CLEVELAND LONGSHOREMEN'S WELFARE PLAN

COMBINED PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

Updated April 1, 2012

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Welfare Benefits Plan

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PREAMBLE

This booklet provides a description of those benefits available to eligible Participants and Dependents and is your Summary Plan Description as provided in Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This booklet shall also serve as the formal Plan document for your benefit program.

This booklet describes your health care benefits. Please read it carefully. It is designed to help you understand your Health and Welfare Plan. It explains when you and your dependents are eligible for benefits, what your benefits are and how claims are processed for your benefits. The Plan is administered by a Trust Fund under the direction of a Board of Trustees.

Only the Board of Trustees is authorized to interpret the Plan. No employer or union, nor any representative of any employer or union, is authorized to interpret the Plan, nor does any such person act as an agent of the Board of Trustees. The Board of Trustees shall be the sole judge of the standard of proof required in any case. In the application and interpretation of any of the provisions of the Plan, decisions of the Board shall be final and binding on all parties or persons affected. Such decisions shall receive judicial deference to the extent they do not constitute an abuse of discretion.

The Trustees reserve the right and shall have full authority to amend, alter, modify and interpret all questions of nature, amount and duration of benefits to be provided under this Plan. The Board of Trustees reserves the right to determine eligibility for benefits and all other questions arising under the Plan. The Board of Trustees reserves the right to terminate the Plan. Plan amendments will be communicated to all parties as required by law.

Any retiree or surviving dependent benefits that have been made available by this Plan are a privilege, not a right. No person acquires a vested right to such benefits, either before or after his retirement. The Trustees may expand, reduce or cancel coverage for retirees, change eligibility requirements or the amount of self-payment and otherwise exercise prudent discretion at any time without legal right or recourse by a retiree or any other person.

This document and the benefits provided hereunder are not guarantees for employment or otherwise a contract for employment. Wherever used in this document, the masculine pronoun includes the masculine and feminine gender, unless the context clearly indicates otherwise.

ARTICLE I

DEFINITIONS AND CONSTRUCTION

Where the following words and phrases appear in this Plan, they have the respective meanings set forth below, unless their context clearly indicates otherwise.

1.01 Accident and Sickness Benefit means the benefit paid when an eligible Employee is unable to work because of either an accident or illness.

1.02 Administrative Service Agreement means any agreement with a third party for administration of the Plan and Fund.

1.03 Beneficiary means an individual who is designated by an Employee or by the terms of the Plan who is or may become entitled to a benefit. If at the time of distribution of a benefit there has been no Beneficiary named or the Beneficiary is not alive, the Beneficiary shall be deemed to be the Employee's estate.

1.04 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

1.05 COBRA Continuation Coverage or Continuation Coverage means the continuation of health care benefits, on a self-pay basis for Covered Participants and their Dependents on the occurrence of a Qualifying Event under the Plan.

1.06 Code means the Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings pertaining to such section and shall also be deemed a reference to comparable provisions of future laws.

1.07 Collective Bargaining Agreement means any collective bargaining agreement which exits between the Employer and the Union which provides for contributions into the Fund as well as any extension, renewal or new bargaining agreement.

1.08 Continuation Coverage Payment(s) means the payment required for COBRA Continuation Coverage which shall be an amount equal to a reasonable estimate of the cost to the Plan of providing coverage for all Covered Participants at the time of the Qualifying Event plus a two percent (2%) administrative expense. In the case of a disabled individual who receives an additional eleven (11) month extended coverage under COBRA, the Employer may assess up to one hundred and fifty percent (150%) of the cost determined under this Section. Such cost shall be determined on an actuarial basis and take into account such factors as the Secretary of the Treasury may prescribe in regulations.

1.09 Corporate Trustee means any bank, trust company or other financial institution as may be designated by the Trustees to hold property of the Fund.

1.10 Covered Employment means each Employee of an Employer covered by a Collective Bargaining Agreement.

1.11 Declaration of Trust means the amended and restated Agreement and Declaration of Trust of the Cleveland Longshoremen's Welfare Fund, and as incorporated by reference herein.

1.12 Dependent means a Participant's Spouse and children up to age 26 who are eligible to receive benefits hereunder. Effective until April 1, 2014, a child between the ages of 19 and 26 is not eligible if he is eligible for employer sponsored coverage other than that from either parent.

The term Dependent shall not apply to an individual who is in full-time military service.

The word "Child"/ "Children" includes the following:

(a). Your natural born child;

(b). Legally adopted Child (including a Child living with you during the period of probation for that Child begin placed for adoption, but only to the extent coverage is not available and provided by another individual or agency);

(c). Stepchild; and

(d). A child for whom you have been granted legal custody by a court of record according to the applicable requirements of any Qualified Medical Support Order (QMCSO) as defined in ERISA Section 609(a).

1.13 Employee means any member of a collective bargaining unit represented by the Union who is eligible to participate in and receive the benefits under the Plan. Employee includes any employee of the Union or of the Trustees, or any employee of the International Longshoremen's Association or affiliate, participating in the Plan pursuant to Section II. Employee shall exclude any self-employed person, partner or sole proprietor and any person considered a leased employee.

Employee shall include any individual who was formerly employed by an Employer as a member of a collective bargaining unit represented by the Union or by the Union or Trustees for the purpose of allowing self-contribution direct payments to and/or coverage under the Fund in accordance with the rules prescribed by the Trustees.

1.14 Employer means any individual, firm, association, partnership or company, which is bound by the Collective Bargaining Agreement with the Union to contribute to the Fund. Employer also means the Union to the extent that it acts in the capacity of an Employer of its Employees on whose behalf contribution is made to the Fund. Employer also means the Trustees to the extent that it acts in the capacity of an Employer of its Employees on whose behalf contributions are made to the Fund. Employer also means the International Longshoremen's Association or affiliate to the extent that it acts in the capacity of an Employer of its Employees on whose behalf contribution is made to the Fund and such participation is authorized by the Trustees.

1.15 Employer Contributions means payments made to the Fund by an Employer.

1.16 ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.17 Fund means the Cleveland Longshoremen's Welfare Fund and its entire assets including all Funds received by the Trustees in the form of Employer Contributions, together with all contracts (including dividends, interest, refunds and other sums payable to the trust Fund on account of the contracts), all investments made and held by the Trustees, all income, earnings and profits on the Fund and any and all property or funds received and held by the Trustee.

1.18 Funeral Leave Benefit means the benefit provided to an Employee for attending the funeral or memorial service for certain specified relatives of the Employee and the Employee's Spouse.

1.19 Holiday Benefits means the payments made for Selected Holidays, regardless of whether the Employee worked or did not work on such holiday. Each payment for a Selected Holiday is for 8 hours at the eligible Employee's regular rate of pay.

1.20 Holiday Period means the Plan Year.

1.21 Insurance Company means any insurance company or companies as may be selected by the Trustees as a medium of funding the Plan.

1.22 Insurance Contracts means the policy of insurance or certificates of coverage as may be issued pursuant to the Declaration of Trust and this Plan. The Insurance Contract shall be deemed to include any amendments or riders attached to the Insurance Contracts.

1.23 Life Insurance Benefit means the group term life insurance benefits provided by an Insurance Company selected by the Trustees to pay survivor benefits in the event of the Participant's death.

1.24 Medical Benefit Plan or Medical Benefits means the medical program set forth in Section 4.01(a).

1.25 Navigation Season means the period from April 1 to December 31.

1.26 Off-Season Supplement Benefits means the benefits payable each March to an Employee who is otherwise eligible for health and welfare benefits and who continued to be an active member of the Plan as of the preceding December 1. The amount of the benefit is determined each year based on Employer Contributions for containers and tonnage royalties during the preceding April 1 through March 31. The total Employer Contributions, less Employer FICA taxes, are divided among the number of eligible Employees.

1.27 Participant means any Employee of an Employer, who is eligible to participate in the Plan in accordance with the terms hereof.

1.28 Plan Administrator means the Board of Trustees of the Fund comprised of two Union trustees and two Employer trustees.

1.29 Plan means the Cleveland Longshoremen's Welfare Benefits Plan as it may be amended from time to time.

1.30 Plan Year means the 12 month period commencing April 1 and ending March 31 of each year.

1.31 Qualifying Hours means the number of hours worked in a Plan Year or in a preceding Plan Year that are required to establish eligibility for specified benefits under the Plan. The number of hours shall be determined by the Board of Trustees at its discretion. Such determination is made each Plan Year based on the level of work available in the Port of Cleveland for the current vacation period.

1.32 Qualifying Dependent means a Dependent who loses coverage under this Plan due to a Qualifying Event.

1.33 Qualifying Event means any of the following events that, but for COBRA Continuation Coverage, would result in a Participant's or eligible Dependent's loss of coverage:

(a) death of a Covered Employee;

(b) termination of employment of a Covered Employee, except for a termination due to gross misconduct;

(c) reduction in hours of a Covered Employee;

(d) divorce or legal separation of the Covered Employee;

(e) the Covered Employee's entitlement to Medicare benefits; or

(f) a Dependent child ceasing to qualify as a Dependent under the Plan.

1.34 Selected Holidays means the following days:

(a) New Years Day
(b) Martin Luther King Day
(c) Easter
(d) Memorial Day
(e) Fourth of July
(f) Labor Day
(g) Columbus Day
(h) Veterans Day
(i) Thanksgiving Day
(j) Christmas
(k) Law Day
(l) Birthday

1.35 Spouse means the legally married and not legally separated husband or wife of an Employee.

1.36 Trustee or Trustees mean(s) any person or persons designated as a Trustee pursuant to the provisions of the Declaration of Trust.

1.37 Union means the International Longshoremen's Association, Local No. 1317, AFL-CIO, also known as the Cleveland Longshoremen's Union and its successor or successors.

1.38 Vacation Benefits means benefits paid during the latter part of each Plan Year to Employees who qualify on the basis of hours worked in Covered Employment during each Plan Year. The amount of Vacation Benefit payable to an Employee who qualifies for payment depends on the number of preceding years in which the Employee had sufficient Qualifying Hours worked and the Employee's rate of pay.

ARTICLE II

ELIGIBILITY FOR PARTICIPATION

2.01 Eligibility for Medical Benefits

(a) In order to establish initial eligibility for coverage, you must have worked in Covered Employment during the immediately preceding Plan Year (i.e., April 1 – March 31) the required number of Qualifying Hours, as determined by the Board of Trustees. The Trustees shall determine the required number of hours on an annual basis based, at least in part, on the level of work available in the Port of Cleveland in the preceding Plan Year. For example, if you are newly hired in June 2010, and work the required number of Qualifying Hours in Covered Employment during that Plan Year (i.e., April 1, 2010 – March 31, 2011) as determined by the Trustees, you will be eligible for coverage first beginning the next following Plan Year (i.e., April 1, 2011).

(b) Subsequent Monthly Eligibility - An Employee remains eligible for each succeeding month by working 100 or more Qualifying Hours in Covered Employment in the prior month.

(c) Quarterly Eligibility- An Employee remains eligible for each succeeding quarter by working 250 or more Qualifying Hours in Covered Employment in the prior quarter.

Notwithstanding the above-provisions regarding subsequent monthly or quarterly eligibility, all Employees in Covered Employment, who had Medical Benefits in the prior Plan Year ending March 31, are eligible for Medical Benefits for the entire following Plan Year beginning April 1 provided the Employee (1) worked the required number of Qualifying Hours, as determined by the Trustees, in Covered Employment during the immediately preceding 12 month period (i.e., April 1 – March 31) and (2) continues to work the required number of Qualifying Hours, as determined by the Trustees, in Covered Employment during April, May and June. Benefits shall continue until March 31 of the Plan Year provided the Employee is available for work in the Port of Cleveland and works at least one hundred (100) Qualifying Hours per quarter during the Navigation Season (April 1 to December 31). However, if you fail to satisfy any of these requirements, you will lose eligibility and will need to reestablish initial eligibility for future coverage.

The Trustees shall determine the required number of Qualifying Hours on an annual basis based, at least in part, on the level of work available in the Port of Cleveland in the preceding Plan Year.

(d) Dependent Eligibility - Dependents eligible to participate in the Medical Benefits become eligible at the same time as the Employee becomes eligible or on the first

day they become eligible Dependents, if later. Newborn and adopted children participate in the Plan immediately upon birth or adoption, provided that the Employee enrolls such child within 30 days of birth or adoption.

(e) Employees off work due to work-related injury or illness- An Employee shall be granted up to thirty-five (35) hours per week of Qualifying Hours under this Plan for each week the Employee receives temporary total disability benefits through the workers' compensation state system; subject to the following conditions:

i. Such Qualifying Hours shall be limited to and shall not exceed the annual number of Qualifying Hours required by the Trustees for the Plan Year;

ii. Such Qualifying Hours shall be limited to only two (2) consecutive calendar years from the initial date of said injury or illness;

iii. Two (2) shall be the maximum number of years of eligibility that will be provided to an Employee based on Qualifying Hours granted under this subsection 2.01(e); and

iv. The Employee's Employer shall pay contributions to the Fund for each week he is granted Qualifying Hours in accordance with this subsection 2.01(e).

2.02 Eligibility for Selected Holiday Benefits - All Employees in Covered Employment will be eligible for Holiday Benefits provided he has worked the requisite number of hours as determined by the Trustees during the preceding Holiday Period. In addition, each Employee must have been actively at work or available for work on the June 30 in the Holiday Period.

2.03 Eligibility for Vacation Benefits - Eligibility for Vacation Benefits shall be met by working a specified number of Qualifying Hours in the current Plan Year and succeeding Plan Years.

2.04 Eligibility for Funeral Leave Benefits - Employees in Covered Employment shall be eligible for a Funeral Leave Benefit provided the Employee attends the funeral or memorial service and has not performed any work on the day the claim for the Funeral Leave Benefit is made. No Funeral Leave Benefits are paid on days that are Holidays or days on which you are collecting unemployment compensation benefits.

2.05 Eligibility for the Off-Season Supplement Benefits - An eligible Employee in Covered Employment shall qualify for an Off-Season Supplement Benefit each March provided the Employee is eligible for Insured Benefits and was an Eligible Employee of the Plan as of the preceding December 1.

2.06 Eligibility for Life Insurance Benefits –An active Employee in Covered Employment shall be eligible for a Life Insurance Benefit provided he otherwise meets the requirements of Section 2.01.

2.07 Eligibility for Accidental Death and Dismemberment Benefits - An Employee in Covered Employment shall be eligible for an Accidental Death and Dismemberment Benefit provided he otherwise meets the requirements of Section 2.01.

2.08 Eligibility for Non-Occupational Weekly Accident and Sickness Benefits – An Employee in Covered Employment shall be eligible for the Non-Occupational Weekly Accident and Sickness Benefit provided he otherwise meets the requirements of Section 2.01.

2.09 Termination of Coverage - Coverage will terminate when:

1. The Employee fails to meet the hours' requirements described in this Article II or elsewhere in the Plan.
2. The Employee retires or dies.
3. The Employee is on long-term disability coverage under the Cleveland Longshoreman's Pension Plan.
4. The Plan is terminated.
5. The Employee ceases to be available for work in the Port of Cleveland.

ARTICLE III

ENROLLMENT FOR BENEFITS

3.01 Enrollment - Each Employee shall have the right to elect Medical Benefits when eligible.

3.02 Hospital, Surgical and Major Medical Benefits - Each eligible Employee shall have the option of choosing benefits under the following health plan:

GLDC-ILA Health & Welfare Plan ("GLDC-ILA Plan")

Medical Benefits are provided by the GLDC-ILA Plan as the result of an agreement entered between the Trustees and the GLDC-ILA Plan. Each eligible Employee must complete an enrollment form and return such form to the Plan Administrator. Benefits shall commence on the eligibility date provided the enrollment form is returned within 30 days. A newly eligible Employee who fails to return the form within 30 days of his eligibility date, will become covered as of the first of the month following receipt of the form.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Special Enrollment

If you were eligible to enroll under this Plan and declined this Plan's coverage because you were covered under a group health plan, Medicaid, or other health insurance coverage, and lose the other coverage, you and your eligible Dependent(s) will be permitted to enroll in this Plan during a special enrollment period. However, you must notify the Fund of your request for special enrollment within thirty (30) days after the other coverage ends. The Fund may require you to provide it with written documentation of the termination of the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be eligible to enroll yourself and your eligible Dependent(s) in this Plan. However, you must provide the Fund with notice of your intent to enroll yourself and your eligible Dependent(s) in this Plan within thirty (30) days of the event (having or becoming a new dependent). Coverage under these special enrollment provisions will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received. If you or your eligible Dependent(s) are eligible for coverage under Medicaid or a State Children's Health Insurance Program (S-CHIP), and you or your eligible Dependent(s) were denied enrollment in this Plan due to the other coverage, you may request special enrollment in this Plan if either: (i) your own or your eligible Dependent(s)' coverage under Medicaid or a State Children's Health Insurance Program terminates due to a loss of eligibility; or (ii) you or your eligible Dependent(s) become eligible for premium assistance from Medicaid or a State Children's Health Insurance Program allowing you or your eligible Dependent(s) to enroll in a group health plan. In either situation, however, you must provide the GLDC-ILA Plan with notice of your intent to enroll yourself or your eligible Dependent(s) within sixty (60) days.

3.03 Dental Benefits – Dental Benefits are provided by the GLDC-ILA Plan as the result of an agreement entered between the Trustees and the GLDC-ILA Plan. Each eligible Employee

must complete and return an enrollment form to the Plan Administrator. Benefits shall commence on the eligibility date provided the enrollment form is returned within 30 days. A newly eligible Employee who fails to return the enrollment form within 30 days of his eligibility date, will become covered as of the first of the month following receipt of the enrollment form.

3.04 Accidental Death and Dismemberment and Life Insurance Benefits - These benefits are provided by the GLDC-ILA Plan as the result of an agreement entered between the Trustees and the GLDC-ILA Plan. Each Employee must complete a designation of Beneficiary form when initially eligible. Such form may be updated at any time by filing a new designation of beneficiary form with the Plan Administrator.

ARTICLE IV

BENEFITS

4.01 Medical and Dental Benefits

(a) Medical and Dental - Medical and Dental benefits shall be determined as set forth in the GLDC-ILA Plan. A full description of the coverage available to you and your eligible dependents, and the terms of such coverage, are explained in a separate written document that is provided directly to you by the GLDC-ILA Plan at no cost to you. The GLDC-ILA Plan is a separate legal entity from the Fund.

(i) Newborns' and Mothers' Health Protection Act – To the extent the applicable medical plan provides benefits for hospital lengths of stay in connection with childbirth, the plan will cover the minimum length of stay required for deliveries (i.e. a 48 hour hospital stay after a vaginal delivery or a 96 hour stay following a delivery by Caesarian section.) The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by law. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing length of stay not in excess of 48 hours (or 96 hours). Such coverage shall be subject to any applicable deductible or coinsurance amounts as long as any cost-sharing provisions are consistent throughout the 48-hour or 96-hour (depending on the type of delivery) hospital length of stay period.

(ii) Women's Health and Cancer Rights Act of 1998 – To the extent the applicable medical plan provides benefits for mastectomies, it will provide, for an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance and prosthesis and coverage for physical complications of all stages of the mastectomy, including lymphedemas. Such coverage shall be subject to any applicable deductible or coinsurance amounts.

Mental Health Parity and Addiction Equity Act of 2008 - To the extent the applicable medical plan provides mental health and substance abuse benefits, it will not place financial requirements, such as co-pays and deductibles, and treatment limitations, such as visit limits, on mental health or substance use disorder benefits that are more restrictive than the predominant requirements or limitations applied to substantially all medical and/or surgical benefits. Such coverage shall be subject to any

applicable deductibles and coinsurance, as well as any limits on the number of covered hospital days and/or outpatient visits.

(iii) Grandfathered Health Plan Notice-Upon information and belief, the applicable medical plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Board of Trustees. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

4.02 Holiday Benefits

(a) Selected Holidays - Each eligible Employee shall receive pay for 8 hours at his regular rate of pay for each of the Selected Holidays.

(b) Payment - Holiday Benefits shall be paid regardless of whether the Employee worked or did not work on such holiday.

4.03 Vacation Benefits - Vacation Benefits shall be determined based on the number of Qualifying Hours worked as follows:

(a) 40 hours of Vacation Benefits for a minimum number of Qualifying Hours worked for one or more Employers during the Plan Year.

(b) 80 hours of Vacation Benefits for a minimum number of Qualifying Hours worked for one or more Employers during the Plan Year and one preceding Plan Year.

(c) 120 hours of Vacation Benefits for a minimum number of Qualifying Hours worked for one or more Employers during the Plan Year and two preceding Plan Years.

(d) 160 hours of Vacation Benefits for a minimum number of Qualifying Hours worked for one or more Employers during the Plan Year and four preceding Plan Years.

(e) 200 hours of Vacation Benefits for a minimum number of Qualifying Hours worked for one or more Employers during the Plan Year and nine preceding Plan Years.

The amount payable shall be the highest amount determined under (a), (b), (c), (d) or (e). Covered Employment for Vacation Benefits must be continuous. An Employee who does not work in Covered Employment for one or more years and then returns to Covered Employment shall be treated as a new Employee for Vacation Benefit purposes.

The Trustees are authorized to reduce the amount of the vacation benefit determined and otherwise payable herein when, in the Trustees' sole judgment, the financial condition of the Plan so warrants. The amount of such reduction shall be within the sole discretion of the Trustees.

4.04 Funeral Leave Benefits

(a) Funeral Leave Benefits shall be provided to an Employee for up to three days for attending the funeral or memorial service for an Employee's Spouse, children or step-children living in the same household, mother, father, mother-in-law, father-in-law, brother, sister, brother-in-law and sister-in-law.

(b) Funeral Leave Benefits of one day shall be provided to attend the funeral or memorial service for an Employee's grandmother, grandfather, aunt or uncle or the grandmother, grandfather, aunt or uncle of the Employee's spouse.

(c) No Funeral Leave Benefit shall be provided if the Employee does not attend the funeral or memorial service or if the Employee performs any work on the day the claim for the Funeral Leave Benefit is made. No Funeral Leave Benefits are paid on days that are Holidays or days an Employee is collecting unemployment compensation benefits.

4.05 Off-Season Supplement Benefits - An Off-Season Supplement Benefit shall be paid based on the Employer Contributions paid to the Plan for containers and tonnage royalties during the preceding April 1 through March 31. Such Benefit shall be determined by taking the total Employer Contributions so paid, subtracting Employer FICA taxes and dividing by the number of eligible Participants.

4.06 Life Insurance Benefits – A Life Insurance Benefit shall be paid to the Beneficiary of an eligible Employee upon the death of such Employee. The Life Insurance Benefit is provided pursuant to a group term life insurance policy selected by the Trustees and the amount of such benefit will be based on the terms of such policy as selected by the Trustees from time to time in their sole discretion.

4.07 Accidental Death and Dismemberment - An Accidental Death and Dismemberment Benefit of $20,000 shall be paid to the Beneficiary of an eligible Employee in the event of a death of the Employee within 90 days of an accident causing such death. This benefit is payable in addition to the Life Insurance Benefit.

Accidental dismemberment benefits for injuries suffered by an eligible Employee within 90 days of an accident shall be paid for the following losses:

	FOR LOSS OF:	AMOUNT PAYABLE
(a)	Both feet	$20,000
(b)	Both hands	20,000
(c)	Sight of both eyes	20,000
(d)	One hand and one foot	20,000
(e)	One hand and sight of one eye	20,000
(f)	One foot and sight of one eye	20,000
(g)	One hand, one foot or one eye	10,000

No benefits shall be paid if the loss was caused by an injury received on the job, contributed to by sickness or infection, by suicide or attempted suicide, by way of any act of war or engaging in insurrection or riot or which is self inflicted.

The maximum benefit payable for one accident shall be $20,000.

4.08 Non-Occupational Weekly Accident and Sickness - Non-Occupational Weekly Accident and Sickness Benefits are provided in the amount of $250 per week for Employees unable to work due to an accident or an illness which is not terminal, and in which the employee is expected to recover and return to covered employment. Benefits shall be provided for 26 weeks or to the date of recovery and return to covered employment, if earlier. Successive periods of disability may be paid full benefits; however, periods of disability separated by less than one week of active full-time work will be considered as one period of disability.

(a) Sickness - If disability is caused by sickness and hospitalization is required, benefits shall commence as of the first day hospitalized. If disability is caused by sickness and hospitalization is not required, benefits shall commence as of the eighth day of sickness.

(b) Accident - If disability is caused by an accident, benefits shall commence on the first day of disability.

Exclusions: Accident and Sickness Benefits are not paid for:

1. Any period of sickness disability during which you are not under the care of a duly qualified physician.
2. Disability resulting from
   (a) injuries sustained in the course of any occupation or employment for remuneration or profit, or
   (b) sickness for which benefits are payable in accordance with the provisions of any Workers' Compensation Laws.
3. Any periods for which you are entitled to and/or collecting state unemployment benefits.

ARTICLE V

CONTINUATION AND CONVERSION RIGHTS

5.01 Continuation and Conversion Rights

Certain Participants shall have all COBRA continuation rights required and all conversion rights, if any, required by a program, which is, considered a group health plan under COBRA. COBRA Continuation Coverage shall be continued based upon the following circumstances:

(a) COBRA Continuation Coverage for Terminated Participants - A covered Participant may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of the following Qualifying Event: termination of employment or reduction of hours with an Employer, other than for gross misconduct.

The Participant may also cover any Dependents that were covered and are losing their coverage. If you have a newborn child, adopt a child, or have a child placed with you for adoption while your COBRA Continuation Coverage is in effect, you may add this child to your coverage.

(b) COBRA Continuation Coverage for Dependents - A Qualified Dependent may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of a Qualifying Event.

(c) Period of Continuation Coverage for Covered Participants - A covered Participant who qualifies for COBRA Continuation Coverage as a result of termination of employment or reduction in hours of employment described in Section 5.01, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event.

Coverage under this Section 5.01(c) may not continue beyond:

(i) the date on which the Trustees cease to maintain a group health plan;

(ii) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 5.01(e);

(iii) The date on which the person first becomes, after the date of election:

Covered under any other group health plan (as an employee

or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary or at the point when the new plan may no longer exclude coverage for any of such beneficiary's pre-existing conditions as a result of HIPAA; or

Entitled to benefits under Medicare.

(d) Period of COBRA Continuation Coverage for Dependents - If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the covered Participant's termination of employment as described in Section 5.01, Continuation Coverage may be continued for up to 18 months measured from the date of the Qualifying Event. COBRA Continuation Coverage for all other Qualifying Events may continue for up to 36 months.

Continuation Coverage under this Section 5.01(d) may not continue beyond:

(i) the date on which premium payments have not been made, in accordance with Section 5.01(e) below;

(ii) the date on which the Trustees cease to maintain a group health plan; or

(iii) The date on which the person first becomes, after the date of election:

Covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary or at the point when the new plan may no longer exclude coverage for any of such beneficiary's pre-existing conditions as a result of HIPAA; or

Entitled to benefits under Medicare.

(e) Contribution Requirements for COBRA Continuation Coverage - Covered Participants and Dependents who elect COBRA Continuation Coverage as a result of one (1) of the Qualifying Events specified in Section 5.01 will be required to pay Continuation Coverage Payments.

Covered Participants and Dependents must make the Continuation Coverage Payment monthly prior to the first day of the month in which such coverage will take effect. However, a Covered Participant or Dependent has 45 days from the date of an affirmative election to pay the Continuation Coverage Payment for the first month's payment and the cost for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the Covered Participant and/or Qualified

Dependent actually elects COBRA Continuation Coverage, and for the first month's coverage. The Covered Participant and/or Qualified Dependent shall have a 30-day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the 30-day grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made. The 30-day grace period shall not apply to the 45-day period for payment of COBRA premiums as set out in this Section 5.01(e).

(f) Limitation on Participant's Rights to COBRA Continuation Coverage

(i) If a Qualified Dependent loses, or will lose medical coverage under the Plan as a result of divorce, legal separation, entitlement to Medicare or ceasing to be a Dependent, such Qualified Dependent is responsible for notifying the Plan Administrator in writing within 60 days of the Qualifying Event. Failure to make timely notification will terminate the Qualified Dependent's rights to COBRA Continuation Coverage under this Article.

(ii) A Participant must complete and return the required enrollment materials within 60 days from the later of (i) the date of loss of coverage, or (ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage. Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Article V. An affirmative election of COBRA Continuation Coverage by a covered Participant or his spouse shall be deemed to be an election for that covered Participant's Dependents who would otherwise lose coverage under the Plan.

(g) Subsequent Qualifying Event - If a second Qualifying Event occurs during an 18 month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first Qualifying Event. In the event the Dependent loses coverage due to a Qualifying Event and after such date the Participant becomes entitled to Medicare, the Dependent shall have available up to 36 months of coverage measured from the date of the Qualifying Event which causes the loss of coverage. If the Participant was entitled to Medicare prior to the Qualifying Event, the Dependent shall have up to 36 months of coverage measured from the date of entitlement to Medicare.

(h) Extension of COBRA Continuation Period for Disabled Individuals - The period of continuation shall be extended to 29 months in total (measured from the date of the Qualifying Event) in the event the individual is disabled as determined by the Social Security laws within 60 days of the Qualifying Event. The individual must provide evidence to the Plan Administrator of such Social Security determination prior to the earlier of 60 days after the date of the Social Security determination, or the expiration of the initial 18 months of COBRA continuation coverage. In such event, the Employer may charge the individual up to 150% of the COBRA cost of the coverage.

5.02 Conversion of Policies

Conversion to an individual policy shall be available if provided under the terms of the applicable medical benefits program.

5.03 Continuation of Coverage during Family or Medical Leave

During any period during which a Participant is on a family or medical leave as defined in the Family and Medical Leave Act of 1993, any Medical Benefits elections in force for the Participant shall remain in effect. While the Participant is on paid leave, contributions shall continue. If the Participant is on an unpaid leave, the contributions will be suspended and placed in arrears but his coverage will remain in place. Upon his return from the family or medical leave or upon notification that he will not be returning to work, the Participant will be responsible for the repayment of the amount in arrears. Upon return from family or medical leave, the Participant will be reinstated in his benefits at the level in place prior to the leave.

5.04 Rights while on Military Leave

Pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994, an Employee on military leave will be considered to be on a leave of absence and will be entitled during the leave to the health and welfare benefits that would be made available to other similarly situated Employees if they were on a leave of absence. This entitlement will end if the Employee provides written notice of intent not to return to work following the completion of the military leave. The Employee shall have the right to continue his coverage, including any Dependent coverage, for the lesser of the length of the leave or 18 months. If the military leave is for a period of 31 days or more, the Employee will be required to pay 102% of the total premium (determined in the same manner as a COBRA continuation coverage premium). If coverage is not continued during the entire period of the military leave because the Employee declines to pay the premium or the leave extends beyond 18 months, the coverage must be reinstated upon reemployment with no pre-existing condition exclusions (other than for service-related illnesses or injuries) or waiting periods (other than those applicable to all eligible Employees.) These rules apply to the Medical Benefit Plan.

5.05 HIPAA Certification

Pursuant to the provisions of the Health Insurance and Portability and Accountability Act (HIPAA), limits have been placed on preexisting condition exclusion periods. Under HIPAA, an Employee's period of coverage under this Plan will offset the exclusion period of a new medical plan as long as the break in medical coverage is not over 63 days.

If an Employee loses coverage under this Plan a certificate will be issued that provides written confirmation of his prior medical coverage. This certificate will be used to determine preexisting condition exclusion periods. The certification will identify the persons covered under the plan, the period of coverage and the waiting periods. Certification is provided when: the Employee leaves his Employer, the Employee or his dependent loses coverage, the Employee or his dependent's COBRA coverage ends, the Employee requests certification up to 24 months after he leaves the Employer, the Employee or his dependent becomes eligible for coverage under another plan.

ARTICLE VI

CONTRIBUTIONS

6.01 Contributions by the Employers

The Employer makes contributions as specified under the Collective Bargaining Agreement or other written agreement to provide for the payment of benefits under the Plan.

6.02 Contributions by Participants

Participants covered by the Plan shall make such contributions as may be required under the terms of the Plan. Contributions for individuals receiving COBRA Continuation Coverage, or individuals on an unpaid leave of absence shall be paid in accordance with the Plan's procedures regarding same.

ARTICLE VII

CLAIM AND APPEAL PROCEDURE

7.01 Procedure for Filing Claims

Any claim for benefits through the GLDC-ILA Plan or third party administrator shall be submitted to the third party administrator or to the GLDC-ILA Plan, whichever is applicable in accordance with the provisions of the that program.

Any claim for other benefits shall be made to the Plan Administrator. If you believe that you are eligible to receive any type of benefit from the Plan, you should first contact the Fund Office. You must file a claim for benefits on the form approved by the Board of Trustees. The Fund Office will provide you with an application for benefits which must be completed in full. This application must be filed with the Fund Office within any applicable time limits.

7.02 Payment to Legal Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant, any such payment under the Plan may be made to such representative and such payment will discharge any liability under the Plan.

7.03 Denial of Claim & Claims Review Procedure

If the GLDC-ILA Plan or third party administrator denies any claim, the Participant or Beneficiary shall follow the claims review procedure established by the GLDC-ILA Plan or third party administrator.

If the Plan Administrator denies a claim, in whole or part, you will be advised of the following within a reasonable period of time but no longer than ninety (90) days after receipt of your claim by the Plan (forty-five (45) days in the case of disability benefits):

1. The specific reason(s) for the denial;
2. Specific reference to the Plan provisions on which the denial was based, and a copy of these procedures;
3. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. An explanation of the procedures required for further review and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the ERISA following an adverse benefit determination on review;
5. For disability benefit claims, notice of the internal rule, guideline or protocol relied upon in making the decision; you will be provided a copy free of charge

upon request; and

6. For disability benefit claims, if the claim is denied based on medical necessity or experimental treatment or similar exclusion, you will be provided with an explanation of the scientific or clinical judgment for the determination free of charge upon request.

However, in special cases requiring a delay, you will receive our claim determination within an additional 90 days (thirty (30) days in the case of disability benefits). If such an extension is needed, you will be provided with written notice. The 30-day extension for disability benefit determinations can be extended an additional 30 days upon notice to you. If additional information is needed of you to determine your disability benefit entitlement, you will be provided with at least 45 days to provide such information.

If you disagree with the denial by the Plan Administrator, you or your duly authorized representative may:

1. Request review by the Board of Trustees upon written application to the Plan;
2. Upon request and free of charge, review and copy documents, records, and other information relevant to your claim for benefits; and
3. Submit issues and comments in writing.

The request for review must be in writing and made within sixty (60) calendar days of your receipt of the written notification of denial (180 days in the case of disability benefits).

Normally, you will receive a final decision within 60 days of the date your request for review is received (forty-five (45) days in the case of disability benefits). However, in special cases requiring a delay, you will receive notice of the final decision within 120 days (ninety (90) days in the case of disability benefits). If such an extension is needed, you will be provided with written notice. The appeal determination will normally be made at the next regular meeting of the Trustees held after the date we receive your review request, unless, the request is filed within 30 days preceding the meeting. In that case, the appeal decision may be made at the second meeting following our receipt of your appeal request. If special circumstances exist that require a further extension, the Trustees can make its decision by the third meeting. You would receive an extension notice in that event. If your claim is decided at a regular meeting of the Trustees, you will be notified of that decision within five (5) calendar days of the meeting. The decision on review will be in writing and include specific reasons for the decision, specific references to the pertinent Plan provisions on which the decision is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim, as well as a statement of your right to bring an action under Section 502(a) of ERISA. If you do not receive our decision within the time set forth herein, the claim shall be deemed denied on review.

In the event your appeal is denied, the determination will include the following information:

1. The specific reason(s) for the denial;

2. Specific reference to the Plan provisions on which the denial was based;

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

4. A statement of your right to bring a civil action under Section 502(a) of the ERISA following an adverse benefit determination on review;

5. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

6. For disability benefit claims, notice of the internal rule, guideline or protocol relied upon in making the decision; you will be provided a copy free of charge upon request; and

7. For disability benefit claims, if the claim is denied based on medical necessity or experimental treatment or similar exclusion, you will be provided with an explanation of the scientific or clinical judgment for the determination free of charge upon request.

The Plan does not offer any voluntary arbitration provisions. The Plan will not administer its benefits in any way which restricts or otherwise hinders your ability to file a claim for benefits. The Plan does not require any fees or payment as a condition to filing a claim for benefits. These Procedures are designed to treat all Participants and Dependents filing claims for benefits fairly and consistently. You may have a representative file a claim for benefits or appeal of an adverse decision on your behalf at any time.

The Plan gives the Board of Trustees full discretion and authority to make the final decision regarding all areas of Plan interpretation and administration, including: eligibility for benefits, the level of benefits provided, or interpretation of Plan language (including the Summary Plan Description) or administrative procedures.

The decision of the Board of Trustees is final and binding on all individuals dealing with or claiming benefits under the Plan, and if challenged in court, the Plan intends for the Board of Trustees' decision to be upheld, unless found by a court of competent jurisdiction to be arbitrary and capricious.

You must comply with these appeal procedures prior to instituting legal action on a claim for benefits. Any legal action must be filed within ninety (90) calendar days following your receipt of the Board of Trustees' decision on review. If you have any questions regarding these Procedures, please contact the Plan Administrator or its authorized representative.

7.04 Proof of Incurred Charge

Unless stated to the contrary in the applicable Medical Benefits program, proof of an incurred charge under the Plan must be provided in writing and furnished to the Plan

Administrator within one (1) year after the incurred charge and must cover the occurrence, character, and extent of the expense.

7.05 Right to Examine by Plan Administrator

The Plan Administrator shall have the right and opportunity to, at its own expense, have a Physician examine the individual whose injury or disease is the basis of a claim when and as often as it may reasonably require.

7.06 Failure to File a Request

If a claimant fails to file a request for review in accordance with the procedures outlined herein, such claimant shall have no rights of review and shall have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

ARTICLE VIII

COORDINATION OF BENEFITS WITH OTHER PLANS

8.01 Coordinating Benefits with Coverage from Another Source

If a Participant has coverage under this Plan as well as coverage from another source, benefits that are received through this Plan shall be coordinated with the benefits available under the plan containing the Participant's other source of benefits. This coordination of benefits provision shall apply to all benefits provided under this Plan.

8.02 Ordering of Benefits

When coverage is provided by two or more sources, the plan that is primary is established in the following order:

(a) the plan that has no Coordination of Benefits (COB) provision will be considered primary to a plan that has COB provisions;

(b) the plan covering the person as an employee will be primary to the plan covering the person as a dependent;

(c) for purposes of a dependent covered under a plan of both of his non-divorced parents, the plan covering the parent whose birthday falls first in the year will be primary to the plan covering the parent whose birthday falls later in the year. If both parents have the same birthday, the plan covering the parent for the longest period of time will be primary.

(d) for a dependent whose parents are divorced or separated, and the dependent is covered by plans of both parents, the plan covering the parent who is responsible for the dependent's health care under the terms of the court decree will be the primary payor. In the absence of such a court decree, payment will be made in the order as follows:

(1) the plan of the parent with custody;

(2) the plan of the step-parent with custody;

(3) the plan of the parent without custody.

(e) vehicle insurance, including but not limited to uninsured/underinsured, medical payment coverage, no-fault, and similar policies or coverage, as well as casualty and liability insurance coverages are primary.

In the event that no rule above applies, the plan covering the person the longest period of time shall be primary to the plan covering the person for a shorter period.

8.03 Reduction of Benefits Payable by the Plan

Whenever this Plan is considered as secondary to another plan, benefits will be payable by the primary plan to the extent that the expense is an incurred charge, and the secondary plan shall be liable for the remainder to the extent that the eligible expenses would be payable in total under this Plan.

8.04 Recovery of Duplicate Payments

In the event that duplicate payment have been made by the Plan. The Trustees may take whatever action they deem necessary to recover the amount.

ARTICLE IX

MISCELLANEOUS PROVISIONS

9.01 Plan Interpretation

This Plan document sets forth the provisions of this Plan. This Plan shall be read in its entirety and not severed except as provided in Section 9.05.

9.02 Non-Alienation of Benefits

No benefit, right or interest of any person hereunder shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process or be liable for, or subject to, the debts, liabilities or other obligations of such individual, except as otherwise required by law.

9.03 Limitation on Participant Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

(a) to give any individual any legal or equitable right against the Employer or Plan Administrator, except as expressly provided herein or provided by law; or

(b) to create a contract of employment for any Employee, to obligate the Union, Trustees or Employer to continue the service of any Employee or to affect or modify his or her terms of employment in any way.

9.04 Governing Law

This Plan is governed by the Code and ERISA and the regulations issued thereunder. In no event shall the Employers or Trustees guarantee the favorable tax treatment available to the Plan as a tax-exempt organization under applicable provisions of the Code. To the extent not preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Ohio.

9.05 Severability

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

9.06 Verification

The Plan Administrator shall be entitled to require reasonable information to verify any claim or the status of any person as a Participant under the Plan. If the Participant does not supply the requested information or provide a release for such information, such Participant shall not be entitled to benefits under the Plan.

9.07 Captions

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

9.08 Qualified Medical Child Support Orders

The Plan will comply with any Qualified Medical Child Support Order issued by a court of competent jurisdiction or administrative body which requires the Plan to provide medical coverage to a Dependent child of an Employee. The Plan Administrator will establish reasonable procedures for determining whether a court order requiring medical coverage for a Dependent child meets the requirements for a Qualified Medical Child Support Order. The additional cost of such coverage, if any, shall be borne by the Employee.

9.09 Non-Gender Clause

Whenever used in this Plan, the masculine gender shall include the feminine and the plural form shall include the singular.

9.10 Right of Recovery

If the Plan has made an erroneous or excess payment to any Participant or Dependent, the Plan Administrator shall be entitled to recover such excess from the Participant or Dependent to whom such payments were made. The recovery of such overpayment may be made by offsetting the amount of any other benefit or amount payable by the amount of the overpayment under the Plan.

9.11 Right of Subrogation

The Fund's right of subrogation and recovery arises and will be exercised when any benefits, including short-term disability, hospital, surgical and/or medical benefits, are paid to or on behalf of a participant or Dependent (hereinafter referred to as the "Covered Person") due to a loss, injury or illness for which another person or entity is our may be legally responsible. This would include but not be limited to a loss, injury or illness compensable under the workers' compensation system, and/or due to medical malpractice, negligence, tortious and/or criminal conduct of a third party, or any other situation. In consideration for the Fund's advancement of benefits in this context, the Covered Person agrees to the terms set forth herein.

The Fund shall be fully reimbursed when recovery occurs or is available from any source, including but not limited to the person or entity that is or may be responsible for such loss, injury or illness, the insurer of such person or entity, the Covered Person's insurer including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance the workers'

compensation system, or any other source (each of the aforementioned hereinafter collectively referred to as "Responsible Person(s)"). Such recovery includes but is not limited to court judgments, administrative or agency orders, private settlements, any and all monies however characterized, or any other payments. No settlement shall be made or release given for claims arising out of the Covered Person's loss, injury or illness without prior written consent of the Fund. In consideration for the Fund's advancement of benefits in this context, the Responsible Person(s) agrees to the terms set forth herein.

In connection with the above paragraphs, the Fund shall be reimbursed in the full gross amount of any and all benefits, of whatever type, paid or otherwise provided by the Fund. The Fund shall receive full and complete reimbursement first, and prior to any other disbursements including disbursement to the Covered Person, payment of attorney's fees and/or expenses. The Fund's right to full reimbursement shall not be subject to reduction for reasons including but not limited to the Covered Person's failure to recover the perceived full or actual value of his or her claim for whatever reason, attorneys fees, expenses or other costs, and/or the Fund's failure to actively participate in the claim and/or recovery. Further, the Fund expressly rejects, disclaims and otherwise prohibits application of the "make-whole" doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights. Additionally, the Fund expressly rejects, disclaims and otherwise prohibits application of the “common fund” doctrine or any similar doctrine or common law rule with respect to its subrogation, recovery and reimbursement rights.

The Covered Person shall complete all paperwork deemed necessary by the Fund to protect its subrogation interests, including the signing of the Fund's subrogation and reimbursement agreement; failure to do so entitles the Fund to deny coverage for the subject loss, injury or illness. The Covered Person will do nothing to impair or negate the Fund's right of subrogation and will fully cooperate with the Fund. If the Covered Person performs any act or fails to act, fails to reimburse the Fund in the full amount of benefits of whatever nature that were paid by the Fund, or otherwise compromises the Fund's rights, the Fund may immediately seek recovery of all benefit amounts paid by any available means, including legal action. The Fund shall also have the right to offset or otherwise reduce any future benefit payments that would otherwise be payable to or on behalf of the Covered Person, to the extent of its lien. The Covered Person shall permanently forfeit these offset benefits and the Covered Person shall be legally responsible for any unpaid amounts.

The Covered Person assigns to the Fund any and all claims, demands and contractual rights the Covered Person has or may have against Responsible Person(s) arising from or related in any way to the Covered Person's loss, injury or illness, and agrees that the Fund is substituted in the place of the Covered Person against such Responsible Person(s) to the extent of the amount paid by the Fund as a result of such loss, injury or illness. This entitles the Fund to make claim or file suit in the name of the Covered Person. The Covered Person agrees that the Fund shall hold a lien against any amounts the Covered Person receives will receive or has available from any source as a result of the loss, injury or illness to the extent of benefits paid by the Fund. The Covered Person agrees that the Fund may at any time notify or otherwise communicate with the Responsible Person(s)

and the Covered Person's attorney and release information relative to the loss, injury or illness. The Covered Person agrees to promptly make claims against the Responsible Person(s), and, if necessary, to commence and prosecute a lawsuit against such Responsible Person(s) with all due diligence. Any recipient of settlement proceeds or assets collected from judgments are subject to the imposition of a constructive trust.

Constructive Trust

A Participant or his attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A Participant or his attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the Participant or his attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

Recoupment

If the Plan should provide any form of benefit under the Plan to you and/or your dependent(s) and, for whatever reason, such benefit was not required under the terms of the Plan or otherwise mistakenly paid, the Plan shall have the right to offset future benefits to the extent of the overpayment. This provision does not limit the Plan's right to recover such amount by any other lawful means.

9.12 Rescission of Benefits

In accordance with the Patient Protection and Affordable Care Act (the "Affordable Care Act"), the Fund will only "rescind," or cancel, or discontinue coverage retroactively in cases where a participant or the participant's eligible dependent (or a person seeking coverage on behalf of such individual) has performed an act, practice, or omission that constitutes fraud, or in cases where such an individual makes an intentional misrepresentation of a material fact, as prohibited by the terms of the Fund. If the Fund seeks to rescind benefits on such grounds, it will provide the individual with thirty (30) calendar days advance written notice prior to rescission, along with information about appeal rights. Please note that a retroactive termination of coverage due to a participant's failure to timely pay premiums is not a rescission.

9.13 Facility of Payments

If any Participant, Dependent or Beneficiary entitled to receive benefits hereunder is a minor or, in the opinion of the Trustees is physically or mentally incapable of receiving or administering such benefits or acknowledging receipt thereof and the Trustees are not aware of any legal representative having been appointed for him, the Trustees may cause any such benefit to be paid to any one or more of the following as may be chosen by the Trustees: an institution maintaining the individual entitled to the benefits; the individual's spouse, parent(s), child(ren) and/or other relatives by blood or marriage; and /or any person whom the Trustees reasonably determine is caring for the individual or otherwise providing him

with support and maintenance. The Trustees shall have no obligation or duty to see that the funds are used or applied for the purposes for which paid and any payment so made shall be a complete discharge of any and all liability under the Plan with respect to such payment.

9.14 Entire Plan

This document including all documents incorporated by reference constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing and approved by the Trustees.

ARTICLE X

PLAN ADMINISTRATOR

10.01 Plan Administrator

The Plan Administrator shall have overall responsibility for the administration of this Plan and any decisions made in accordance herewith shall be final and conclusive on all Employees, Spouses and their Dependents.

10.02 Powers and Duties of the Plan Administrator

The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have complete and final discretionary authority to construe and interpret the Plan, control over the operation and administration of the Plan, including interpretation of all plan documents, decisions concerning all questions of eligibility to participate and the determination of the amount, manner and time of payment of any benefits or covered expenses (including questions of medical necessity) hereunder and without limitation, the determination of all related or non-related questions and matters that arise under the Plan such decisions shall be final and conclusive, and there shall be no de novo review of any such decision by any court. Any review of such decision shall be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;

(d) to receive from the Union or Employer, Participants and other appropriate parties such information as shall be necessary for the proper administration of the Plan;

(e) to receive, review and keep on file (as it deems necessary) reports of benefit payments and reports of disbursements for expenses directed by the Plan Administrator;

(f) to exercise such discretionary authority and responsibility as it deems appropriate in order to comply with the terms of the Plan, including collection of Employer Contributions;

(g) to appoint individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal and actuarial counsel; and

(h) any and all additional duties and powers set forth in the declaration of trust.

The Plan Administrator may rely upon any reasonable direction, or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under this Plan, and is not required under this Plan to inquire into the propriety of any such direction or information. It is intended under this Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under this Plan and shall not be responsible for any act or failure to act by any other party. The Plan Administrator does not make any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in this Plan.

10.03 Disclaimer of Liability

Except as may be otherwise provided under ERISA, neither the Union, the Plan Administrator, any Employer, the Corporate Trustee, (if any) nor any other person delegated to act on behalf of the Plan shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

ARTICLE XI

AMENDMENTS, TERMINATIONS AND MERGERS

11.01 Right to Amend, Merge or Consolidate

The Trustees reserve the right to merge or consolidate the Plan, and to make any amendment or amendments to the Plan from time-to-time or at any time, including those which are retroactive in effect. Such amendments may be applicable to any Participant, Dependent or any other affected party.

11.02 Right to Terminate

The Plan is intended to be permanent, but the Trustees may at any time terminate the Plan in whole or in part.

ARTICLE XII

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits
Examination, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5000 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the 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 5000 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against

you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relative to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ERISA requires that certain information be furnished to each participant in an Employee Benefit Plan. This booklet is the Plan document and Summary Plan Description for purposes of ERISA.

ARTICLE XIII

IMPORTANT INFORMATION ABOUT THE PLAN

Name of the Plan: Cleveland Longshoremen's Welfare Plan

Board of Trustees:
The Board of Trustees, which consists of an equal number of Union and Employer representatives, is responsible for the operation and administration of the Plan. If you wish to contact the Board of Trustees, you may use the following address and phone number:

Board of Trustees
Cleveland Longshoremen's Welfare Fund
c/o Compensation Programs of Ohio, Inc.
33 Fitch Blvd.
Austintown, OH 44515
(330) 270-0453

Currently, the four individuals who serve on the Board of Trustees are:

Union Trustees	**Employer Trustees**
Sean Baker Local 1317 ILA 700 Erieside Avenue Cleveland, Ohio 44114	Keith Flagg Federal Marine Terminals, Inc. 775 Erieside Avenue Cleveland, Ohio 44114
John D. Baker, Jr. Local 1317 ILA 101 Erieside Avenue Cleveland, Ohio 44114	Joseph McJunkin Federal Marine Terminals, Inc. 775 Erieside Avenue Cleveland, Ohio 44114

Plan Sponsor and Administrator:
The Board of Trustees is both the Plan Sponsor and Administrator.

Identification Number:
The plan number is #501. The employer identification number assigned to the Plan Sponsor by the Internal Revenue Service is #34-09311120.

Type of Plan:
This Plan is a welfare plan providing for medical and related health benefits.

Fiscal Year:
The Plan year for purposes of maintaining the Plan's fiscal records is the twelve-month period beginning each April 1 and ending on the following March 31. This is also referred to as the Plan year.

Agent for Service of Legal Process:
The agent for service of legal process is Compensation Programs of Ohio, Inc., who has been retained to assist in the administration of the Plan. The address of Compensation Programs of Ohio, Inc. is 33 Fitch Blvd., Austintown, OH 44515. Accordingly, if legal disputes involving the Plan arise, any legal documents may be served upon the Board of Trustees at this address, or upon any Trustee or the Plan Administrator.

Funding:
Employers make contributions to the Fund in accordance with collective bargaining agreements with the International Longshoremen's Association, Local No. 1317, AFL-CIO, or other written agreement. The Fund Office will provide you, upon written request, a list of all employers who participate in the Plan and such list is available for your review. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Fund on behalf of its employees as well as that employer's address. Copies of the agreements may be obtained and are available for review at the Fund Office.

Benefits:

Holiday, Vacation, Funeral Leave, Off-Season Supplement, and Non-Occupational Weekly Accident and Sickness Benefits are self-funded by the Fund and paid from Trust Fund assets.

Medical, Dental, Vision, Life Insurance and Accidental Death and Dismemberment Benefits are provided through the GLDC-ILA Plan, subject to that plan's terms and conditions, in return for the Fund paying, on behalf of its eligible Participants, the required monthly contribution amount to the GLDC-ILA Plan. The GLDC-ILA Plan is located at 101 Erieside Avenue, Cleveland, Ohio 44114; (216) 781-7816.

Your Financial Responsibilities:
Your financial responsibilities with respect to those benefits provided through the GLDC-ILA Plan shall be explained in such plan's written document provided to you, such as all applicable deductibles, coinsurance, etc.

HIPAA - Protected Health Information:

A. Use and disclosure of Protected Health Information (PHI): The Fund will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Fund will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Fund to obtain premiums or determine or fulfill its responsibility for coverage and provision of Fund benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Fund maximums, and copayments as determined for an individual's claim);

- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant (and their authorized representatives') inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary in the future;
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges;
- Utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- Reimbursement to the Fund.

"Health Care Operations" include, but are not limited to, the following activities:

- Quality Assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions;
- Rating provider and Fund performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business funding and development, such as conducting cost-management and funding-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.

Business management and general administrative activities of the entity, including, but not limited to:

- Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;
- Customer service, including the provision of data analyses for policyholders, Fund sponsors, or other customers;
- Resolution of internal grievances;
- Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

B. The Fund will use and disclose PHI as required by law and as permitted by authorization of the participant or beneficiary. With an authorization or under any applicable business associate agreement, the Fund will disclose PHI to other related funds which may provide retirement and/or disability benefits to a participant or beneficiary solely for purposes related to administration of these funds.

For purposes of this section the Board of Trustees is the Fund Sponsor. The Fund will disclose PHI to the Fund Sponsor upon certification from the Fund Sponsor that the Fund documents have been amended to incorporate these provisions.

C. With respect to PHI, the Fund Sponsor agrees to:

1) Not use or further disclose the information other than as permitted or required by the Fund documents or as required by law;
2) Ensure that any agents, including a subcontractor, to whom the Fund Sponsor provides PHI received from the Fund agree to the same restrictions and conditions that apply to the Fund Sponsor with respect to such information;
3) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;
4) Not use or disclose the information in connection with any other employee benefit fund of the Fund Sponsor unless otherwise authorized or under any applicable business associate agreement;
5) Report to the Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6) Make available PHI to the individual in accordance with the access requirements of HIPAA;
7) Make available PHI for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8) Make available the information required to provide an accounting of disclosures;
9) Make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of HHS for the purposes of determining compliance by the Fund with HIPAA;
10) If feasible, return or destroy all PHI received from the Fund that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible,

limit further uses and disclosures to those purposes that make the return or destruction infeasible.

D. Adequate separation between the Fund and the Fund Sponsor must be maintained. Therefore, in accordance with HIPAA, only the following persons, employees or classes of employees may be given access to PHI (unless pursuant to authorization or business associate agreement):

- The Fund's Administrative Manager, Fund Manager or Fund Chairman, as applicable;
- Staff designated by the Fund's Administrative Manager, Fund Manager or Fund Chairman, as applicable;
- Board of Trustees of the Fund

The individuals described in this section may only have access to and use and disclose PHI to the extent and in accordance with the uses and disclosures permitted by HIPAA.

If the individuals described in this section do not comply with these requirements, the Fund Sponsor shall provide a mechanism for resolving issues of noncompliance, including any disciplinary sanctions.

HIPAA- Security:

The Fund and the Fund Sponsor agree to comply with the Security Regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160, 162, and 164 (the "Security Regulations"). The Security Regulations are incorporated herein by references, and, unless defined otherwise in the Fund in a way not inconsistent with the Security Regulations, all capitalized terms herein shall have the definition given to them by the Security Regulations.

These provisions shall apply to that Electronic Protected Health Information ("ePHI") created, received, maintained, or transmitted to or by the Fund Sponsor on behalf of the Fund except, as provided in the Security Regulations, for ePHI (1) disclosed to the Fund Sponsor consistent with the provisions set forth in 45 CFR section 164.504(f)(1)(ii) or (iii), or (2) as authorized under the provisions set forth in 45 CFR section 164.508. To the extent any other terms of the Fund should conflict with the following provisions, the following provisions shall control.

The Fund Sponsor is required to and shall, in accordance with the Security Regulations:

1. Implement Administrative, Physical, and Technical Safeguards (each as defined in 45 CFR § 164.304) that reasonably and appropriately protect the Confidentiality, Integrity, and Availability (each as defined in 45 CFR § 164.304) of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund.

2. Ensure that the adequate separation required 45 CFR section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures. In general, the required adequate separation means that the Fund Sponsor will use ePHI only for Fund administration functions it performs for the Fund.

3. Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect information, including those security measures that are required pursuant to the HITECH Act.

4. Obtain signed business associate agreements from the Fund's business associates that are updated to reflect the changes imposed by the HITECH Act.

5. Report to the Fund any Security Incident of which it becomes aware, and to make such other reports, notices, and/or disclosures that are required pursuant to HITECH Act's Breach Notification Requirements.

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