified in the Collective Bargaining Agreement(s).

Participating Employers and Unions

A list of the employers and unions that sponsor the trust fund and a copy of each Collective Bargaining Agreement are available for examination without cost to you and your beneficiaries at the Trust Administrative Office. A copy of any of these documents may be obtained by written request to A&I Benefit Plan Administrators. You will be charged a reasonable fee for each copy requested.

Employer Identification Numbers and Plan Numbers

The Plan has been given ID numbers so you can identify the Plan and benefit program, should you need to contact the Department of Labor with a complaint about the benefit program.

The Plan ID number is: 91-6070467

The Plan Number is: 501

Type of Plan

This is a health and welfare plan, providing medical, prescription drug, dental, vision, transportation, supplemental, weekly time loss and life insurance benefits.

Plan Year

The fiscal year of this Plan starts on January 1 and ends on December 31 each year.

Description of Collective Bargaining and Joinder Agreements

This Plan is maintained following the terms of Collective Bargaining Agreements between employers and the International Longshoremen and Warehousemen's Union and other employers who have signed joinder agreements with the Plan, all of whom have been accepted by the Board of Trustees. These agreements require that employers make contributions to this Plan for the purpose of allowing employees working under the Collective Bargaining Agreements to participate in the All Alaska Longshore Health & Welfare Trust. The contribution rates are listed in each Collective Bargaining Agreement. Your rights, if any, to participate in the Plan are outlined in the Collective Bargaining Agreement. A copy of any agreement requiring contributions to this Plan can be obtained from the Union or from the Trust Administrative Office, A&I, for a reasonable charge.

Type of Administration

The Trust Administrative Office is the Board of Trustees. The Board of Trustees is responsible for operating the trust fund, and it is made up of Trustees appointed by the participating employers and the unions. The names, titles and addresses of these Trustees are as follows:

Names and Addresses of Trustees

Board of Trustees of the All Alaska Longshoremen are:

Employer Trustee	**Employee Trustees**
Marion Davis Horizon Lines 1717 Tidewater Rd. Anchorage, AK 99501	Patrick Day P.O. Box 788 Valdez, AK 99686
Jeff Bentz North Star Terminal & Stevedore Co. P.O. Box 102019 Anchorage, AK 99510	Alan Coté IBU National 1711 W Nickerson St #D Seattle, WA 98119
Jim Taro Southeast Stevedore P.O. Box 8080 Ketchikan, AK 99901	Pete Danelski P.O. Box 2333 Kodiak, AK 99615
Eugene Makarin American President Lines 3443 W Marginal Way SW Seattle, WA 98106	Chuck Wendt ILWU P.O. Box 1367 Seward, AK 99664

The Trustees have the exclusive right, power and authority in their sole and absolute discretion, to administer, apply and interpret the Plan, and all other documents that describe this Trust Fund. The Trustees may decide all matters arising in connection with the operation or administration of the trust fund. The Trustees may, in their sole discretion, amend the trust fund by a majority vote of the Trustees. Without limiting the rights just described, the Trustees may also:

- Take all actions, and make all decisions, with respect to the eligibility for, and the amount of, benefits reimbursed under the trust fund;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the trust fund according to the terms of the trust fund;
- Decide questions, including legal or factual, relating to the calculation of trust fund benefit payments;
- Resolve and or clarify any ambiguities, inconsistencies and omissions arising under the trust fund or other trust fund documents;
- Process and approve or deny benefit claims, and decide any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the trust fund, and any other trust fund document, will be final and binding on all parties.

From time to time the Trustees may find it advisable to change the benefit provisions of the Plan. In the event this occurs, you will be informed of any changes by mail.

A&I Benefit Plan Administrators will assist the Trustees with the day-to-day administration of the trust fund. A&I Benefit Plan Administrators employees, however, are not Plan fiduciaries. You can contact A&I Benefit Plan Administrators at:

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

Organizations Providing Benefits

Under the All Alaska Longshore Health & Welfare Trust, some of the benefits are provided through the trust fund and some are provided through an insurance contract.

Medical, Prescription Drug, Dental, Vision and the IBU Time Loss and life Insurance Benefits

Medical, prescription drug, dental, vision and the IBU Time Loss benefits are purchased from the Inlandboatmen's Union of the Pacific National Health Trust (IBU). Claims arising from these plans for employees and dependents are paid directly from IBU trust fund assets. The IBU Trust is responsible for paying claims submitted by providers. The initial claims review will be provided by the IBU Trust. However, upon appeal, decisions will be made by the All Alaska Longshore Trustees.

Transportation and Time Loss Benefits

Claims arising for transportation and from time loss are paid directly from Plan Fund assets.

Life Insurance - Standard Insurance Company

Life insurance benefits for employees are provided by an insurance contract with Standard Insurance Company. The benefits are provided and covered under a group contract between the Plan and Standard Insurance Company. Standard Insurance Company is responsible for administering the benefit program and paying the claims.

Standard Insurance Company
900 S.W. Fifth Avenue
Portland, OR 97204

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for purposes of accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are listed under the Administrative Information section. Legal process may also be served on:

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

Plan Funding

This Plan is funded through employer contributions, the amount of which is determined through Collective Bargaining between participating employers and labor organizations, and which is specified in the underlying Collective Bargaining Agreement. The employer contributions and investment income from Trust assets are held in trust for the benefit of eligible plan participants.

Plan benefits can be paid only to the extent that the trust fund has adequate resources available for payments. The availability of health and welfare benefits depends entirely upon the Plan receiving the employer contributions that are required by the Collective Bargaining Agreement. No Contributing Employer has liability, directly or indirectly, to provide the benefits established in this Plan, beyond the obligation to make contributions as stipulated in its Collective Bargaining Agreement.

Termination of Eligibility and Benefits

You have the right to participate in this Plan if you meet the eligibility requirements, work under a Collective Bargaining Agreement described under Description of Collective Bargaining and joinder agreement, and if your employer makes contributions to the Plan on your behalf. Also, certain non-bargaining unit employees are allowed to participate following any special agreements between your employers and the Board of Trustees. If you are an employee of the Union you are also eligible to participate.

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth in the Eligibility sections of this booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits

You are eligible for Trust benefits but may become ineligible as a result of one or more of the following circumstances:

- Not earning enough hours to maintain eligibility as explained in the Eligibility sections;
- Failing to make self-payments to the extent permitted;
- Failing to take COBRA coverage after a reduction in hours or the end of employment. See the COBRA Coverage sections.

Your spouse who is eligible for health care benefits may become ineligible as a result of one or more of the following circumstances:

- You become ineligible as described above;
- Your death, and your spouse does not choose to take COBRA coverage and after which COBRA rights end;
- Divorce or legal separation between you and your spouse, without your spouse taking COBRA coverage.

Dependent children may become ineligible for health care benefits if:

- They are no longer dependent on you;
- They have reached a disqualifying age, unless they elect to take COBRA coverage. See the Eligibility and COBRA sections.

After meeting all the prior eligibility requirements you or your Dependent may still be denied health benefits as a result of one or more of the following circumstances:

- Failure to file a claim for benefits within one year of the date the claim was incurred (one year, three months for life insurance claims), see the How to File Claims sections; or
- Failure to file a complete and truthful benefit application;

If you or your Dependent has other group health coverage or a claim against a third person, it is possible that benefits payable under this Plan may be reduced or denied because of the Plan's subrogation rights or the coordination of benefits between the two plans, see the Subrogation and Coordination of Benefits section of this booklet.

Terminating the Plan

This Trust may be terminated at any time by action of the Trustees. In any event, this Trust will be automatically stopped at the time all Collective Bargaining Agreements requiring the payment of contributions to the trust fund expire. Terminating the Plan will not result from the expiration of all Collective Bargaining Agreements, as long as any employer continues to have a legal obligation to continue to make contributions to the trust fund, or continues during contract negotiations to voluntarily contribute to the trust fund without the Union's objections, and provided the Plan is permitted by law to receive these contributions. After the Plan ends, the Trustees will finish the affairs of the trust fund. In the event of any termination, any and all assets remaining in the trust fund, after the payment of expenses, will be used for the payment of benefits according to the Plan, until all assets have been used up. In no event will any of the remaining assets be paid to or be recovered by a participating employer, other employer, association or labor organization.

LEGISLATION AFFECTING HEALTH CARE BENEFITS

Newborn's 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 Trust Administrative Office.

Patient Protection and Affordable Care Act (PPACA) - 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 Administrative 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
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html	CHIP Phone: 1-800-701-0710

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 other 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
877-267-2323, ext. 61565

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 dependants 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. <u>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</u>.

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.

ERISA STATEMENT OF RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Trust Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Trustees, copies of 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 an updated summary plan description. The Trust Administrative Office may make a reasonable charge for the copies.

- 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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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 schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Trust documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit 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 administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file an appeal in accordance with the claim review procedures described elsewhere in this booklet and you may file suit in a state or federal court if you are dissatisfied with the result

of the appeal. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Trust 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 a 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.

Assistance with Your Questions

If you have any questions about your Plan benefits, you should contact the Trust Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from Trust Administrative Office, you should contact the nearest office of the Employee Benefits Security Administration, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 at 866-444-3272.

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, that plan has its own Privacy Practices to protect your health information.

Policy of The Health Plans Regarding Your Health Information

The Health Plan understands that your health information is personal. The Plan is committed to protecting your health information. This notice will tell you about the ways in which the Health Plan 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 Plan is 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 Plan May Use And Disclose Health Information About You

The following categories describe different ways the Health Plan 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 Plan is permitted to use and disclose your health information will fall within one of these categories.

To Make or Obtain Payment

The Health plan 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 Plan 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 Plan 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 Plan may disclose health information about you with physicians who are treating you.

To Coordinate Health Care Operations

The Health Plan may use and disclose your health information to facilitate the administration of the Health Plan. These uses and disclosures are necessary to run the Health Plan. 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 Plan, including customer service and resolution of appeals and grievances.

When Required by Law

The Health Plan will disclose health information about you when required to do so by federal, state or local law. For example, the Health Plan 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 Plan 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 Plan 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 Plan may release health information about you as required by military command authorities. The Health Plan may also release health information about foreign military personnel to the appropriate foreign military authority.

For Treatment Alternatives

The Health Plan 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 Plan 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 Plan may disclose your health information to another health plan maintained by the Plan or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Health Plan. In addition, the Health Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan 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 Plan as described in the Right to Request Restrictions section on page 59.**

Personal Representative

The Health Plan 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 Plan 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 Plan has 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 Plan determines, 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 Plan. 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 Plan. 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 Plan 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 Plan may disclose your health information to a health care provider when needed by the provider to render treatment to you or the Health Plan 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 Plan 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 Plan 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 Plan 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 Plan has met the administrative requirements of the Health Insurance Portability and Accountability Act of 1996 (hereinafter the "HIPAA Privacy Rule"). For example, the Health Plan may disclose your health information in response to a subpoena for such information, but only after the Health Plan meets certain conditions required by the HIPAA Privacy Rule.

Law Enforcement

Under certain conditions, the Health Plan 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 Plan 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 Plan 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 Plan may disclose to a governmental entity authorized to receive such information your health information if the Health Plan believes that you have been a victim of abuse, neglect or domestic violence.

Research

The Health Plan 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 Plan 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 Plan 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 Plan may also disclose, as authorized by law, information to funeral directors so they may carry out their duties. Further, the Health Plan may disclose health information to organizations that handle organ, eye or tissue donation and transplantation.

Workers' Compensation

The Health Plan 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 Plan is 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 Plan 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 Plan will be required to operate. For example, where such laws have been enacted, the Health Plan 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 Plan maintains:

Right to Request Restrictions

You have the right to request restrictions or limitations on the health information the Health Plan uses or discloses 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 Plan is not required to agree to your request. If the Health Plan does agree to the restriction, the Health Plan 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 administrator's office. Any restrictions that may have been provided to the administrator for the Health Plan before April 14, 2004 must be renewed in writing. In your request, you must tell the Health Plan:

- 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 Plan 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 Plan 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 administrator's office. The Health Plan will not ask you the reason for the request. The Health Plan 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 administrator's office. If you request a copy of your health information, the Health Plan 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 Plan amend their records. The request may be made as long as the health information is maintained by the Health Plan.

A request for an amendment of health information records must be made in writing to the administrator's office. The Health Plan 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 Plan, 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 Plan determines 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 Plan 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 Plan 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 PLAN

The Plan is 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 Plan is required to abide by the terms of this notice, which may be amended from time to time. The Plan reserves 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 Plan changes their policies and procedures, the Plan 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 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 Plan should be made in writing to the organization listed below. The Plan encourages 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 Fund
1220 S.W. Morrison Street, Suite 300
Portland, OR 97205-2222
(503) 224-0048 or outside Portland (800) 547-4457
Email: Alaskalongshore@aibpa.com

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