Summary Plan Description
For
Alyeska Pipeline Service Company
Retiree Medicare Eligible Reimbursement Health Plan

Effective July 1, 2015

July 2015

TABLE OF CONTENTS

INTRODUCTION

The Alyeska Pipeline Service Company (the "Company") has established, effective as of July 1, 2014 (the "Effective Date"), the Alyeska Pipeline Service Company Retiree Medicare Eligible Reimbursement Health Plan (the "Plan") for the benefit of its retirees. The purpose of the Plan is to provide eligible retirees and their spouses with annual credits that can be used to reimburse them for certain healthcare expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended ("Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. The Plan is also intended to be a stand-alone retiree-only plan.

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description ("SPD") is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Company's offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Company.

Note that capitalized terms used in this SPD are defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that "you," "your" and "my" when used in this SPD refer to you, the retiree.

PART I
GENERAL INFORMATION ABOUT THE PLAN

Q-1. What is the purpose of the Plan?

The purpose of the Plan is to provide Participants and their Eligible Dependents (as defined in Q-2 and Q-3) with annual credits that can be used to reimburse them for Eligible Health Care Expenses (as defined in Q-7) that are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Health Care Expenses are generally excludable from the Participant's taxable income.

Q-2. Who can participate in the Plan?

If you satisfy each of the requirements discussed below you are considered an Eligible Retiree and are eligible to participate in the Plan. An Eligible Retiree who begins to participate in the Plan is called a "Participant" (see Q-5 for a discussion of how to become a Participant).

You are considered an Eligible Retiree if you:

(1) Are a former common law employee of the Company for reasons other than your gross midconduct;

(2) Attained age 55 and completed at least 10 Years of Service at the time of your retirement from the Company ('Years of Service' for this purpose means credited eligibility service as determined in accordance with section 2.16 of the Alyeska Pipeline Service Company Pension Plan as in effect on July 1, 2014);

(3) Are enrolled in the Alyeska Pipeline Service Company Group Medical and Dental Plan (the "Group Plan") or the Alyeska Pipeline Service Company Group Retiree Medical and

Dental Plan (the "Pre-65 Plan") at the later of July 1, 2014 and the time you become eligible for Medicare (normally you become eligible for Medicare at age 65 but you could become eligible earlier if you qualify for disability coverage under Medicare); and

(4) Are not eligible to participate in the Alyeska Pipeline Service Company Retiree Health Account Plan.

You are not eligible to participate in the Plan unless you are classified by the Company as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former common-law employee of the Company. It is expressly intended that such individuals are excluded from Plan participation for any period of time during which they are so designated even if that designation, classification or treatment is later changed for any reason (including, without limitation, a determination by a court or administrative agency that such individuals are common-law employees).

Q-3. Can my dependents participate in the Plan?

Your spouse is considered an Eligible Dependent and may become a Participant in the Plan (see Q-5 for a discussion of how to they become a Participant). None of your other dependents are eligible to participate in the Plan.

Your spouse can become a Participant in the Plan before you become a Participant if:

- He/she qualifies for Medicare before you do;
- You are retired from the Company and participating in either the Group Plan or the Pre-65 Plan;
- He/she is not eligible to participate in the Alyeska Pipeline Service Company Retiree Health Account Plan.
- Your spouse is enrolled in the Group Plan or the Pre-65 Plan at the time of Medicare eligibility.

Your spouse must purchase a health insurance policy from the Third Party Administrator at the time of his/her eligibility for Medicare within the time period prescribed in Q-5 or fall under an insurance coverage exception as described in Q-5.

Q-4. If the surviving spouse of a deceased employee is participating in the Alyeska Pipeline Service Company Retiree Group Medical and Dental Plan for Operating Company Employees, can he/she participate in the Plan?

Yes, provided the deceased employee was ineligible to participate in the Alyeska Pipeline Service Company Retiree Health Account Plan on the date of his death. The surviving spouse would be considered an Eligible Dependent who can commence participating in the Plan on the later of the Effective Date or the date the spouse becomes eligible for Medicare.

Q-5. When do I actually become a Participant in the Plan?

An Eligible Retiree or an Eligible Dependent actually becomes a Participant in the Plan on the later of the Effective Date of the Plan or the date that he or she has satisfied all of the following requirements:

- Become eligible for Medicare;

- Obtained an individual health insurance policy (medical or dental coverage) through the Third Party Administrator; and

- Completed any enrollment forms or procedures required by the Plan Administrator.

In addition, the Eligible Retiree or Eligible Dependent must have medical or dental coverage under the Group Plan or the Pre-65 Plan at the time of initial Plan eligibility to become a participant in the Plan. Furthermore, if the Eligible Retiree or Eligible Dependent has medical coverage under the Group Plan or the Pre-65 Plan at the time of initial Plan eligibility, the Eligible Retiree or Eligible Dependent must obtain medical insurance through the Third Party Administrator. If the Eligible Retiree or Eligible Dependent only has dental coverage under the Group Plan or the Pre-65 Plan at the time of initial Plan eligibility, the Eligible Retiree or Eligible Dependent must obtain either medical or dental insurance (or both) through the Third Party Administrator.

These requirements must be completed within two months of initial eligibility to participate in the Plan or the Eligible Retiree or Eligible Dependent will be permanently precluded from participating in the Plan.

An Eligible Retiree or Eligible Dependent who resides outside the United States at the time of initial participation in the Plan is not required to obtain insurance through the Third Party Administrator while living outside the United States since nonresidents of the United States are not permitted to purchase insurance through the exchange. An Eligible Retiree or Eligible Dependent may establish that he or she has qualified health coverage under any other individual or governmental health plan, including, without limitation, TRICARE, VA Health Benefits, and an existing Medicare supplemental plan or has health coverage under a policy or plan provided by his or her spouse's employer in lieu of obtaining an individual policy through the Third Party Administrator.

Q-6. How does the Plan work?

A separate HRA Account will be established for each Participant (i.e., for each Eligible Retiree and a separate one for each Eligible Dependent) and credits for each Participant will be added to his or her own HRA Account.

For each Plan Year, the Company will credit a discretionary annual amount, to be determined in the sole discretion of the Company each Plan Year, to the HRA Account of each Participant. The credit will be added at the time of the Participant's initial eligibility to participate and on the first day of each subsequent Plan Year, provided the Participant continues to remain eligible to participate. At any time, the Participant may receive reimbursement for Eligible Health Care Expenses up to the amount in his or her HRA Account. Note that the law and the Plan's terms do not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind. All benefits under the Plan are paid entirely from the Company's general assets.

Q-7. What is an "Eligible Health Care Expense"?

An Eligible Health Care Expense is an expense incurred by you or an Eligible Dependent for the payment of premiums for medical care, as that term is defined by Code Section 213(d), but limited to the premiums for medical, prescription drug, dental or vision insurance or any Medicare premiums.

All other expenses are NOT Eligible Health Care Expenses for purposes of the Plan.

Only Eligible Health Care Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only Eligible Health Care Expenses incurred while your Eligible Dependent is a Participant in the Plan may be reimbursed from his or her HRA Account. Eligible Health Care Expenses are "incurred" when the health insurance coverage is provided, not when you or your Eligible Dependent is billed, charged or pay for the expense.

Q-8. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Retiree for any reason;
- the date you are rehired by the Company as an active employee;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan;
- the date the Plan is terminated; or
- the last day of the first Plan Year during which you have not made a claim for reimbursement of an Eligible Health Care Expense.

If you are an Eligible Dependent, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an Eligible Dependent for any reason;
- the date you cease to be eligible for Medicare;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan;
- the last day of the first Plan Year during which you have not made a claim for reimbursement of an Eligible Health Care Expense; or
- the date the Plan is terminated.

An Eligible Retiree or an Eligible Dependent will also cease to be a Participant as of the last day of the Plan Year during which he or she allows required coverage obtained through the Third Party Administrator to lapse.

Required coverage for this purpose means:

(1) If the Eligible Retiree or Eligible Dependent had medical coverage with the Third Party Administrator, required coverage is medical coverage.

(2) If the Eligible Retiree or Eligible Dependent did not have medical coverage with the Third Party Administrator but is allowed to participate (per Q-5) by having dental coverage, required coverage means dental or medical coverage.

You may not obtain reimbursement of any Eligible Health Care Expenses incurred after the date your eligibility ceases. (For the definition of "incurred," see Q-7.) You have 180 days after your eligibility ceases, however, to request reimbursement of Eligible Health Care Expenses you incurred before your eligibility ceased.

Q-9. What happens if I do not use all of the credits allocated to my HRA Account during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, you will forfeit the Plan Year's balance remaining on June 30 of the following Plan Year.

Q-10. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as provided in the Plan Information Appendix, along with a copy of your insurance premium bill. You can obtain a reimbursement form from the Third Party Administrator identified in the Plan Information Appendix. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

You must submit requests for reimbursement of Eligible Health Care Expenses by June 30 following the Plan Year in which the expense is incurred.

The Claims Submission Agent will review your claim and respond thereto within thirty (30) days after receiving the claim. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. If the Claims Submission Agent determines that an extension is necessary due to matters beyond the control of the Plan, you will be notified within the initial thirty (30) days that an additional fifteen (15) days is necessary to review the claim. If the extension is necessary because you failed to provide the information necessary to process your claim, the notice of extenstion will describe the information that the you will need to provide. You will have no less than forty-five (45) days from the date you receive the notice to provide the requested information. Claims are paid in the order in which they are received by the Claims Submission Agent.

If your claim is denied, you will receive written notification setting forth the specific reasons for the denial; specific references to pertinent plan provisions on which the denial is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination, or a statement that such rule, guideline, protocol, or other criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; and a description of the Plan's appeal procedures and the time limits applicable to such procedures,

including a statement of your right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

Q-11. What happens if my claim for benefits is denied?

If your claim for reimbursement is wholly or partially denied, you may request in writing a review by the Plan Administrator within one-hundred and eighty (180) days of receipt of the notice of denial of your claim. In connection with such review, you may, upon request and free of charge, have reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits, and may submit issues and comments in writing. The Plan Administrator will make a decision promptly, but not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review will be in writing, in a manner calculated to be understood by the claimant, and shall include:

- specific reasons for the decision;
- specific references to the pertinent Plan provisions on which the decision is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to claimant free of charge upon request; and
- a statement of your right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review.

The decision of the Plan Administrator will be final and conclusive, subject to applicable law. If you challenge the decision of the Plan Administrator within one year after the date of the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described above must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Q-12. What happens if I die?

If the Eligible Retiree dies, the HRA Account of the Eligible Retiree is immediately forfeited upon death, but the deceased Eligible Retiree's estate or representatives may submit claims for Eligible Health Care Expenses incurred by the Eligible Retiree before his or her death. Claims must be submitted within 180 days of his or her death.

The Eligible Dependent will retain his or her HRA Account and submit claims for Eligible Health Care Expenses in the normal course.

If an Eligible Dependent dies, his or her HRA Account shall be immediately forfeited, but the deceased Eligible Dependent's estate or representatives may submit claims for Eligible Health

Care Expenses incurred by the Eligible Dependent before the Eligible Dependent's death. Claims must be submitted within 180 days of his or her death.

Q-13. Are my benefits taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Company cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-14. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Dependent will be required to refund the overpayment or erroneous reimbursement to the Company.

If you do not refund the overpayment or erroneous payment, the Company reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-15. How long will the Plan remain in effect?

Although the Company expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant's HRA Account.

Q-16. Who do I contact if I have questions about the Plan?

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II
LEGAL NOTICES

Health Insurance Portability And Accountability Act Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or "Protected Health Information" ("PHI") and to inform you about:

- the Plan's uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" or "PHI" includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Company obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Company receives PHI, the Plan has been amended to require that the Company only use and disclose PHI received from the Plan for administrative plan purposes as permitted by federal law.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Company for administrative purposes permitted by law and related to treatment, payment or health care operations. The Company has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

The Plan has taken action in reliance on your authorization before it received your written revocation; and

You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

When required by law.

When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For research, subject to conditions.

When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. *"Designated Record Set"* includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained

by or for a health plan; or other information used by the Plan entity to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan at the address provided at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan at the address provided at the end of this Notice.

D. Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; (3) prior to April 14, 2004; or (4) pursuant to your authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. You or your personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan at the address provided at the end of this Notice.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Company's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. The Right to be Notified of a Breach.

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

G. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 6. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

ERISA Statement of Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's 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 Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, 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 updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report.

The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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 your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 plan 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 Plan Administrator 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART III
PLAN INFORMATION APPENDIX

Name of Plan:	Alyeska Pipeline Service Company Retiree Medicare Eligible Reimbursement Health Plan
Effective Date:	July 1, 2014
Name, address, and telephone number of the Plan Sponsor:	Alyeska Pipeline Service Company 3700 Centerpoint Drive Anchorage, Alaska 99503 907-787-7000
Plan Number:	520
Name, mailing address, and telephone number of the Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Alyeska Pipeline Service Company Timothy Adamczak – Compensation/Benefits Manager P.O. Box 196660 – MS536 Anchorage, Alaska 99519 907-787-8457
Agent for Service of Legal Process:	Alyeska Pipeline Service Company Compensation and Benefits Manager – MS536 3700 Centerpoint Drive Anchorage, Alaska 99503 907-787-8700
Sponsor's federal tax identification number:	92-0039154
Plan Year:	January 1 to December 31. The initial Plan Year is a short Plan Year from July 1, 2014 to December 31, 2014
Type of Plan:	Self-funded stand-alone retiree-only welfare benefit plan.
Third Party Administrator:	Towers Watson OneExchange 10975 South Sterling View Drive Suite A-1 South Jordan, UT 849059 855-241-5725

	https://medicare.oneexchange.com/Alyeska

Claims Submission Agent: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	PayFlex Systems USA, Inc. Towers Watson OneExchange P.O. Box 3039 Omaha, NE 68103-3039 Fax: (402) 231-4310
Funding:	Benefits are paid from the Company's general assets. There is no trust or other fund from which benefits are paid.