

All Alaska Longshore Health & Welfare Trust

October 2026

RE: READ CAREFULLY!! IMPORTANT INFORMATION ENCLOSED

Dear Participant:

Enclosed with this letter, you will find five important items regarding the All Alaska Longshore Health and Welfare Plan

- 1) HIPAA Notice of Privacy Practices Availability Notice *Page 1*
- 2) Annual Women's Health Notice *Page 2*
- 3) The Medicare Part D Annual Notice *Page 3*
- 4) Nondiscrimination Notice *Page 5*
- 5) Beneficiary Designation Form *Page 7*

It is important to have an updated Beneficiary Designation Form on file with the Trust. This form allows you to control who receives your assets after you pass away.

HIPAA Notice of Privacy Practices Availability Notice

The Alaska Longshore Health Trust maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. You have the right to request a copy of the Plan's Notice of Privacy Practices from the Trust Office by submitting a written request to: PMB#116, 5331 S Macadam Suite 258, Portland, OR 97239. You may also obtain a copy of this notice on the Plan's website:

www.AlaskaLongshorebenefits.org

If you (and or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 2-3 for more details.

All Alaska Longshore Health & Welfare Trust

October 2026

Subject: Women's Health and Cancer Rights Act of 1998

Dear Health Plan Participant:

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 the 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 us at BeneSys, Inc.

BeneSys, Inc.

Creditable Coverage Disclosure Notice for Medicare Part D

Do Not Enroll in Medicare Part D If You Plan on Staying in the Alaska Longshore Health Plan

Date: October 2026

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 the All Alaska Longshore Health 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 Health Plan 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 Alaska Longshore Medical Plan and enroll in a Medicare prescription drug plan, you and your dependents will not be able to re-enroll in the Alaska Longshore Medical Plan. Your current Alaska Longshore Medical Plan medical coverage pays for other health expenses in addition to prescription drugs.

You will NOT be eligible to receive any of your current medical benefits, including prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage for the Alaska Longshore 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

All Alaska Longshore Health & Welfare Trust

NOTICE OF NONDISCRIMINATION

All Alaska Longshore Health & Welfare Trust (“the Health Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact the Health Plan at 800-547-4457 and ask for assistance.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



ATTENTION: FOR FREE LANGUAGE ASSISTANCE CALL 1 (800) 547-4457

Language	Message About Language Assistance
Tagalog Filipino	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (800) 547-4457.
Español Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (800) 547-4457.
한국어 Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1 (800) 547-4457 번으로 전화해 주십시오.
Hmoob Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1 (800) 547-4457.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (800) 547-4457.
繁體中文 Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1 (800) 547-4457.
Gagana fa'a Sāmoa Samoan	MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1 (800) 547-4457.
ພາສາລາວ Lao	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1 (800) 547-4457.
日本語 Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1 (800) 547-4457 まで、お電話にてご連絡ください。
Ilokano Ilocano	PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1 (800) 547-4457
Tiếng Việt Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (800) 547-4457.
Українська Ukrainian	УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1 (800) 547-4457
ภาษาไทย Thai	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1 (800) 547-4457
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1 (800) 547-4457.
Polski Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1 (800) 547-4457

All Alaska Longshore Health & Welfare Trust

Beneficiary Designation Form

Please check the appropriate box for the plan(s) that apply to this beneficiary designation form:

All Alaska Longshore Health Benefit Trust – Self Funded Retiree

Member's Name: _____ Social Security Number: _____

DESIGNATED BENEFICIARY NAME: (Primary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

CONTINGENT BENEFICIARY NAME (Secondary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

Custodial Designation

If my above-named beneficiary is a minor, I hereby designate (print full name) _____ to act as Custodian to receive such benefits on behalf of such child (or children). I understand that I may change this Custodial Designation at any time. I also understand that if I fail to name a Custodian, then the natural parent(s) of the minor will automatically be designated as Custodian. I also understand that if the amount of the benefit is more than \$10,000, and I fail to name a Custodian, the benefit cannot be paid until a Custodian is appointed by the Superior Court.

CUSTODIAN NAME:		Date of Birth:		SSN	
Relationship		Address:			
Phone					

*If you designate more than one Beneficiary, benefits will be paid to them in equal shares, unless you fill in a different percentage to be received where indicated on this form. For example, if you name two beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Secondary Beneficiary only in the event your designated Beneficiaries have died. If you fail to designate a Beneficiary or if all of your designated Beneficiaries have died, the benefits will be paid in accordance with Trust rules.

Member's Signature: _____ Date: _____

Witness (Non-Relative) Signature: _____ Date: _____

Witness Address: _____