PLAN DOCUMENT

and

BENEFIT BOOKLET

for the

ALASKA SEAFOOD PROCESSORS' PLAN

Dental / Vision/ Life Insurance / Accidental Death and Dismemberment Benefits

Effective March 1, 2015

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INTRODUCTION

The Trustees are pleased to issue this new Benefit Booklet effective March 1, 2015. This Benefit Booklet serves as the Plan Document and Summary Plan Description for the Alaska Seafood Processors' Plan.

This Benefit Booklet summarizes the Plan's requirements relating to:

- Eligibility to participate in the Plan;
- The circumstances that may result in termination of eligibility to participate in the Plan;
- The benefits provided by the Plan;
- Appeal rights if your claim for a benefit has been denied; and
- Your rights under the Employee Retirement Income Security Act.

The benefits provided by the Plan are provided on a month-to-month basis and are not vested. The Trustees reserve the right, in their sole discretion, to terminate, amend, or change, at any time, the benefits provided by the Plan and the eligibility rules to participate in the Plan.

The Trustees have the complete and exclusive discretionary authority to construe and interpret this Benefit Booklet, including, but not limited to, eligibility for benefits, subject to the Plan's appeal procedures set forth later in the Benefit Booklet. No individual Trustee, union representative, employer representative, or employee of the Trust Office is authorized to interpret this Benefit Booklet for the Trustees or to act as agent for the Trustees. The Trustees have authorized employees of the Trust Office to respond informally to inquiries from Employees. However, written and oral answers are not binding upon the Trustees.

Words and phrases that have initial capital letters are defined terms. See the Definition of Terms section starting on page 46.

If You would like further information or assistance, please call or write the Trust Office:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

SUMMARY OF BENEFITS

This is a summary of benefits provided by the Plan. The purpose is to give You quick access to the information You will most often want to review.

For specific eligibility and benefit information please refer to the later sections of the Benefit Booklet for a more detailed explanation of eligibility, benefits and any limitations or restrictions that might apply.

Eligibility for Benefits

Not all benefits in this Benefit Booklet are available to all Employees. The type of benefits available to the Employee and the length of coverage is determined by Your collective bargaining agreement. Some Employees will only receive the life insurance and accidental death and dismemberment benefit.

Dental, vision, life insurance, and accidental death and dismemberment benefits are not available to Dependents.

If You have questions, please check Your collective bargaining agreement or contact the Trust Office at:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457
Fax: (503) 228-0149

Summary of Benefits (Effective October 1 – September 30)	
Dental Expense Coverage (Employee Only)	
Annual Deductible	None for Covered Charges under Dental Care Units 1 and 2 $75 of Covered Charges under Dental Care Unit 3
Maximum Annual Benefit Amount (October 1 through September 30)	$2,000
Dental Services	
– Diagnostic and Preventive Care (Unit 1)	100% of Covered Charges up to the Maximum Annual Amount ($2,000)
– Basic and Restorative Procedures (Unit 2)	80% of Covered Charges up to the Maximum Annual Amount ($2,000)
– Other Procedures (Unit 3)	50% of Covered Charges up to the Maximum Annual Amount ($2,000) after the Deductible of $75

Vision Care Expense Coverage (Employee Only)	
Maximum Annual Benefit Amount (October 1 through September 30)	$150
Vision Services – Complete Visual Analysis Single Vision Lenses (pair) – Bifocal Lenses (pair – Trifocal Lenses (pair) – Lenticular Lenses (pair) – Eyeglass Frames – Contact Lenses	The Plan will pay 80% of Reasonable and Customary Charges for Covered Charges up to the Maximum Annual Amount ($150). There is no Deductible.
Life Insurance (Employee Only)	
Amount of Insurance	$2,000
Accidental Death and Dismemberment (Employee Only)	
Loss of life	$2,000
Loss of one hand, one foot, or one eye	$1,000
Two or more of the above losses	$2,000

HOW TO BE COVERED – EMPLOYEES

Eligibility

To be eligible to receive one or more of the benefits provided by the Plan, You must have worked under a collective bargaining agreement that requires contributions to the Trust, You must have worked a sufficient number of hours to qualify for an Employer contribution to the Trust, and Your Employer must have made the required contribution to the Trust for You. The following collective bargaining agreements require a contribution to the Trust for Employees who work a sufficient number of hours:

- Peter Pan Seafoods, Inc. and the Alaska Fisheries Division of United Industrial Workers, a Division of the Seafarers International Union;
- Peter Pan Seafoods, Inc. and the Inlandboatmen's Union of the Pacific, Region 37; and
- Any other collective bargaining agreement which requires contributions to the Trust.

Please review Your collective bargaining agreement or call the Trust Office at 1-800-547-4457 with any questions concerning your eligibility for Plan benefits.

The number of hours You work for an Employer for the period October 1 through September 30 generally determines the Plan benefits You are eligible to receive. Employees will generally fall within one of three groups:

- *Group 1.* Employees who qualify for life insurance and accidental death and dismemberment insurance benefits only for the period October 1 through September 30.
- *Group 2.* Employees who qualify for life insurance and accidental death and dismemberment insurance benefits only for the period October 1 through March 31.

- *Group 3.* Employees who qualify for dental, vision, life insurance, and accidental death and dismemberment insurance benefits for the period October 1 through September 30.

Termination of Coverage

Your coverage will terminate on the earliest of:

(a) the date the Plan terminates; or
(b) the end of the calendar month for which premiums are paid.

SPECIAL ENROLLMENT RIGHTS

Employees have special enrollment rights in the Plan if the Employee did not enroll when first eligible and the criteria set forth below are met. Special enrollment rights are available only if the Employee's collective bargaining agreement provides for Dental and Vision Coverage.

Late Enrollees. A late enrollee is an Employee who did not enroll in the Plan when first eligible for benefits and does not qualify as a special enrollee. A late enrollee may enroll for coverage during the next open enrollment period.

Special Enrollee. A special enrollee is an Employee that is allowed to enroll in the Plan after initial eligibility for coverage and before the next open enrollment period because of a loss of other group health coverage, change in family status or eligibility under the Children's Health Insurance Program as described below.

Special Enrollment Period. If an Employee qualifies as a special enrollee under one of the circumstances described below, he or she may enroll in the Plan during the special enrollment period described below.

Special Enrollees Due to a Loss of Other Group Health Coverage. If an Employee does not enroll himself for Plan coverage because other group health coverage was in effect, the Employee may enroll himself for Plan coverage within thirty (30) days after the other group health coverage ends, so long as the following conditions are met:

(a) The person to be enrolled was covered under another group health plan at the time coverage under this Plan was offered; and

(1) COBRA continuation coverage under another group health plan was exhausted. Failure to pay the premium or premature termination of COBRA continuation coverage does not satisfy this requirement; or

(2) Coverage under another group health plan was terminated as the result of loss of eligibility for reasons such as legal separation, divorce, death, termination of employment or reduction in number of hours of employment (failure to pay the premium does not satisfy this requirement); or

(3) Employer contribution toward the premium for other group health plan coverage was terminated; and

(b) The person requests Plan coverage not later than thirty (30) days after the date the other group health plan coverage ends. Contact the Trust Office for enrollment information.

Coverage under this Plan will become effective on the first day of the month following the Trust Office's receipt and acceptance of a completed enrollment form. If the Trust Office does not receive a completed enrollment form within thirty (30) days after the date the other group health plan coverage ended, the individual will be considered a late enrollee.

Special Enrollees Due to a Change in Family Status. If an Employee declined to enroll himself for Plan coverage and later has a change in family status, the Employee may be eligible to enroll as a special enrollee. Marriage, adoption, placement of a child for adoption, placement of a foster child, or birth of a child are considered a change in family status. You must request enrollment within thirty (30) days of the marriage, adoption, placement for adoption, placement of a foster child, or birth of a child.

Contact the Trust Office for enrollment information. If the Trust Office does not receive the enrollment form within thirty (30) days of the date of the change in family status, the individual will be considered a late enrollee.

Special Enrollees under the Children's Health Insurance Program (CHIP). A federal law, known as the Children's Health Insurance Program Reauthorization Act, requires the Plan to allow an Employee who is eligible to enroll in the Plan, but who is not enrolled, a special enrollment opportunity under the following circumstances:

(a) An Employee's Medicare coverage is terminated as a result of loss of eligibility and the Employee requests coverage from the Plan within sixty (60) days of the loss of coverage; or

(b) An Employee becomes eligible for a premium assistance subsidy from Medicaid to help pay for the cost of medical coverage from this Plan and the Employee requests coverage from this Plan within sixty (60) days after the date the Employee is eligible for premium assistance.

Contact the Trust Office for an enrollment form and information about how to enroll. Coverage under this Plan will start on the first day of the month the Employee qualifies for premium assistance or loses coverage under Medicare. If the Trust Office does not receive the enrollment form within sixty (60) days, the individual will be considered a late enrollee.

COBRA – CONTINUATION OF COVERAGE

Introduction

This section contains important information about the right to COBRA continuation coverage which is a temporary extension of dental and vision coverage. COBRA continuation coverage can become available to You at the time You would otherwise lose dental and vision coverage provided by the Plan. This section explains COBRA continuation coverage, when it becomes available, and what You need to do to preserve Your right to COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of dental and vision coverage that would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose dental and vision coverage because of a qualifying event. Depending on the type of qualifying event, Employees may be qualified beneficiaries.

Qualifying Events for COBRA

For Employees

You become a qualified beneficiary and eligible for COBRA coverage if You lose Your coverage under this Plan due to either of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends.

Notice Procedures

Any notice that You provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver Your written notice to the Trust Office at this address:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the Plan name (Alaska Seafood Processors' Plan), the name and address of the Employee covered by the Alaska Seafood Processors' Plan.

You will be notified of the right to elect COBRA continuation coverage automatically when coverage is lost because the Employee's employment ends or hours of employment are reduced.

You must elect COBRA continuation coverage within sixty (60) days of receiving the COBRA election form or, if later, sixty (60) days after coverage ends by completing and returning the election form to the

Trust Office. **If You do not elect COBRA continuation coverage within the sixty (60)-day election period, you will lose the right to elect COBRA continuation coverage. The election to accept COBRA continuation coverage is effective on the date the election is mailed to the Trust Office.** A qualified beneficiary may change a rejection of COBRA continuation coverage at any time until the election period expires.

When considering whether to elect COBRA, You should take into account that a failure to elect COBRA will affect Your future rights under federal law. You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within thirty (30) days after Your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if You get COBRA continuation coverage for the maximum time available.

Benefits Available under COBRA Continuation Coverage

A qualified beneficiary has the right to elect COBRA continuation coverage for dental and vision coverage. COBRA continuation coverage is identical to the dental and vision coverage available to similarly situated Employees. If the dental and vision coverage is modified, COBRA continuation coverage will be modified in the same way.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of health and welfare coverage.

When the qualifying event is the Employee's termination of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months.

Disability Extension of Eighteen-Month Period of COBRA Continuation Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and You notify the Trust Office in a timely fashion, You may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability must have to have started at a time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify the Trust Office **in writing** of the Social Security Administration's disability determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must follow the procedures under the heading **Notice Procedures** on page 7. In addition, Your written notice must include the name of the disabled person, the date that he or she became disabled, the date that the Social Security Administration made its determination and include a copy of the Social Security Administration's disability determination. IF THESE PROCEDURES ARE NOT FOLLOWED OR IF THE NOTICE IS NOT PROVIDED IN WRITING TO THE TRUST OFFICE WITHIN THE REQUIRED TIME, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, You must notify the Trust Office in writing within thirty (30) days after the Social Security Administration's determination.

How Much COBRA Continuation Coverage Costs

A qualified beneficiary who elects COBRA continuation coverage will be required to pay the cost of COBRA continuation coverage. The cost may not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the group health plan for coverage of a similarly situated Employee who is not receiving COBRA continuation coverage.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance. Under the Trade Act of 2002, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health coverage, including COBRA continuation coverage. If You have questions about the Trade Act of 2002, You may call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

When and How Payment for COBRA Continuation Coverage Must Be Made

First Payment for COBRA Continuation Coverage. If You elect COBRA continuation coverage, You do not have to send a payment for COBRA continuation coverage with the election form. However, You must make Your first payment for COBRA continuation coverage no later than forty-five (45) days after the date of Your election. This is the date the election form is postmarked, if mailed. If You do not make Your first payment for COBRA continuation coverage in full no later than forty-five (45) days after the date of Your election, You will lose all COBRA continuation coverage rights.

Your first payment must cover the cost of COBRA continuation coverage from the time Your coverage under this Plan would have otherwise terminated up to the time You make the first payment. You are responsible for making sure that the first payment is enough to cover the entire cost. You may contact the Trust Office to confirm the correct amount of Your first payment.

Your first payment for COBRA continuation coverage should be sent to:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

Monthly Payments for COBRA Continuation Coverage. After You make Your first payment for COBRA continuation coverage, You are required to pay for COBRA continuation coverage for each subsequent month of coverage. The monthly payments are due by the first day of the month. If You make a monthly payment on or before the first day of the month, Your coverage will continue for that coverage period without any break. **The Trust Office will not send notices of payments due for these coverage periods.**

Monthly payments for COBRA continuation coverage should be sent to:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

Grace Period for Monthly Payments. Although monthly payments are due by the first day of the month, You have a grace period of thirty (30) days to make each monthly payment. Your COBRA continuation

coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if You pay a monthly payment later than the first day of the month but before the end of the grace period, Your coverage under this Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim You submit for benefits while Your coverage is suspended may be denied and may have to be resubmitted once Your coverage is reinstated. **If You fail to make a monthly payment by the end of the grace period, You will lose all rights to COBRA continuation coverage.**

Termination of COBRA Continuation Coverage Before the End of the Maximum Period

COBRA continuation coverage will automatically end (even before the end of the maximum coverage period) if:

(a) The premium is not paid by the end of the grace period;

(b) After electing COBRA continuation coverage, You become entitled to Medicare (Part A, Part B or both);

(c) After electing COBRA continuation coverage, You become covered under another group health plan (but only after any exclusions in the other plan for a preexisting condition has been exhausted or satisfied);

(d) The Trust no longer provides group dental and vision coverage for any of its participants; or

(e) During a disability extension period (explained on page 8), the disabled person is determined by the Social Security Administration to no longer be disabled. In this circumstance, COBRA continuation coverage will be terminated for any qualified beneficiary who is receiving extended COBRA continuation coverage under the disability extension as of the later of (i) the first day of the month that is more than thirty (30) days after the final determination by the Social Security Administration that You are no longer disabled; or (ii) the end of the COBRA coverage period that applies without regard to the disability extension.

You must notify the Trust Office in writing within thirty (30) days if, after electing COBRA continuation coverage, You become entitled to Medicare (Part A, Part B or both), You become covered under another group health plan, or it is determined by the Social Security Administration that You are no longer disabled. Follow the **Notice Procedures** on page 7.

More Information about COBRA Continuation Coverage

Questions concerning this Plan or Your COBRA continuation coverage rights should be addressed to the Trust Office. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act and other laws affecting group health plans, contact the nearest Regional or District office of the US Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website.

Keep the Trust Office Informed of Address Changes

In order to protect Your rights, You should keep the Trust Office informed of any changes in Your address. You should keep a copy of any notices You send to the Trust Office.

DENTAL EXPENSE COVERAGE
Employee Only – No Dependent Dental Coverage

Benefit Qualification

To qualify for payment of dental benefits provided by the Plan, You must be enrolled for and eligible to receive dental benefits on the date dental treatment or service is received except as provided under the Extended Benefits section on page 13.

Benefits Payable

Benefits payable will be as described in this section, subject to:

(a) all listed limitations; and

(b) the terms and conditions of the COORDINATION OF BENEFITS section of the Plan (page 26).

Payment Conditions

If You receive treatment or service that is listed in the Schedule of Dental Procedures starting on page 14, the Plan will pay for Covered Dental Charges:

(a) in excess of the deductible amount;

(b) at the payment percentage(s) indicated;

(c) to the Maximum Annual Allowance ($2,000 from October 1 through September 30); and

(d) as described in this section.

Covered Dental Charges

For a dental service to be covered, the treatment or service must be performed by a Dentist, a licensed denturist, or a Dental Hygienist working under the supervision of a Dentist or who is licensed to practice dental hygiene.

Covered Dental Charges will be the actual charges for treatment or service, but not more than $2,000 from October 1 through September 30, subject to the following:

(a) Covered Dental Charges will include only charges for treatment or service that begins while You ***are*** covered under the Plan. See Beginning Date for Treatment or Service on page 13; and

(b) Covered Dental Charges will include only charges for treatment or service that is completed while You are covered under the Plan except when the treatment or service is covered under the Extended Benefits provision on page 13.

Beginning Date for Treatment or Service

Treatment or service will be considered to begin:

(a) For root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex.

(b) For crowns, fixed bridgework, inlays or for onlay restoration, on the date the tooth or teeth are fully prepared.

(c) For full or partial dentures, on the date the master impression is made.

(d) For all other treatment, on the date the treatment or service is performed.

Extended Benefits
(after termination of Plan coverage)

If Dental Expense Coverage ceases, the Plan will pay for:

(a) root canal therapy, if the pulp chamber was opened and the pulp canal explored to the apex while You were covered under the Plan; and

(b) crowns, fixed bridgework, inlays or for onlay restorations if the tooth or teeth were fully prepared while You were covered under the Plan; and

(c) full or partial dentures if the master impression was made while You were covered under the Plan

provided the treatment or service is received within two months after Your Dental Expense Coverage ceased.

Dental Expense Limitations and Exclusions

Covered Dental Charges do not include and benefits will not be paid for:

(a) treatment or services that exceeds Prevailing Charges;

(b) treatment or services by any person who is not a Dentist, denturist, Dental Hygienist, or who resides in Your Immediate Family;

(c) treatment or services for cosmetic purposes including but not limited to personalization or characterization of dentures or crowns except when required due to an accidental bodily injury or surgical procedure for removal of a tumor;

(d) drugs and medicines (except for antibiotic injections);

(e) bite registration or occlusal analysis;

(f) instructions for plaque control, oral hygiene or diet;

(g) treatment or services to alter vertical dimension or restore occlusion or to duplicate a lost or stolen prosthetic device or to duplicate a lost or stolen appliance;

(h) orthodontic treatment or service;

(i) treatment or services for which You have no financial liability or treatment that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);

(j) treatment or services that results from war or act of war or from voluntary participation in criminal activities;

(k) treatment or services that is covered by a Workers' Compensation Act or other similar law;

(l) failure to keep a scheduled appointment;

(m) treatment or services that is not dentally necessary and/or not recognized by the American Dental Association;

(n) treatment or services that began prior to eligibility for dental expense coverage;

(o) treatment or service incurred after the termination date for dental expense coverage except as allowed by the Extended Benefits section on page 13.

Schedule of Dental Procedures

Covered Dental Charges will include only charges for procedures listed in this Schedule of Dental Procedures below.

DENTAL CARE UNIT 1 – DIAGNOSTIC AND PREVENTIVE PROCEDURES

Subject to the terms and conditions described under Payment Conditions on page 11, the maximum amount the Plan will pay for the procedures described below will be the actual charges, but only to the extent that the actual charges do not exceed Prevailing Charges. Covered Dental Charges for the following procedures are payable at 100% up to the Maximum Annual Benefit Amount ($2,000 from October 1 through September 30) and are not subject to the deductible.

Dental Procedure Examinations

Oral Examination. Only one oral examination (other than emergency examination) will be covered each six-month period.

Radiographs

Intraoral x-rays
Complete series
Covered once each three-year period.
Only one bitewing x-ray will be covered in a six-month period.

Occlusal Periapical Extraoral x-rays

Panoramic
Sialography
TMJ
Cephalometric film
Posteroanterior and lateral skull and facial bone survey
Other extraoral
Only one of the listed extraoral procedures will be covered in a six-month period.
Diagnostic x-rays performed in conjunction with root canal therapy or orthodontic treatment will not be considered Unit 1 Covered Charges.

Preventive Services

Prophylaxis (cleaning of teeth) covered once in a six-month period.

Other Services

Biopsy of oral tissue
Palliative treatment
Covered as a separate procedure if no other service (except x-rays) is provided during the visit.
Bacteriologic culture
Histopathologic examination
Pulp vitality test
Diagnostic cast
Covered once in a two-year period.

DENTAL CARE UNIT 2 – BASIC PROCEDURES

Subject to the terms and conditions described under Payment Conditions on page 11, the maximum amount the Plan will pay for the procedures described below will be the actual charges, but only to the extent that the actual charges do not exceed Prevailing Charges. Covered Dental Charges for the following procedures are payable at 80% of the Prevailing Charges up to the Maximum Annual Benefit Amount ($2,000 from October 1 through September 30) and are not subject to the deductible.

Dental Procedure Restorations

Fillings (amalgam, silicate, plastic, or composite, including pin retention when necessary)
Stainless steel crown

Oral Surgery

Extraction of teeth
Alveoloplasty
Removal of dental cysts and tumors
Surgical incision and drainage of dental abscess
Other surgical procedures:
- Tooth replantation
- Surgical exposure to aid eruption
- Surgical repositioning of teeth
- Excision of hyperplastic tissue

Periodontic Services

Surgical procedures:
- Gingivectomy
- Gingival curettage
- Osseous surgery
- Osseous graft

Only one of the listed periodontic surgical procedures is covered for each quadrant in a 12-month period.

Dental Procedures

Scaling and root planing (each quadrant). One quadrant in a six-month period.
Periodontal appliance. One appliance in a three-year period.
Periodontal prophylaxis

Endodontic Services

Pulp cap
Vital pulpotomy
Root canal therapy including treatment plan, diagnostic x-rays, clinical procedures, and follow-up care
Apexification
Apicoectomy
Retrograde filling
Apicoectomy and retrograde filling
- will be covered as a separate procedure if performed more than one year after the root canal therapy is completed.

Apical curettage Root resection
Hemisection

Anesthesia

General Anesthesia
- Covered as a separate procedure when required for complex oral surgical procedures covered under this Plan and when not performed in a Hospital.

Other Services

Repairs to bridges and full or partial dentures adding tooth to partial denture
Relining full or partial denture (upper or lower)

Covered if relining is done more than one year after the initial installation but not more than once each two-year period.

Recementing
Inlay
Crown
Bridge
Space maintainer
Consultation with specialist
Antibiotic Drug injection

DENTAL CARE UNIT 3 – OTHER PROCEDURES

Subject to the terms and conditions described under Payment Conditions on page 11, the maximum amount the Plan will pay for each procedure described below will be the actual charges, but only to the extent that the actual charges do not exceed Prevailing Charges. Covered Dental Charges for the following procedures are payable at 50% of the Prevailing Charges after payment of a $75 deductible each year (October 1 through September 30) up to the Maximum Annual Benefit Amount ($2,000 from October 1 through September 30).

Dental Implants

Gold Fillings and Crowns

VISION EXPENSE COVERAGE
Employee Only – No Dependent Vision Coverage

Benefit Qualification

To qualify for payment of vision benefits provided by the Plan, You must be enrolled for and eligible to receive vision benefits on the date vision materials or services are provided.

Benefits Payable

Benefits payable will be as described in this section subject to:

(a) all listed limitations; and

(b) the terms and conditions of the COORDINATION OF BENEFITS section of the Plan (page 26).

Payment Conditions

If You receive vision treatment or service that is listed as Covered Vision Services, the Plan will pay vision benefits for Covered Vision Services:

(a) to the Maximum Annual Allowance ($150) from October 1 through September 30; and

(b) as described in this section.

Covered Vision Services

The following charges for materials and vision-related services are covered when performed by a legally qualified ophthalmologist or Optometrist:

(a) routine eye exam;

(b) lenses for eyeglasses;

(c) contact lenses; and

(d) eyeglass frames.

Vision Expense Coverage Limitations and Exclusions

(a) a visual analysis that is not performed by an ophthalmologist or Optometrist;

(b) vision aids that are not prescribed by an ophthalmologist or Optometrist;

(c) a visual analysis or vision aids provided by a member of Your Immediate Family;

(d) non-prescription sunglasses, or duplication or replacement of a vision aid that is broken, lost or stolen;

(e) more than one complete visual analysis in a period of twelve (12) consecutive months;

(f) more than two lenses in a period of twelve (12) consecutive months;

(g) more than one set of frames in a period of twelve (12) consecutive months;

(h) a visual analysis or vision aids for which You have no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States Government or one of its agencies (except as required under Medicaid provisions or Federal law);

(i) a visual analysis or vision aids that is covered by a Workers' Compensation Act or other similar law; or

(j) a visual analysis or vision aids provided as the results from war or an act of war or voluntary participation in criminal activities.

CLAIM PROCEDURES

How to File a Claim for Benefits

The procedure set forth below is applicable to dental and vision benefits. See page 30 of the Benefit Booklet for the procedure to file a claim for life insurance or accidental death and dismemberment insurance benefits.

Claim Forms

Claim forms must be completed in order to receive benefits. Claim forms may be obtained by calling the Trust Office or online at www.ibu.aibpa.com. After completing the claim form, mail, fax or email it together with the itemized billing from the provider to the Trust Office for processing. You may call the Trust Office for assistance in completing a claim form. Submit Your completed dental or vision claim form to the Trust Office with all supporting documents as follows:

Alaska Seafood Processors' Plan
c/o BeneSys Administrators, Inc.
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

If You have questions regarding a dental or vision claim form or payment, please call:

Alaska Seafood Processors' Plan
Local: (503) 224-0048 X1651
Toll free: (800) 547-4457 X1651
Fax: (503) 228-0149
Email: ibu@aibpa.com

How to File a Dental or Vision Claim

Follow the steps shown below when filing a claim:

- Obtain itemized bills, listing all services and treatments received. The bill should include the date of service and the person who received the service.

- Obtain and complete a claim form.

- The claim form must be submitted within ninety (90) days after the treatment or service is incurred. Failure to file a claim form within ninety (90) days will not invalidate or reduce the claim if it can be shown that the claim form was submitted as soon as reasonably possible. Failure to file a claim form within one (1) year will invalidate any claim.

- Forward Your itemized bills and claim form to:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
In Portland (503) 224-0048 Outside Portland (800) 547-4457

PLEASE BE SURE TO INCLUDE THE EMPLOYEE'S IDENTIFICATION OR SOCIAL SECURITY OR ID NUMBER ON ALL BILLS AND CLAIM FORMS.

If Your claim form is incomplete, processing may be suspended until complete information is provided.

Direct Payments

Any benefits payable to a Dentist or for covered dental or vision services which You have assigned will be paid to the Dentist or provider of the services. If You have not assigned the benefits, the Plan will pay You.

Benefits unpaid at Your death may be paid, at the Plan's option to:

- Your beneficiary; or
- Your estate.

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

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

Return of Overpayment

If the Trust Office mistakenly pays a claim for which You are not entitled or makes a payment to a Dentist or provider who is not entitled to the payment, or You do not make a required subrogation or reimbursement payment, the Trustees have the right to recover the payment from the person paid or anyone else who benefitted from it, including a Dentist or provider. The Trustees' right to recover includes the right to deduct the amount paid by mistake or not paid via subrogation or reimbursement from future Covered Charges for You.

APPEAL PROCEDURES

If You have a claim concerning life insurance or accidental death and dismemberment insurance, refer to page 30 of the Benefit Booklet for the claim and appeals procedures.

The appeal procedures below are the sole and exclusive procedures available to an Employee who is dissatisfied with: (i) an eligibility determination, including a rescission of coverage, i.e. discontinuation of coverage that has a retroactive effect for a reason other than failure to make a timely payment; (ii) a benefit determination involving a dental or vision claim, including the denial, reduction, or termination of or failure to provide or make payment (in whole or in part) for a claim that is based on a determination that a benefit is not covered by the Plan, exceeds the maximum allowable benefit, exceeds Prevailing Charges, or other Plan limitation prohibiting payment; or (iii) an action or decision by the Trust Office or the Trustees.

Timeframe for Initial Decision by Trust Office

The timeframe in which an initial decision concerning a claim will be made depends on the type of claim.

Post-Service Claim. A post-service claim is a claim for benefits after the care or treatment has been provided. An example is the amount of a Dentist's bill that will be paid. The Trust Office will provide notice of the benefit determination (whether the claim is approved or denied) within a reasonable period of time but not later than thirty (30) days after receipt of the claim. The time period may be extended up to an additional fifteen (15) days for matters beyond the Trust Office's control but You will be notified of the extension before the end of the 30-day period. The notice will identify circumstances requiring an extension of time and the date by which the Trust Office expects to issue the decision. If the extension is necessary because You did not submit necessary information, the notice will describe the information needed and give You at least forty-five (45) days to furnish the information. You may appeal an adverse benefit determination to the Appeals Review Committee / Trustees and they or their designee will act on the appeal within the timeframe specified in the **Review by the Appeals Review Committee / Trustees** section.

Eligibility Claim. The Trust Office is responsible for deciding issues and claims concerning eligibility-type issues such as eligibility to enroll in the Plan, a late self-payment, COBRA coverage issues and rescission of coverage issues. You will be notified in writing of an eligibility decision. The written decision will normally be provided within ninety (90) days after receipt of Your written notice concerning an eligibility issue. You may appeal an adverse eligibility decision to the Appeals Review Committee/Trustees and they or their designee will act on the appeal within the timeframe specified in the **Review by the Appeals Review Committee / Trustees** section.

Independence of Decision Makers

Throughout the appeal process, the Plan will insure that all claims and appeals are adjudicated in a manner designed to insure the independence and impartiality of the persons involved in making the decision. The Plan will not provide bonuses to individuals or organizations based on the number of denials made by the claims adjudicator or the entity employing the claims adjudicator. The Plan will not contract with an expert based on the expert's reputation for outcomes in contested cases. Rather, the Plan will contract with experts based on each expert's professional qualifications.

Content of Adverse Benefit Determination/Eligibility Determination

If your claim is denied by the Trust Office or its designee, the adverse benefit determination will be in writing and will provide:

- Information sufficient to identify the claim involved including (to the extent applicable) the date of the service, the name of the provider, a statement that the diagnosis code and treatment code and their meanings will be provided upon request and an explanation of the standard used in making the decision, e.g., dental necessity;

- The specific reason(s) for the adverse benefit determination which must include the denial code and its meaning and an explanation used in making the decision if the claim exceeds the maximum allowable payment under the Plan;

- A description of any additional material or information necessary to perfect the claim and an explanation why such material or information is necessary;

- If the adverse benefit determination is based on an internal rule, guideline, protocol or similar criterion, the internal rule, guideline, protocol or similar criterion will be described or You will be notified of Your right to receive the document free of charge upon request;

- If the adverse benefit determination is based on a decision involving dental necessity or because the service is an experimental or investigational procedure, You will be notified of Your right to receive a statement of the scientific or clinical judgment for the decision free of charge upon request;

- A description of internal and external review procedures including information on how to file an appeal and the time limits for filing an appeal; and

- Contact information for any ombudsman/health insurance consumer assistance services available under the Public Service Health Act.

Procedure to Appeal an Adverse Benefit Determination

If you disagree with the adverse benefit determination issued by the Trust Office or its designee, You or Your authorized representative may file a written appeal within 180 days after receipt of the adverse benefit determination. The written appeal must be filed as follows:

Alaska Seafood Processors' Plan Attention:
Appeal Review Committee
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

You or Your authorized representative may request, in the appeal, to appear at a hearing before the Appeals Review Committee / Trustees when the appeal is considered.

Upon written request to the Trust Office, You will be entitled to review or receive Your entire claim file.

Scope of Review

The appeal will be referred to the Appeals Review Committee and, if necessary, the Trustees as described in the **Review by the Appeals Review Committee/Trustees** section. In either case, the claim will be reviewed *de novo* (meaning without deference to the initial decision). All relevant information will be reviewed regardless of whether the information was previously submitted.

If the Appeals Review Committee/Trustees intends to issue an adverse benefit determination based on new or additional evidence or a new or additional rationale, it will provide the new or additional evidence or new or additional rationale to You free of charge as soon as possible and in advance of the date the decision will be made in order to give You a reasonable opportunity to respond to the new evidence or rationale prior to the decision being made.

If the claim involves issues of dental judgment, such as whether a particular treatment or item is an experimental or investigational procedure or dentally necessary, a health care professional who has appropriate training and experience will be consulted. If a health care professional is consulted, that person will be different from any health care professional previously consulted involving Your claim and will not be the subordinate of the health care professional previously consulted. If a health care professional is consulted, he will be identified regardless of whether his advice is relied on.

Review by the Appeals Review Committee / Trustees

The Co-Chairmen of the Trustees appoint the Appeals Review Committee which consists of an equal number of Employer Trustees and Union Trustees. The Co-Chairmen may be the Appeals Review Committee.

Upon receipt of an appeal, the Trust Office will submit the appeal and all relevant information to the Appeals Review Committee. If a timely request to appear at the hearing of the Appeals Review Committee is made, the claimant may appear at the hearing or the claimant may be represented at the hearing by an attorney or other representative of his choosing at his own cost and expense.

The appeal will be considered by the Appeals Review Committee no later than the next regularly scheduled meeting of the Trustees following receipt of the appeal unless the appeal is received less than thirty (30) days prior to the meeting. In that event, the Appeals Review Committee will consider the appeal no later than the date of the next Trustees' meeting. If due to special circumstances, the Appeals Review Committee requires an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

If the Appeals Review Committee deadlocks or has not reached a unanimous decision prior to the regularly scheduled meeting of the Trustees, a decision will be made by the Trustees at their next regularly scheduled meeting following receipt of the appeal by the Trust Office unless the appeal is filed thirty (30) days prior to the meeting. In that event, the Trustees will review the appeal not later than the date of the subsequent regularly scheduled Trustees' meeting if the Appeals Review Committee has not, by that date, reached a decision. If, due to special circumstances, the Trustees require an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made. If a timely request to appear at a hearing of the Trustees is

made, the claimant may appear at the hearing or the claimant may be represented at the hearing by an attorney or other representative at his choosing and at his cost and expense.

A decision by the Appeals Review Committee or the Trustees will be in writing and sent to You within five days after the decision is made.

Content of an Adverse Benefit Determination on Appeal

If the Appeals Review Committee denies Your appeal, the adverse benefit determination will be in writing and include the same type of information described under the heading **Content of Adverse Benefit Determination / Eligibility Determination** and will also include a discussion of the reason(s) for the decision and reference to the specific Plan provision(s) on which the adverse benefit determination is based and describe the claimant's rights under Section 502(a) of ERISA.

Authority of the Appeals Review Committee and Trustees

The Appeals Review Committee and the Trustees have the full and exclusive authority to administer the Trust and Plan, construe and interpret the Trust, the Plan, and the Benefit Booklet and resolve all questions arising in the administration, interpretation and application of the Trust, the Plan, and the Benefit Booklet. The authority of the Appeals Review Committee and the Trustees includes but is not limited to:

- The right to resolve all matters when review has been requested;
- The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA; and
- The right to construe and interpret all Trust documents including but not limited to the Plan and the Benefit Booklet.

COORDINATION OF BENEFITS

The Plan coordinates dental and/or vision benefits of this Plan with other plans which provide for payment of dental and/or vision benefits. The intent is to provide that benefits from all plans will not exceed 100% of Allowable Expenses.

An "Allowable Expense" is any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the plans covering an Employee for whom a claim is made. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

A "plan" for the purpose of Coordination of Benefits means a plan that provides dental and/or vision benefits. The plan must be provided by Group Insurance, or a Group Hospital or Health Care Service Contractor, or a Health Maintenance Organization Group Contract, or any other coverage arranged through any employer, trustee, union, employee benefit association, or any coverage sponsored by, or provided through, an educational institution. A "plan" also includes any coverage required by statute and any governmental program including Part A and Part B of Title XVIII of the Social Security Act, as amended (Medicare).

The word "plan" shall not include student accident insurance.

The word "plan" shall be construed separately with respect to each policy, agreement, or other arrangement that provides for the benefits or services.

When a claim is made, the Primary Plan pays its benefits without regard to any other plans. The Secondary Plans adjust their benefits so that the total benefits will not exceed the Allowable Expenses exclusive of copayments, deductibles and other cost-sharing arrangements. No plan pays more than it would without the coordination provision.

When this Plan is the Secondary Plan and its payment is reduced to consider the Primary Plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the Employee's later claims in the same calendar year to the extent there are Covered Charges that would not otherwise be fully paid by this Plan and the other plans.

Order of Benefit Determination

A plan without a Coordination of Benefits provision is always a Primary Plan.

If all or both plans have a Coordination of Benefits provision, the claim is determined as follows:

(a) The plan covering the patient directly as an employee is the Primary Plan and the other plan the Secondary Plan.

(b) The plan which covers an individual who is neither laid off nor retired, will be the Primary Plan, and the Plan which covers an individual who is laid off. or retired will be the Secondary Plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on who is Primary, this rule will not apply.

(c) If the rules outlined above do not establish an order of benefit determination, the benefits of the plan which has covered the individual for the longer period is the Primary Plan.

Exchange of Information

Any person who claims benefits under this Plan must, upon request, provide all information that is needed to coordinate benefits.

In addition, all information that is needed to coordinate benefits may be exchanged with other companies, organizations, or persons.

Facility of Payment

The Plan may reimburse another plan if:

(a) benefits were paid by the other plan; but

(b) should have been paid by this Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid by this Plan and, to the extent of those amounts, will discharge the Plan from liability.

Right of Recovery

If it is determined that benefits paid under this Plan should have been paid by any other plan, the Plan will have the right to recover those payments from:

(a) the person to or for whom the benefits were paid; and/or

(b) the other companies or organizations liable for the benefit payments.

THIRD-PARTY REIMBURSEMENT AND/OR SUBROGATION

Third Party Liability

The payment of dental and vision benefits is subject to reimbursement or subrogation under this Plan.

A Employee, upon accepting payment of dental or vision benefits, agrees to do whatever is necessary to fully secure and protect, and do nothing to prejudice, the Trust's rights to reimbursement or subrogation. This provision applies when a Employee incurs Covered Charges that:

- Total at least $1,000, and
- Result from treatment or service for which the Employee might have a right of recovery from a third party or his/her own insurance company.

If the Employee received payment for such Covered Charges from a third party or his/her own insurance company, the Trust will be reimbursed by the Employee for all dental and vision benefits it has paid. Such reimbursement will not exceed:

- The amount recovered by the Employee from the third party or his/her own insurance company, or
- The amount the Trust paid for the dental and vision benefits.

The amount the Trust will be reimbursed may be reduced by a maximum of 25% if an attorney assisted in obtaining the recovery. No attorneys' fees will be allowed on the portion of the recovery attributable to PIP insurance benefits. No deduction will be made for any out-of-pocket costs incurred in the recovery.

After the Employee enters into a settlement agreement or obtains satisfaction of a judgment against the third party that caused the need for treatment or services, the Trust will provide no further benefits to the Employee for any treatment or service caused by the third party that was subject to the settlement agreement or judgment.

Recovering Payment

If an Employee brings an action or claim against a third party or the Employee's insurance company, the Employee must also seek recovery of the benefits paid by the Trust. The Trust asserts the right to recover benefits directly from the third party or from the Employee.

Upon making a claim for benefits from the Trust, the Employee will be required to agree to reimburse the Trust for the full amount of payment of Trust benefits, less attorneys' fees to a maximum of 25%, up to the full amount that the Employee receives from the third party by judgment or settlement.

LIFE INSURANCE AND ACCIDENTIAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS

For Employees Only

Life insurance benefits and accidental death and dismemberment insurance benefits are available to Employees only. The life insurance and accidental death and dismemberment insurance is provided through a group policy with Standard Insurance Company.

Amount of Life Insurance

The Plan provides $2,000 of life insurance coverage.

Amount of Accidental Death and Dismemberment Insurance

The Plan provides the following amount of accidental death and dismemberment insurance:

Loss	Amount
Life	$2,000
One hand, one foot, or loss of one eye	$1,000
Two or more of the above losses	$2,000

No more than $2,000 will be paid for all losses resulting from one or more accidents.

Life Insurance and Accidental Death and Dismemberment Insurance Effective Date of Coverage

Your life insurance and accidental death and dismemberment insurance become effective on the date You qualify for Plan coverage.

When Life Insurance and Accidental Death and Dismemberment Insurance Ends

Your life insurance and accidental death and dismemberment insurance automatically end at the earliest of:

(a) The date the group policy with Standard Insurance Company terminates;

(b) The date the last required premium is made on Your behalf to Standard Insurance Company by the Trust;

(c) The date You cease to be eligible Plan coverage as the result of employer contributions. Employees who elect COBRA coverage will not have life insurance and accidental death and dismemberment insurance; or

(d) The date You become a full-time member of the Armed Forces of any country (except as provided under the Uniformed Services Employment and Reemployment Rights Act).

Summary of the Accidental Death and Dismemberment Insurance Benefits

When Benefits are Payable. If You have an accident while insured for accidental death and dismemberment insurance benefits, and the accident results in a loss, Standard Insurance Company will pay benefits according to the terms of the group policy after satisfactory proof of loss is received.

Definition of Loss. Loss means a loss of life, hand, foot, or sight that:

(a) Is caused solely and directly by an accident;

(b) Occurs independently of all other causes; and

(c) Occurs within 365 days after the accident.

Accidental Death and Dismemberment Insurance Exclusions. No accidental death and dismemberment insurance benefit is payable if the loss is caused or contributed to by any of the following:

(a) War or act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature;

(b) Suicide or other intentionally self-inflicted Injury, while sane or insane;

(c) Committing or attempting to commit assault or a felony, or actively participating in a violent disorder or riot. Actively participating does not include being at a scene of a violent disorder or riot while performing Your official duties;

(d) The voluntary use or consumption of any poison, chemical compound, or drug, unless used or consumed according to the directions of a physician;

(e) Sickness or pregnancy existing at the time of the accident;

(f) Heart attack or stroke;

(g) Medical or surgical treatment for any of the above.

How to File a Claim for Life Insurance Benefits and Accidental Death and Disability Insurance Benefits

(a) Claims should be filed on Standard Insurance Company forms. You may obtain a claim form by calling the Trust Office as follows:

Alaska Seafood Processors' Plan
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
503-224-0048
800-547-4457

(b) A claim should be filed within ninety (90) days after the date of loss. If that is not possible, it must be filed as soon as reasonably possible, but not later than one year after that

ninety-day period. If a claim is filed outside this time limit, the claim will be denied. This time limit will not apply if You or Your beneficiary lack legal capacity.

(c) Proof of loss means written proof that a loss occurred:

(1) For which the group policy provides benefits;

(2) That is not subject to any exclusions; and

(3) That meets all other conditions for the benefit.

Proof of loss includes any other information Standard Insurance Company may reasonable require in support of a claim.

(a) Standard Insurance Company may have You examined at its expense at reasonable intervals. Standard Insurance Company may have an autopsy performed at its expense, except where prohibited by law.

(b) Benefits will be paid within sixty (60) days after proof of loss is satisfied.

(c) Standard Insurance Company will evaluate a claim for benefits promptly after it is received. Within ninety (90) days after receipt of a claim, Standard Insurance Company will send the claimant:

(1) A written decision about the claim; or

(2) A written notice that Standard Insurance Company is extending the time to decide the claim for an additional ninety (90) days.

If Standard Insurance Company extends the time to decide a claim, it will notify the claimant of the following:

(a) The reason(s) for the extension;

(b) When it expects to decide the claim;

(c) An explanation of the standards on which entitlement to benefits is based;

(d) The unresolved issue(s) preventing a decision; and

(e) Any additional information Standard Insurance Company needs to resolve the issue(s).

If Standard Insurance Company requests additional information, the claimant will have forty-five days to provide the information. If the claimant does not provide the requested information within forty-five days, Standard Insurance Company may decide the claim based on the information it has received.

If Standard Insurance Company denies any part of the claim, it will send the claimant a written notice of denial containing:

(a) The reason(s) for the decision;

(b) Reference to the part(s) of the group policy on which the decision is based;

(c) A description of any additional information needed to support the claim;

(d) Information concerning the claimant's right to review Standard Insurance Company's decision; and

(e) Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

Review Procedures

If all or part of a claim is denied, the claimant may request review. The claimant must request review in writing addressed to Standard Insurance Company within sixty (60) days after receiving notice of denial of the claim. The address and telephone number for Standard Insurance Company are on page 34.

The claimant may send Standard Insurance Company written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard Insurance Company's review will include any written comments or other information the claimant submits.

Within sixty (60) days after Standard Insurance Company receives the request for review, it will send the claimant:

(a) A written decision regarding the appeal; or

(b) A notice that Standard Insurance Company is extending the review period for sixty (60) days.

If the extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review will not begin until the claimant provides the information or otherwise responds. If Standard Insurance Company extends the review period, it will notify the claimant of the following:

(a) The reason(s) for the extension;

(b) When it expects to decide the claim on review; and

(c) Any additional information it needs to decide the claim.

If Standard Insurance Company requests additional information, the claimant will have forty-five days to provide the information. If the claimant does not provide the requested information within forty-five days, Standard Insurance Company may conclude its review of the claim based on the information it has received.

If Standard Insurance Company denies any part of the claim on review, the claimant will receive a written notice of denial containing:

(a) The reason(s) for the decision;

(b) Reference to the part(s) of the group policy on which the decision is based;

(c) Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and

(d) Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.

Benefit Payment and Beneficiary Provisions

(a) Benefits payable because of Your death or dismemberment will be paid to Your beneficiary. Beneficiary means the person You name to receive Your insurance benefits. Dismemberment benefits will be paid to You if You are living. Any dismemberment benefits which are unpaid at Your death will be paid to Your beneficiary.

(b) The beneficiary(ies) You name for Your life insurance benefit will be Your beneficiary for accidental death and dismemberment insurance benefits. You may name more than one beneficiary. Two or more surviving beneficiaries will share equally unless You specify otherwise. You may name a beneficiary or change a beneficiary at any time without the consent of the beneficiary.

You must name or change beneficiaries in writing. Your beneficiary designation must:

(1) Be signed by You and dated;

(2) Delivered to the Trust Office during Your lifetime;

(3) Relate to the life insurance and accidental death and dismemberment insurance provided under the group policy; and

(4) Will take effect on the date it is received by the Trust Office.

You may obtain a beneficiary designation form by calling the Trust Office.

(c) If a beneficiary dies on the same day You die or within fifteen days thereafter, benefits will be paid as if that beneficiary died before You unless proof of loss is delivered to Standard Insurance Company before the date of the beneficiary's death.

(d) If You do not name a beneficiary or if You are not survived by a beneficiary, benefits will be paid in equal shares to the first surviving class below:

(1) Your spouse or domestic partner. Domestic partner means an individual recognized as such under applicable law;

(2) Your child or children;

(3) Your parents;

(4) Your brothers and sisters;

(5) Your estate.

Authority of Standard Insurance Company. Standard Insurance Company has full and exclusive authority to control and manage the group policy, to administer claims, to interpret the group policy, and to resolve all questions arising in the administration, interpretation, and application of the group policy.

Time Limits on Legal Actions. No action at law or in equity may be brought until sixty (60) days after Standard Insurance Company has been given proof of loss. No action may be brought more than three years after the earlier of:

(a) The date Standard Insurance Company receives proof of loss; or

(b) The time within which proof of loss is required to be given.

Address and Telephone Number

The address and toll-free telephone number of Standard Insurance Company are:

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204
800-628-8600

LEGAL RIGHTS, NOTICES, AND DISCLOSURES

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child for less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six [96] hours, as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require a provider obtain authorization from a group health plan or health insurance issuer for prescribing length of stay not in excess of forty-eight (48) hours (or ninety-six [96] hours).

Women's Health and Cancer Rights Act

If, following a Mastectomy, an Employee elects breast reconstruction in connection with such Mastectomy, the following charges will be covered under medical plans:

(a) Reconstruction of the breast on which the Mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce symmetric appearance;

(c) Coverage for prostheses and physical complications of all stages of Mastectomy, including lymphedemas, in a manner determined in consultation between You and Your attending Physician;

(d) This benefit is subject to the benefit maximum as described in the Summary of Benefits.

Military Service

If You join the Armed Forces of the United States or are called to active duty for more than thirty (30) days, Plan coverage for You will end on the date You enter full-time active duty.

The Federal Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA) provides certain rights that include:

(a) When Your military leave is expected to last thirty-one (31) days or less, Your Employer may be required to pay for the health and welfare coverage for this limited period of time. You must notify Your Employer of the expected military leave and must return to employment within the time frames established by USERRA.

(b) When Your military service ends, any eligibility waiting period cannot be applied to You unless the waiting period was established after You left for military service and the new waiting period applies to all Employees.

If You have questions concerning Your rights under USERRA, contact Your Employer or the Trust Office.

Disclosure of Grandfathered Status

The Trustees do not believe the Plan is subject to the Affordable Care Act because the only benefits that are provided are excepted dental, vision, life insurance and accidental death and dismemberment insurance benefits. If the Plan is subject to the Affordable Care Act, the Plan is a "non-grandfathered health plan."

Questions regarding which protections apply and which protections do not apply do a grandfathered health plan and what may cause a plan to change from grandfathered health plan status can be directed to the Trust Office whose address and telephone number are on page 1 of the Benefit Booklet. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to a grandfathered health plan.

Privacy Practices of the Trust and Plan

This section describes how health information about You may be used and disclosed and how You can get access to this information. Please review this section carefully.

1. Policy of the Plan Regarding Your Protected Health Information

This section describes the legal obligations of the Plan and Your legal rights regarding Your Protected Health Information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economics and Clinical Health Act (HITECH). Among other things, this section describes how Your Protected Health Information may be used or disclosed to carry out treatment, payment or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule only protects certain health information known as Protected Health Information. Generally, Protected Health Information is individually identifiable health information, including demographic information, collected from You or created or received by a health care provider, a health care clearinghouse, a health plan or this Plan from which it is possible to identify You and relates to Your past, present or future physical or mental health or condition; the provisions of health care to You; or the past, present or future payment for Your health care.

This section will tell You about the ways in which the Plan may use and disclose Protected Health Information about You. This section also describes the Plan's obligations and Your rights regarding the use and disclosure of Protected Health Information. Your Dentist or health care provider may have different policies or notices regarding their use and disclosure of Your health information created in the Dentist's office or clinic.

2. The Plan's Responsibilities

The Plan is required by law to:

(a) Maintain the privacy of Your Protected Health Information;

(b) Provide You with certain rights with respect to Your Protected Health Information;

(c) Give You notice of the Plan's legal duties and privacy policies regarding Your Protected Health Information; and

(d) Follow the terms of this section until modified.

The Trustees reserve the right to change this section and to make new provisions regarding the use and disclosure of Your Protected Health Information that the Plan maintains, as allowed or required by law. If there are material changes to this section, You will be provided with a revised notice mailed to Your last known address.

3. How the Plan May Use and Disclose Health Information about You

Under the law, the Plan may use and disclose Your Protected Health Information under certain circumstances without Your permission. The following paragraphs describe different ways the Plan may use and disclose Your Protected Health Information. Each paragraph will explain what is meant and will present examples. Not every use or disclosure in a paragraph will be listed. However, all of the ways the Plan is permitted to use and disclose Your Protected Health Information will fall within one of these paragraphs.

(a) *To Make or Obtain Payment*. The Plan may use and disclose Protected Health Information about You to determine eligibility for benefits and to determine benefit responsibility under the Plan. For example, the Plan may tell Your health care provider about Your medical history to determine whether a particular treatment is an experimental or investigational service or dentally necessary or to determine whether the Plan will cover the treatment. The Plan may also share Protected Health Information with a stop loss insurance carrier or a utilization review or precertification service provider. The Plan may share Your Protected Health Information with another entity to assist with the payment of health claims or with another health plan to coordinate benefit payments.

(b) *To Facilitate Treatment*. The Plan may use and disclose Your Protected Health Information to facilitate treatment or services by providers, including coordination or management of health carrier related services. For example, the Plan may disclose Protected Health Information about You with Dentists who are treating You.

(c) *To Coordinate Health Care Operations*. The Plan may use and disclose Your Protected Health Information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. For example, health care operations include activities such 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 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. However, Your genetic information will not be used for underwriting purposes;

- 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 Plan, including customer service and resolution of appeals and grievances.

(d) *When Required by Law*. The Plan will disclose Protected Health Information about You when required to do so by federal, state or local law. For example, the Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a dental malpractice case.

(e) *To Avert a Serious Threat to Health or Safety*. The Plan may use and disclose Protected 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 Plan may disclose Protected Health Information about You in a proceeding regarding the licensure of a Dentist.

(f) *Military and Veterans*. If You are a member of the armed forces, the Plan may release Protected Health Information about You as required by military command authorities. The Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

(g) *For Treatment Alternatives*. The Plan may use and disclose Your Protected Health Information to tell You about or recommend possible treatment options or alternatives that may be of interest to You.

(h) *For Disclosure to the Trustees*. The Plan may disclose Your Protected Health Information to another health plan maintained by the Trust or to the Trustees for Plan administration functions performed by the Trustees on behalf of the Plan. In addition, the Plan may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers or modify, amend or terminate the Plan. The

Plan may also disclose to the Trustees information whether You are participating in the Plan. Your Protected Health Information cannot be used for employment purposes without Your specific authorization.

(i) *A Family Member or Close Personal Friend Involved in Your Health Care*. The Plan may make Your Protected Health Information known to a family member or close personal friend. Disclosure of Your Protected 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 Plan will normally provide information to a family member confirming Your eligibility for dental and vision coverage or if a claim was paid but not the specific treatment or diagnosis provided or the reason the provider was consulted. If You are not present or able to agree to these disclosures of Your Protected Health Information, the Plan, through the Trust Office or Trustees, may use professional judgment to determine whether the disclosure is in Your best interest. **If You do not want Your Protected Health Information disclosed to a family member or close personal friend as outlined in this paragraph, You must notify the Plan as described in the Right to Request Restrictions on page 42.**

(j) *Personal Representative*. The Plan will disclose Your protected health information to individuals authorized by You, or to an individual designated as Your personal representative, attorney-in-fact, etc., so long as You provide written notice/authorization and any supporting documents (for example, power of attorney). Even if You designate a personal representative, federal law permits the Plan to elect not to treat the person as Your personal representative if the Plan has a reasonable belief that:

- You have been, or may be, subject to domestic violence, abuse or neglect by such person;
- Treating such a person as Your personal representative could endanger You; or
- Plan representatives determine, in their professional judgment, that it is not in Your best interest to treat the person as Your personal representative.

(k) *Business Associates*. Business associates perform various services for the Plan. For example, the Trust Office handles many functions in connection with the operation of the Plan. To perform these functions, or provide the services, the Plan's business associates may receive, create, maintain, use or disclose Your protected health information, but only after agreeing, in writing, to appropriate safeguards concerning Your protected health information. Business associates are subject to the HIPAA privacy and security provisions with respect to Your Protected Health Information.

(l) *Other Covered Entities*. The Plan may use or disclose Your Protected 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 Plan may disclose Your Protected Health Information to a health care provider when needed by the provider to render treatment to You or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.

(m) *To Conduct Health Oversight Activities*. The Plan may disclose Your Protected 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.

(n) *Legal Proceedings*. If You are involved in a lawsuit or a dispute, the Plan may disclose Your Protected Health Information in response to a court or administrative order. The Plan may also disclose Your Protected Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain an order protecting the information requested.

(o) *Law Enforcement*. Under certain conditions, the Plan may disclose Your Protected Health Information to law enforcement officials. Some of the reasons for such a disclosure include, but are not limited to:

- It is required by law or some other legal process;
- Locate or identify a suspect, fugitive, material witness or missing person;
- A death believed to be the result of criminal conduct; or
- It is necessary to provide evidence of a crime that occurred.

(p) *National Security and Intelligence*. In certain circumstances, federal regulations require the Plan to disclose Your Protected Health Information to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

(q) *Research*. The Plan may disclose Your Protected Health Information to researchers when:

- The individual identifiers have been removed; or
- When the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approved the research.

(r) *Inmates*. If You are an inmate in a correctional institution, the Plan may disclose Your Protected Health Information to the correctional institution or to a law enforcement official for:

- The institution to provide health care to You;
- Your health and safety and the health and safety of others; or
- The safety and security of the correctional institution.

(s) *Coroners, Medical Examiners, and Funeral Directors*. The Plan may disclose Your Protected 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 Plan may disclose, as authorized by law, information to funeral directors so they may carry out their duties.

(t) *Organ and Tissue Donation.* If You are an organ or tissue donor, the Plan may disclose Protected Health Information after Your death to organizations that handle organ or tissue donation and transportation or to an organ or tissue donation bank.

(u) *Workers' Compensation*. The Plan may release Your Protected 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.

(v) *Disclosures to the Secretary of the U.S. Department of Health and Human Services*. The Plan is required to disclose Your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

(w) *Public Health Risks*. The Plan may disclose Your Protected Health Information for public health actions. These actions generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and
- To notify the appropriate governmental authority if the Plan believes that a person has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if You agree, or when required or authorized by law.

(x) *Disclosures to You*. At Your request, the Plan is required to disclose the portion of Your Protected Health Information that contains medical records, billing records and other records used to make decisions regarding Your health care benefits. The Plan is also required, when requested, to provide You with an accounting of most disclosures of Your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the Protected Health Information was not disclosed pursuant to Your authorization.

(y) *Disclosures to the Centers for Medicaid and Medicare Services*. The Plan may disclose Your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare Services, in order to comply with mandatory Medicare coordination of benefit requirements. The Plan may share required data, including health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

4. Authorization to Use or Disclose Protected Health Information

Other than as stated above, the Plan will not disclose Your Protected Health Information without Your written authorization. If You authorize the Plan to use or disclose Your Protected Health Information, You may revoke that authorization in writing at any time.

5. Minimum Necessary Disclosure of Protected Health Information

The amount of Protected Health Information the Plan will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

6. 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 Plan will be required to operate. For example, the Plan will follow more stringent state privacy laws that relate to use and disclosure of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

7. Your Rights with Respect to Your Protected Health Information

You have the following rights regarding Your Protected Health Information that the Plan maintains:

(a) *Right to Request Restrictions*. You have the right to request restrictions or limitations on the Protected Health Information the Plan uses or discloses about You for treatment, payment or health care operations. You also have the right to request a limit on the Plan's disclosure of Your Protected Health Information to someone involved in Your care or the payment for Your care such as a family member or friend. For example, You could ask that the Plan not use or disclose information about a dental procedure You had.

Except as provided in the next paragraph, the Plan is not required to agree to Your request. However, if the Plan does agree to the request, it will honor the restriction until You revoke it or the Plan notifies You.

The Plan will comply with any restriction request if: except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment); and the Protected

Health Information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full by You or someone else.

To request restrictions, You must make Your request in writing to the HIPAA Client Service Representative for the Trust at the address on page 45. In Your written request, You must tell the Plan:

- What Protected Health Information You want to limit;
- Whether You want to limit the Plan's use, disclosure or both; and
- To whom You want the limits to apply, for example, non-disclosure to Your spouse.

(b) *Right to Receive Confidential Communications*. You have the right to request that the 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 Protected Health Information could endanger You. For example, You may ask that the Plan communicate with You only at a certain post office box, telephone number or by email.

To request confidential communications, You must make Your request in writing to the HIPAA Client Service Representative for the Trust at the address on page 45. The Plan will not ask You the reason for the request. The Plan will attempt to honor all reasonable requests. Your written request must specify how or where You wish to receive confidential communications.

(c) *Right to Inspect and Copy Your Protected Health Information*. You have the right to inspect and copy Your Protected Health Information that may be used to make decisions about Your Plan benefits. If the Protected Health Information You request is maintained electronically, and You request an electronic copy, the Plan will provide a copy in the electronic form and format You request, if the Protected Health Information can be readily produced in that form and format. If the Protected Health Information cannot be readily produced in that form and format, the Plan will work with You to come to an agreement on form and format. If the Plan cannot agree on an electronic form and format, it will provide You with a paper copy. A request to inspect and copy records containing Your Protected Health Information must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 45. If You request a copy of Your Protected Health Information, the Plan may charge a reasonable fee for copying, mailing, or other supplies associated with the request.

(d) *Right to Amend Your Protected Health Information*. If You believe that Your Protected Health Information records are inaccurate or incomplete, You may request that the Plan amend its records. The request may be made as long as the Protected Health Information is maintained by the Plan.

A request for an amendment of Protected Health Information records must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 45.

The Plan may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny Your request if You ask the Plan to amend Protected Health Information that: is not part of the Protected Health Information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information that You would be permitted to inspect and copy; or is already accurate and complete. If the Plan denies Your request, You have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed Protected Health Information will include Your statement.

(e) *Right to an Accounting of Disclosures*. You have the right to request an accounting of certain disclosures of Your Protected Health Information. The accounting will not include: disclosures for purposes of treatment, payment or health care operations; disclosures made to You; disclosures made pursuant to Your authorization; disclosures made to friends or family members in Your presence or because of an emergency; disclosures for national security purposes; and disclosures incidental to otherwise permissible disclosures.

The request for an accounting must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 45. The accounting request should specify the time period for which You are requesting the accounting. Accounting requests may not be made for periods of time going back more than six years. The 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 Plan will inform You of the fee in advance.

(f) *Right to be Notified of a Breach*. You have the right to be notified in the event that the Plan, or a business associate, discovers a breach of Your unsecured Protected Health Information.

(g) *Right to a Paper Copy of the Plan's Privacy Notice*. You have a right to a paper copy of the Plan's Privacy Practices. You may ask the Plan to give You a copy of this notice at any time. To receive a paper copy, please contact the HIPAA Client Service Representative for the Trust at the address on page 45.

8. Complaints

If You believe that Your privacy rights have been violated, You may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, You should notify the HIPAA Client Service Representative for the Trust, in writing, at the address below.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

9. HIPAA Client Service Representative

The Plan has designated the Trust's HIPAA Client Service Representative to answer all questions and respond to all issues regarding this section and Your privacy rights. You may contact this person at:

Alaska Seafood Processors' Plan
Attention: HIPAA Client Service Representative
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

If You have any questions regarding this section, please contact the HIPAA Client Service Representative.

DEFINITIONS OF TERMS

Benefit Booklet means this document as amended from time to time.

Complete Visual Analysis (for Vision Care Expense Coverage) includes:

(a) case history and professional consultation;

(b) examination for disease or abnormalities;

(c) determination of the ranges of clear single vision;

(d) measurement of refraction, eye muscle coordination and balance; and

(e) special working distance analysis.

Covered Charge means an expense or service eligible for payment under the terms of the Benefit Booklet.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dental Services mean any treatment or service provided to diagnose, prevent or correct:

(a) periodontal disease (disease of the surrounding and supplemental tissues of the teeth including deformities of the bone surrounding the teeth); and/or

(b) malocclusion (abnormal positioning and/or relationship of the teeth); and/or

(c) ailments or defects of the teeth and supporting tissue and bone (excluding appliances used to close an acquired or congenital opening). The term **Dental Services** includes treatment performed to replace or restore natural teeth in conjunction with the use of any appliance.

Dentist means:

(a) a person who is licensed to practice in the state where the dental procedure is performed;

(b) a person who is operating within the scope of the license; and

(c) a person who performs a procedure which is payable under the Plan.

A Dentist does not include a person who lives with You in Your home or is part of Your family (You, Your spouse, or a child, brother, sister or parent of You or Your spouse).

Employee means a person who works or has worked under a collective bargaining agreement with an Employer and, as a result of that employment, is entitled to receive benefits from the Plan.

Employer means any business, firm, or other entity that contributes to the Inlandboatmen's Union of the Pacific National Health Benefit Trust per the terms of a collective bargaining agreement.

Immediate Family means an Employee's mother, father, sister, brother, spouse, or child(ren).

Optometrist (for Vision Expense Coverage) means a person who is licensed to practice optometry.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

Plan means the Alaska Seafood Processors' Plan as described in this Benefit Booklet, as amended from time to time.

Prevailing Charges (for Dental Expense Coverage) mean the amount, as determined by the Plan, that most Dentists or other dental care providers charge for the same or a similar treatment or service in the cost area (or a comparable cost area) where the treatment or service is provided.

Protected Health Information means individually identifiable health information that is not subject to specific exclusion. The definition of Protected Health Information in 45 C.F.R. § 164.501 is adopted for use by the Plan.

Trust or **Trust Fund** means the Inlandboatmen's Union of the Pacific National Health Benefit Trust.

Trust Office means the contract administrator hired by the Trustees.

Trustees means the persons appointed by the Inlandboatmen's Union of the Pacific and certain employers who contribute to the Trust to oversee the operation of the Trust and the Plan.

War means military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by the insured, or civil war or a local or community faction.

You and **Your** means the Employee.

SUMMARY PLAN DESCRIPTION

This is a general explanation of certain terms of the Plan and other legal instruments, and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the Plan are set forth in those instruments, which may be inspected at the Trust Office.

Name of Plan

Alaska Seafood Processors' Plan

Effective Date

March 1, 2015

Plan Sponsor

The Plan is sponsored by:

Board of Trustees of the Inlandboatmen's Union of the
Pacific National Health Benefit Trust
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

Employer and Plan Identification Numbers

The Employer Identification Number and Plan Number assigned to the Plan Sponsor by the Internal Revenue Service are:

Employer Identification Number:	93-0864012
Plan Number:	501

Type of Plan

The Plan is a health and welfare benefit plan that provides dental, vision, life insurance, and accidental death and dismemberment insurance benefits to Employees only. Some Employees only receive life insurance and accidental death and dismemberment insurance benefits. Dependents are not eligible for dental, vision, life insurance, or accidental death and dismemberment insurance benefits. No medical or prescription drug benefits are provided.

Plan Administration

The Plan is administered by the Trustees of the Inlandboatmen's Union of the Pacific National Health Benefit Trust with the assistance of A&I Benefit Plan Administrators, Inc. whose address and telephone numbers are:

BeneSys Administrators, Inc.
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

Agent for Service of Legal Process

Lee Centrone
BeneSys Administrators, Inc.
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

Service of legal process may also be made upon a member of the Board of Trustees.

Board of Trustees

Employee Trustees	**Employer Trustees**
Alan Coté Inlandboatmen's Union of the Pacific 1711 W. Nickerson Street, Suite D Seattle, WA 98119-1663	Lee Egland Crowley Marine Services 1102 SW Massachusetts Street Seattle, WA 98134
Brian Dodge Regional Director-Columbia River Region IBU 2435 NW Front Avenue Portland, OR 97209-1825	Dean Kapoi Hawaiian Tug & Barge 1331 N. Nimitz Hwy. Honolulu, HI 96817
Marina Secchitano Regional Director-San Francisco Region IBU 450 Harrison Street, #103 San Francisco, CA 94105-2640	Carolyn Horgan Blue & Gold Fleet LP Pier 41 Marine Terminal San Francisco, CA 94133
John Skow Regional Director-S. California Region IBU 1911 N. Gaffey Street, Suites A & B San Pedro, CA 90731-1263	Juli Lewis Georgia Pacific Northwest Service Center 3838 NW Front Avenue Portland, OR 97210
Donovan Duncan Regional Director-Hawaii Region IBU 451 Atkinson Drive Honolulu, HI 96814	Michael O'Connor Foss Maritime Company 1151 Fairview Avenue North Seattle, WA 98119
Peter Hart Regional Director -- Puget Sound Region IBU 1711 W. Nickerson Street, Suite D Seattle, WA 98119-1663	Matt Hainley Sause Bros., Inc. 3710 NW Front Avenue Portland, OR 97210

Description of Collective Bargaining Agreements

The Plan is maintained pursuant to the terms of collective bargaining agreements between Peter Pan Seafoods, Inc. and the Alaska Fisheries Division of United Industrial Workers, a division of the Seafarers International Union, and the Inlandboatmen's Union of the Pacific, Region 37. The collective bargaining agreements provide that the Employer will make a monetary contribution to the Inlandboatmen's Union of the Pacific National Health Benefit Trust for Employees who work a sufficient number of hours to qualify for a health and welfare contribution. The contribution formula is specified in the collective bargaining agreements. Copies of the collective bargaining agreements can be obtained from the Inlandboatmen's Union of the Pacific or the Trust Office.

A complete list of Employers contributing to the Plan may be obtained upon written request to the Trustees and is available for review during regular office hours at the Trust Office.

Plan Benefits

The Plan provides dental, vision, life insurance, and accidental death and dismemberment benefits for Employees only. Some Employees only receive life insurance and accidental death and dismemberment insurance benefits. Dependents are not eligible for dental, vision, life insurance, or accidental death and dismemberment insurance benefits. Check your collective bargaining agreement or call the Trust Office to determine the benefits you are eligible to receive.

Eligibility and Termination of Eligibility for Benefits

The Benefit Booklet describes benefits, eligibility, and termination of eligibility requirements for the Plan. If at any time You are unable to locate Your Benefit Booklet, an additional copy may be obtained from the Trust Office:

BeneSys Administrators, Inc.
PMB #116 5331 SW Macadam Avenue Suite 258
Portland, OR 97239

Source of Contributions

The Plan is funded through Employer contributions, the amount of which is specified in collective bargaining agreements.

Organizations Providing Benefits, Funding Media, and Type of Administration

The names and addresses of all the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the Plan and whether the benefit is payable under an insurance policy) are set forth below.

Dental and Vision Benefits

Claims for dental and vision benefits for Employees are paid directly from assets of the Inlandboatmen's Union of the Pacific National Health Benefit Trust.

Life Insurance and Accidental Death and Dismemberment Insurance

Life insurance and accidental death and dismemberment insurance for Employees is provided under a group contract between the Inlandboatmen's Union of the Pacific National Health Benefit Trust and Standard Insurance Company. Claims are sent to Standard Insurance Company which is responsible for administering the life insurance and accidental death and dismemberment benefits and paying the claims.

Standard Insurance Company
900 SW Fifth Avenue
Portland, OR 97204
(800) 628-8600

Plan Year is January 1 through December 31.

Plan Termination. The Trustees retain the authority to terminate the Plan and/or the Trust. The Trust shall automatically be terminated upon the expiration of all collective bargaining agreements requiring contributions to the Trust provided that such termination shall not result from the expiration of all collective bargaining agreements so long as any employer continues to have a legal obligation to continue to make contributions to the Trust or continues during contract negotiations to contribute to the Trust. Upon termination of the Trust, all assets remaining in the Trust, after payment of benefits, shall be used for the payment of benefits in accordance with the purposes of the Trust until such monies and assets have been exhausted, unless some other disposition is required by law.

Liability of Third Parties and the Board of Trustees

No Employer has any liability, directly or indirectly, to provide the benefits established by the Plan beyond the obligation to make contributions required by its collective bargaining agreement. Likewise, there is no liability upon the Trustees, individually or collectively, or any labor organization to provide the benefits established by this Plan if assets are not available to make such benefit payments.

ERISA STATEMENT OF RIGHTS

As a participant in the Alaska Seafood Processors' 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 will be entitled to:

1. Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing operation of 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.

2. 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. A reasonable charge may be made for the copies.

3. 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 annual financial report.

4. Continue dental and vision care for the Employee if there is a loss of coverage under the Plan as a result of a qualifying event. The Employee may have to pay for such coverage. Review this Benefit Booklet starting on page 7 for the rules governing COBRA Continuation Coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 welfare benefit or exercising Your rights under ERISA. If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim. Under ERISA, there are steps You can take to enforce these rights. For instance, if You request materials from the Plan and do not receive them within thirty (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 that is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack of a decision concerning the qualified status of a medical child support order, You may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in 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 the Plan, You should contact the Trust Office. If You have any questions about this Statement, about Your rights under ERISA, or about Your rights under the Health Insurance Portability and Accountability Act of 1996 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. Alternatively, You may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272. You may also find assistance for Your questions and a list of Employee Benefits Security Administration field offices at: www.dol.gov/ebsa.