ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT

Under the transportation benefit, payment is made toward the incurred costs of transportation required to obtain necessary hospital-medical-surgical, dental or vision care not available in an eligible patient's home community in Alaska.

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, effective January 1, 2026, the Plan will reimburse you a per diem of up to $150 per day, for up to 5 days, not to exceed $750 per person, to pay for car rental, lodging, food, etc.

Travel originating from DUTCH HARBOR ONLY: the Plan will reimburse you a per diem of up to $150 per day, for up to 10 days, not to exceed $1,500 per person, 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 (coach class) 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.

Effective as of January 1, 2026, if you are injured or become ill while traveling within the United States and eligible territories, and you are unable to return home, you may be eligible for expenses incurred by you and/or one (1) chaperone/medical escort, for up to a 90-day maximum, after an initial 14-day waiting period starting the date of injury or Illness. Eligible expenses include coach airfare or equivalent transportation cost reimbursement, and reimbursement up to $150 per diem to pay for car rental, lodging, food, etc.

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

PAYMENT FOR NECESSARY ESCORT

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

BENEFIT REQUIREMENTS

Your or your Dependent's attending doctor in Alaska must certify that the necessary care is not available in your home community, and the certification/referral must show the out-of-area licensed doctor, dentist or medical facility that will be providing the service. Out-of-area is defined as a provider that is 75 or more miles from the participant's home. 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 to obtain routine eye examinations, glasses, or contacts.**
- **Travel for cosmetic, experimental or any other therapy or procedures considered not Medically Necessary.**
- **Travel to obtain a retail prescription, unless Medically Necessary drug or pharmaceutical, is only available to be administered by a licensed out-of-area provider.**

****The $150.00 allowance was effective 1/1/2026****

CHECKLIST FOR REQUIRED TRAVEL RECEIPTS

Air transportation:

- ☐ ***Proof of purchase***
- ☐ ***Itinerary*** **(indicating travel dates)**
- ☐ ***E-tickets or paper & Boarding Passes*** **(must match itinerary and purchase price)**

Car rental:

- ☐ ***Rental Agreement***
- ☐ ***Proof of payment***
- ☐ ***Gasoline receipts***

Lodging:

- ☐ ***Hotel Bill and proof of payment*** **(Paid at single rate unless traveling with an escort)**

Food:

- ☐ ***Meal receipts for the dates of travel and treatment*** **(Payment for meals is limited to patient or patient and escort, if applicable)**

Please remember that (per diem) reimbursement is payable for dates of travel and treatment up to a maximum of 5 days per trip.

ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT APPLICATION

NAME:_____
(Name of Insured)

SS#: _____

ADDRESS: _____

_____

PHONE: (_____) _____

PATIENT'S NAME:_____

I AM MAKING APPLICATION FOR TRANSPORTATION BENEFITS FOR THE FOLLOWING DATES:

From _____ Through _____

I TRAVELED FROM THE LOCATION OF_____TO_____,
TO OBTAIN MEDICAL CARE. I REQUEST REIMBURSEMENT FOR TRAVEL EXPENSES***, AS INDICATED BELOW:

☐ AIRFARE FOR PATIENT: $ _____

☐ AIRFARE FOR ESCORT: $ _____

☐ REIMBURSEMENT AMOUNT OF: $ _____

*****PLEASE ENCLOSE ALL RECEIPTS NECESSARY TO CERTIFY THE DOLLAR AMOUNTS THAT YOU ARE REQUESTING BACK*****

-- OR --

☐ PRIVATE CAR: $_____

(If you use a Private/Rental Car once you arrive at your destination it should be included in your reimbursement (per diem) expenses.) If you use a private car to travel from your home city to the city where you are receiving medical attention, please attach receipts here.

Signature:_____Date:_____

ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT APPLICATION

Before benefits can be paid, this page must be completed by the "Referring Doctor"

REFERRING DOCTOR'S CERTIFICATION

DIAGNOSIS OF PATIENT: _____

_____

CARE CANNOT BE ADMINISTERED AT THIS LOCATION. PATIENT MUST TRAVEL

TO: _____

I HAVE REFERRED PATIENT TO: _____
(NAME OF DOCTOR OR MEDICAL FACILITY)

☐ AN ESCORT **IS REQUIRED** TO TRAVEL WITH THE PATIENT.

☐ AN ESCORT **IS NOT REQUIRED** TO TRAVEL WITH THE PATIENT.

DATE(S) OF SCHEDULED TREATMENT: _____

SIGNATURE OF REFERRING DOCTOR: _____

NAME OF REFERRING DOCTOR: _____
(Please print)

ADDRESS:

_____

_____

PHONE: _____

ALL ALASKA LONGSHORE HEALTH & WELFARE TRUST
TRANSPORTATION BENEFIT APPLICATION

Before benefits can be paid, this page must be completed by the "Attending Doctor"

STATEMENT OF ATTENDING DOCTOR

I CERTIFY THAT I ADMINISTERED SERVICES TO:

_____

ON THE FOLLOWING DATE(S):

_____

DIAGNOSIS:

_____

_____

_____

THE PATIENT WAS HOSPITALIZED FROM_____TO_____

SIGNATURE OF ATTENDING DOCTOR:

_____

NAME OF ATTENDING DOCTOR:

_____
(Please print)

ADDRESS:

_____

_____

PHONE: _____