Tampa Banana Handlers Health and Welfare Plan

Summary Plan Description

August 1, 2009

SECTION I

GENERAL PLAN INFORMATION

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

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CONSULTANT

Frank K. Dalrymple, Jr.

TAMPA BANANA HANDLERS HEALTH AND WELFARE PLAN

To All Eligible Participants:

We are pleased to present you with this booklet which has been printed to give you an up-to-date description of the benefits provided by the Welfare Fund.

The Medical benefits are provided through an insurance carrier. Benefits are available to eligible employees and dependents.

The Life Insurance and Accidental Death & Dismemberment benefits are also provided through an insurance carrier.

The Weekly Indemnity Benefit, Dental Benefits, Vision Benefits, Vacation Benefits, and Funeral Services Benefit are self funded and described in this booklet.

Also included in this booklet is certain information concerning the administration of the Plan and your rights under the Plan as required by federal law.

We urge you to read this booklet carefully and become familiar with the eligibility rules and the types of benefits covered.

If you have any questions about the Plan, please call or write the Administrative Manager's office for an explanation, at the address shown on the inside cover of this booklet. **YOU SHOULD KEEP THE ADMINISTRATIVE MANAGER ADVISED OF YOUR CURRENT MAILING ADDRESS TO ENSURE THAT YOU WILL RECEIVE ALL REQUIRED COMMUNICATIONS.**

Sincerely,

THE BOARD OF TRUSTEES

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DEFINITIONS

EMPLOYER — The term "Employer" means any company which has entered into a Collective Bargaining Agreement with the International Longshoremen's Association, Local No. 1402/Manatee or is otherwise obligated to make contributions to the Fund. The term "Contributing Employer" means an employer which makes contributions to Tampa Banana Handlers Welfare Fund by the terms of a participation agreement. The Union and the Trust Fund are considered Employers with respect to its employees for whom it contributes to this Fund.

EMPLOYEE — The term "Employee" means all active employees on whose behalf contributions are required to be made to the Fund by Employers in accordance with a Collective Bargaining Agreement or other written participation agreement by and between Employers and the ILA Local 1402/Manatee, including non-bargaining unit employees of the Employer, elected officials of the Union and employees of the Trust Fund. In addition, officers of the Employer may be considered employees, provided that sole proprietors, partners and persons owning 100% of the stock of a corporation will not be considered employees and will not be eligible to participate in the Plan.

DEPENDENT The term "Dependent" means (1) an employee's spouse as defined by federal law in the Defense of Marriage Act who is not legally separated from the employee, but shall exclude a common law spouse or spouse by civil union whose marriage cannot be evidenced by a duly constituted marriage license issued by the appropriate state or other jurisdiction where the marriage occurred. The term “marriage” means only a legal union between one man and one woman as husband and wife; (2) the employee's unmarried children from birth to age 19, or to age 25 if all of the following conditions are met: (a) the child is dependent on the employee for support, and (b)(1) the child is living in the household of the employee and (b)(2) the child is a part-time or full-time student at an accredited school, college or university, or for Medical benefits coverage only to the end of the calendar year in which he/she attains age 30, if all of the following conditions are met: (a) the Employee has exercised the option to provide coverage for children (b) the child is unmarried and has no dependent of his/her own (c) the child is a part-time or full-time student at an accredited school, college or university (d) the child is not provided coverage as a named insured, insured, enrollee, or a covered person under any other group or individual health care plan or is not entitled to benefits under title XVIII of the Social Security Act.
It shall be the Employee’s responsibility to provide proof acceptable to the trustees documenting the status of any such dependent child(ren).

The term "children" shall include natural children, adopted children (from the moment of placement in the home), stepchildren, provided they regularly reside with the employee, and children under legal guardianship if the child depends primarily upon the employee for support and lives with the employee in a regular parent-child relationship; and the employee's unmarried dependent children who, upon attaining age 19, are mentally or physically handicapped so as to be incapable of self-support, provided such proof is furnished to the Administrative Manager within 30 days of the date benefits would otherwise terminate, and then periodically as requested by the Plan.

NOTE: ANY REFERENCE TO MALE GENDER ALSO INCLUDES FEMALE GENDER, WHERE APPLICABLE.

ELIGIBILITY RULES

The rules below set forth eligibility for all benefits **except** the Holiday/Vacation Benefit. Eligibility for the Holiday/Vacation Benefit is described in that section.

BARGAINING UNIT EMPLOYEES

ELIGIBILITY

An employee will become eligible for employee only benefits (inclusive of Holiday/Vacation benefits) beginning on October 1st, if during prior twelve (12) month period he had a minimum of 900 hours of contributions (but less than 1201 hours of contributions) made or required to be made on his behalf. An employee will become eligible for employee and dependent benefits (inclusive of Holiday/Vacation benefits) beginning on October 1st if during prior twelve (12) month period he had a minimum of 1201 hours of contributions (900 hours for coverage prior to October 1, 2009) made or required to be made on his behalf. He shall remain eligible through September 30th of the following year.

CONTINUED ELIGIBILITY

An employee will remain eligible for employee only benefits (exclusive of Holiday/Vacation benefits) beginning on October 1st, if during prior twelve (12) month period he had a minimum of 900 hours of contributions (but less than 1201 hours of contributions) made or required to be made on his behalf. An employee will remain eligible for employee and dependent benefits (inclusive of Holiday/Vacation benefits) beginning on October 1st if during prior twelve (12) month period he had a minimum of 1201 hours of contributions (900 hours for coverage prior to October 1, 2009) made or required to be made on his behalf. He shall remain eligible through September 30th of the following year.

DISABILITY CREDITS

Credits described below only apply for eligibility periods on or after October 1st, 2009.

A Plan Participant shall receive Disability Credits as set forth herein toward eligibility for coverage under the Plan as follows:

1. Disability Credits will be equal to twenty-four (24) hours per week of disability up to a maximum of one thousand two hundred (1,201) hours in a qualifying period. The maximum Disability Credits granted shall be one thousand two hundred one (1201) hours per disability.

2. A Plan Participant will receive Disability Credits, for each week during the Qualifying Period in which the Plan Participant was disabled by a work related injury occurring while being actively employed by a contributing employer or illness, for which the employee (Plan Participant) received worker's compensation or a temporary total disability benefit for one or more weeks during the Qualifying Period; provided however Disability Credits will be utilized during a Qualifying Period only to the extent necessary to establish continuing eligibility for the succeeding Eligibility Period and further provided that the Plan Participant returns to work as an active employee of a contributing employer during the subsequent

qualifying period. To the extent that a Plan Participant's disability continues into a second Qualifying Period, the Plan Participant will be granted Disability Credits up a maximum of one thousand two hundred (1,201) hours per disability, less the hours for which Disability Credits were previously granted for the same disability, and further provided that the Plan Participant returns to work as an active employee of a contributing employer during the subsequent Qualifying Period.

3. The Qualifying Period shall be October 1st through September 30th immediately preceding the Plan Year for which eligibility is being determined as of October 1st.

4. Disability Credits shall be available only with respect to determination of continuing eligibility. Disability Credits shall not be used to establish initial eligibility or reinstatement.

TERMINATION

Eligibility for benefits will terminate on the earliest of the following dates:

1. On September 30 because the employee has not earned 900 hours in the prior twelve month period as described above;

2. The date the employee enters full time military, naval or air service, provided that if the employee is a reservist called up to active duty, he may be entitled to make COBRA payments regardless of any coverage provided by the military;

3. The date the employee's employer is no longer a contributing employer to the Fund;

4. The date of the employee's death; or

5. For Medical Benefits only, the date the employee opts out of medical benefits coverage under the provisions of the Plan.

6. The date the Plan terminates.

ARMED SERVICES

If an employee goes into active military service for up to 31 days, he may continue his medical coverage during that leave period.

If an employee goes into active military service for more than 31 days, he may be able to continue his medical coverage at his own expense for up to 18 months.

If coverage ends while an employee is on an approved leave of absence for military leave, his coverage will be reinstated on the date he returns to active service, if he returns within 14 days after the leave of absence ends.

NON-BARGAINING UNIT EMPLOYEES

ELIGIBLE EMPLOYERS

An employer or the Union may have its non-bargaining unit employees participate in the Fund if the employer is signatory to a collective bargaining agreement on behalf of its bargaining unit employees and it signs a participation agreement with the Fund. The employer must specifically name the employees to be covered under this Fund, in the participation agreement. Contributions must be made to the Fund on such basis as may be set forth in the in the participation agreement.

Non-bargaining unit employees are subject to the same rules for eligibility as any other employee. Coverage will be terminated at the earliest of the following:

(a) the earliest date set forth in the Termination Section on page 4;

(b) the last day of the month for which contributions were made on a timely basis;

(c) the last day of the month in which the employee terminates; or

(d) the last day of the month for which there is not a valid participation agreement.

DEPENDENT ELIGIBILITY AND TERMINATION

DEPENDENTS OF EMPLOYEES

Dependents of an Eligible Employee shall become or remain eligible for certain benefits under the Plan on the latest of (1) beginning on October 1st if during the prior twelve (12) month period the eligible Employee had a minimum of 1201 hours of contributions, (2) the date he acquires his first dependent, or (3) the date Dependent Coverage is made available under the Plan, provided however that effective May 1, 2009, no such Dependent shall be eligible for medical benefits under the Plan unless the Eligible Employee has authorized the appropriate salary reduction to pay the required portion of the premium attributable to coverage of the Dependent. Failure to authorize the appropriate salary reduction to pay the required portion of the medical premium attributable to coverage of the Dependent will result in termination of Medical Coverage for all dependents for which such salary reduction was not authorized. Failure to authorize salary reductions shall not affect benefits other than medical benefits.

The amount of the salary reduction under the Premium Co-Payment Plan is to be based upon an hourly amount approximately equal to 15% of the monthly additional cost of providing coverage for spouse, children or family coverage that has been elected by the employee. The initial salary co-payment shall be in accordance with the attached schedule. Such salary reduction shall apply for each week that the employee is entitled to a payment of wages from Logistec.

It is further provided that the maximum number of hours in a plan year that the salary reduction is applied to shall be 1201.

If the employee fails to authorize the required salary reduction, the employee will be provided employee only medical benefits coverage under the Plan. Salary reduction elections shall be made only at such times as may be provided under the Premium Co-payment Plan and no coverage beyond single coverage shall take effect prior to a date approved by the HMO. The initial salary co-payment shall be in accordance with the attached schedule.

Further, the Trustees reserve the right to recover premium payments that are unpaid due to not being employed for a week if such failure to be employed is not based upon a work-related or non work-related documented medical disability that prevents the Employee from working that week.

RESTRICTIONS ON DEPENDENT STATUS

The term "dependent" will not include any person who is eligible as an employee or any person who is in full-time military service. If both parents are eligible as employees under the Plan, a child may be included as a dependent of either parent, but not of both.

NEWBORN, FOSTER OR ADOPTED CHILDREN

Foster and adopted children, as well as natural children, may be enrolled upon timely submission of enrollment forms and legal documents, if applicable. Required documents must be submitted within 30 days of the adoption or effective date of legal custody or placement. Natural newborn children must be pre-enrolled at least 30 days prior to the scheduled delivery date. Coverage for such Dependent shall be effective for periods after April 30, 2009, only if the Eligible Employee authorizes the appropriate salary reduction to pay the required portion of the premium attributable to coverage of the Dependent.

NEW SPOUSE

An employee may enroll a new spouse within 30 days of the date of marriage, upon submission of enrollment forms and a copy of the marriage certificate. Medical Benefits coverage for such Dependent shall be effective for periods after April 30, 2009, only if the Eligible Employee authorizes the appropriate salary reduction to pay the required portion of the premium attributable to coverage of the Dependent.

DEPENDENTS OF DECEASED EMPLOYEES

Eligible Dependents are eligible to continue group health coverage as provided under COBRA Continuation of Coverage. COBRA coverage for dependents of deceased employees will automatically be provided without the need for further application or payment of COBRA premiums for all medical, dental, and vision benefits until the end of the period for which the employee would have been covered had the employee survived based upon hours worked for the employer(s). At the end of such period the dependent shall be given the right to continue COBRA coverage for the balance of the 36 months COBRA period by making the required COBRA premiums.

TERMINATION OF DEPENDENT BENEFITS

Eligible Dependent benefits will automatically terminate on the date the employee's benefits terminate, or as of April 30, 2009 if during the prior twelve (12) month period the eligible Employee did not have a minimum of 1201 hours of contributions, except as otherwise provided for eligible Dependents of deceased employees who were eligible for benefits under the Plan on the date of the employee’s death.

In addition, the benefits for any person eligible as a dependent will automatically terminate on the date he or she ceases to qualify as a dependent, or, after April 30, 2009, medical benefits will cease upon the failure of the Eligible Employee to authorize the appropriate salary reduction to pay the required portion of the premium attributable to coverage of the Dependent.

Eligible Dependents may continue coverage by making self-contributions as provided under COBRA Continuation of Coverage, but only for benefits which the Eligible dependent had at the date of employee’s death.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When an employee's or eligible Dependent’s medical benefits coverage ends, he and/or his eligible dependents are entitled by law to and will be provided with a Certificate of Coverage that indicates the period of time he and/or his eligible dependents were covered under this Plan. Such a Certificate will be provided to the employee shortly after the Plan knows or has reason to know that coverage for the employee and his dependents has ended. In addition, such a Certificate will be provided upon receipt of a request for such a certificate that is received by the Administrative Manager within two years after the date coverage ended.

COBRA CONTINUATION OF COVERAGE

Federal law mandates that employer-sponsored group plans provide individuals with the option of continuing their health coverage through self payment of contributions when their

coverage terminates under the group Plan.

This Plan provides eligible individuals with the option of continuing medical benefits only when coverage terminates under the Plan. Provisions relative to continuation coverage are discussed below. It is important that all family members be aware of these provisions in the event coverage terminates.

1. Qualifying Events

An employee and his or her eligible dependents have the right to continue the medical coverage if it terminates for certain reasons, provided the employee or dependents make the required self-payment of premiums. The continuation coverage is available in the event coverage terminates due to:

a. Termination of the employee's employment for any reason, except gross misconduct;

b. A reduction in hours worked by the employee;

c. Death of the employee (see full explanation on Page 7 relating to dependents of deceased employees);

d. Divorce or legal separation of the employee and spouse;

e. A dependent child ceasing to be a dependent, as defined on page 4; or

f. A dependent ceasing to be eligible due to the employee becoming entitled to Medicare.

2. Notice Requirements

If one of the employee's dependents would lose coverage due to d. or e. above, the employee or the dependent must notify the Plan within sixty days of the event so that the Administrative Manager can provide the employee and his covered dependents with appropriate notice of COBRA continuation coverage rights and the terms which apply to the continuation coverage. If events in items a., b., c. or f. above occur, the employee or his dependents should notify the Administrative Office as well. The employee or dependent should try to give notification within 30 days of the qualifying event to assure there is no break in coverage.

3. Election Requirements

The employee and/or dependent must elect to make self payment of contributions within the later of 60 days after his eligibility terminates or within 60 days from the date he is notified by the Administrative Manager of his right to maintain

eligibility through self-payment. If an election is not made and postmarked within the time periods stated in the notice, he cannot continue coverage under this Plan.

4. Self Payment of COBRA Contributions

Self payment, if elected, must be made from the date of termination. No lapse in coverage is permitted.

a. If an employee or dependent elects to continue coverage within 60 days after his or her eligibility terminates, the initial premiums due for continuation coverage must be postmarked and sent to the Plan Office within 45 days after the election. This includes premiums required for months of continuation coverage between the termination date of regular coverage and the date the initial premium is due.

b. After the initial election and payment of contributions, subsequent payments must be postmarked and sent to the Plan Office before the last day of the month for which coverage is to be provided.

c. The contribution rate for continuation coverage will be determined according to federal law and is subject to change in the event the Plan's cost changes.

d. Self-contributors will be notified of any change in contribution rates which they are required to pay.

e. If benefits provided to active employees and/or their dependents change, your continuation of coverage will also change.

5. Maximum Period Allowed Under Continuation Coverage

a. 18 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for an employee, spouse or dependent because the employee ceased covered employment, including retirement or had a reduction in hours of employment for any reason, other than gross misconduct; or

b. 36 months (maximum) from the date coverage would have otherwise terminated, if coverage is being continued for a spouse or dependent for reasons other than those referred to in 5.a. above.

c. If a qualified beneficiary is determined to have been disabled at the time of a Qualifying Event as described in 1.a. or 1.b. or becomes disabled during the initial 18-month period, the period of coverage may be extended from 18 to 29 months, provided the Qualified Beneficiary notifies the

Administrative Office by submitting documentation of such determination within 60 days of the date he receives notice from the Social Security Administration that he is entitled to disability benefits, and within 18 months of the qualifying event. A person who has been determined to be disabled by the Social Security Administration must notify the Plan Office not later than 30 days after the date of any determination by the Social Security Administration that he is no longer disabled.

If extended coverage is elected under this paragraph, the cost of coverage for the period beyond the first 18 months may be higher, at a rate determined by the Board of Trustees.

This coverage may be extended for the disabled person and any other qualified beneficiaries covered under COBRA at the end of the first 18-month period.

d. Multiple Qualifying Event - A spouse or a dependent child who has a subsequent qualifying event while covered under this continuation coverage may elect to continue coverage for the balance of the 36-month period from the initial date of eligibility for continuation coverage. However, if an employee has a qualifying event (as described in 1. a. or b.) after he has become entitled to Medicare, his eligible spouse and dependent children may elect to continue coverage for a maximum of 36 months from the date the employee became entitled to Medicare.

6. Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate on the earliest of:

a. The first day of the month for which premium is not paid on time;

b. The date the individual becomes covered under another employer sponsored group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition;

c. The date the individual becomes entitled to Medicare; or

d. The date the Plan terminates.

If an employee and/or dependent does not elect and pay premiums for COBRA continuation coverage on a timely basis, he will no longer be covered under the Plan and any claims filed during the election period or following termination for non-payment of contributions will not be paid by the Plan. Reinstatement of coverage is not permitted.

Full details of COBRA continuation coverage will be furnished to the employee and/or his dependents when the Administrative Office receives notice that one of the qualifying events described in item 1 has occurred. Therefore, the Board of Trustees urges employees and dependents to contact the Administrative Office as soon as possible after the occurrence of one of those events.

MEDICAL BENEFITS

The benefits payable under this Fund for covered medical services and supplies are determined through negotiation by the Board of Trustees and the service provider, currently United Healthcare. The coverage is provided for eligible Employees, and if during the prior twelve (12) month period he had a minimum of 1201 hours of contributions his eligible Dependents (subject to employee payment requirements), provided the eligible Employee has not elected to opt out of such coverage. You should receive a Certificate of Coverage from the carrier listing covered services and supplies and deductibles, co-payments and coinsurance you are required to pay for such services and supplies.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

The Life Insurance and Accidental Death & Dismemberment benefit is provided for Eligible Employees through an insurance carrier, currently Lincoln National Life Insurance Company. You should have received a Certificate of Insurance, which sets forth the benefits payable, exclusions, conversion rights and rule pertaining to continuation of this benefit in the event of total disability.

DENTAL BENEFIT

This coverage is available to eligible Employees and if during the prior twelve (12) month period the eligible Employee had a minimum of 1201 hours of contributions his Dependents.

DENTAL EXPENSE BENEFIT

The Dental Expense Benefit includes only the charges of a dentist for any necessary dental services and supplied described below are received by a covered person and which (a) are not excluded by other provisions applicable to this coverage (b) do not exceed the regular and customary charges within the area for the service and supplies furnished. A charge is considered to be incurred on the date a covered person receives the services or supplies for which the charge is made.

CALENDAR YEAR LIMIT

Each covered person is subject to a limit of $500 for dental benefits payable under the Plan for each calendar year exclusive of the orthodontic benefit.

ANNUAL DEDUCTIBLE

Each covered person is subject to a $50 calendar year deductible. All covered person's calendar year deductible is considered satisfied when the family has incurred calendar year deductibles totaling $150.

TREATMENT CATEGORIES AND PERCENTAGES

Diagnostic and preventive treatments, "restorative" treatments and "major" dental treatments are all covered at 100% after the satisfaction of the calendar year deductible and the calendar year limit. Below is a representative (not all-inclusive) listing of treatments included in these three categories:

DIAGNOSTIC AND PREVENTATIVE

This Category includes:

(a) Routine oral examination and prophylaxis (cleaning and scaling of teeth), limited to once each in any period of 180 consecutive days.

(b) Topical application of sodium fluoride and stannous fluoride.

(c) Dental x-rays, including full-mouth x-rays (limited to once in any period of 36 consecutive months) supplementary bitewing x-rays (limited to once in any period of 180 consecutive days) and such other dental x-rays as are required in connection with the diagnosis of a specific condition requiring treatment.

RESTORATIVE

This category includes fillings, root canals, periodontic treatment, extractions, oral surgery, amalgam filling restorations, crowns, repair or cementing of crowns, inlays, onlays, and repair of bridgework or dentures.

MAJOR

This category includes initial installation of fixed bridgework, initial installation of partial or full removable dentures.

It also includes replacement of an existing removable denture by new denture, replacement of fixed bridgework by new bridgework, and the addition of new teeth to an existing

partial removable denture or to bridgework, but only if certain preconditions are met. Information concerning these conditions is available from the Fund Office.

ORTHODONTIA BENEFIT

Orthodontia benefits are payable under the Plan subject to a lifetime maximum benefit for orthodontia of $500. The Benefit will be paid in installments of no more than $50 per installment and no less than monthly. Benefits for orthodontia do not count toward your dental calendar year maximum benefit limit.

DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the regular exclusions and limitations, no payment will be made under the Plan for the following:

(a) Treatment by someone other than a licensed dentist, except that scaling or leaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a dentist.

(b) Veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.

(c) Services and supplies that are cosmetic in nature, including personalization or characterization of dentures.

(d) Any duplicate prosthetic device or any other duplicate appliance.

(e) The replacement of a lost, missing or stolen prosthetic device, except as provided herein.

(f) A plaque control program.

(g) Splints; or appliances (such as night guards) used to control harmful habits.

(h) Treatment of conditions related to the temporomandibular jaw joint (TMJ).

(i) Treatment provided as a result of dental disease, defect, or injury due to war, declared or undeclared, or any act of war or aggression.

(j) Dental care or services paid for or furnished by or at the direction of any governmental agency, but only to the extent paid for or furnished.

(k) Any Dental procedures which are included as covered medical expenses under the Plan.

(l) Treatment resulting from any occupational injury or sickness, whether or not covered by a Workers' Compensation Law or similar law.

(m) Any dental treatment which begins while a person is not eligible for Dental Expense Benefits, or prosthetic devices (including bridges and crowns) and the fitting of such devices, which are ordered while the person is not eligible for Dental Expense Benefits. Treatment is considered to begin: (i) for full or partial dentures when the impression is taken for the appliances; (ii) for fillings, bridgework, crowns or other gold restorations, when the tooth is first prepared; and (iii) for root canal therapy, when the tooth is opened. If your eligibility for dental expense benefits is terminated, dental coverage will be extended solely for purposes of completing the above-described treatments, for a period not exceeding 90 days after the above-beginning dates.

(n) Repair or treatment which is primarily for the opening or restoration of the vertical dimension of the face.

VISION BENEFIT

This benefit is provided to eligible employees and, if during the prior twelve (12) month period the eligible Employee had a minimum of 1201 hours of contributions, his dependents. The benefit that is available is as follows:

- There is no deductible to pay and you may select any vision care provider you choose

- The Plan will reimburse you to a maximum per calendar year of $200 if you have single coverage or $400 if you have family coverage. If you have family coverage the calendar year maximum can be used by one member of the family.

- You may use this benefit for eye exams, prescription lenses, frames, contacts and other visual needs as prescribed by your doctor up to the stated calendar year maximums.

FUNERAL SERVICES BENEFIT

This benefit is available to eligible employees only (not dependents).

In order to assure the availability of prompt and dignified funeral services for eligible employees, the Plan shall pay the cost of funeral services not to exceed $4,000 to the licensed funeral home or crematorium providing funeral services for the member. Such benefit shall be paid upon receipt of the following documentation:

1. Death certificate of the employee for whom funeral services have been provided.

2. Copy of the signed contract for the funeral services.

3. Proof that funeral services have been provided.

4. The benefit is payable due to death from any cause except death caused by the commission of or the attempt to commit an assault or felony.

5. No other funeral service benefit will be paid other than as stated here.

WEEKLY INDEMNITY BENEFIT

This benefit is for eligible employees only. This Weekly Indemnity Benefit is payable only if, while covered and as a result of sickness or injury, a covered employee becomes totally disabled to the extent that the employee is completely and continuously prevented from performing any duty of his employment, is under the direct care of a physician and, is not engaged in any other work for compensation or profit. This benefit may not be assigned.

BENEFIT PAYABLE

Weekly Indemnity Benefits are in the gross amount of Two hundred twenty five ($225) per week. The actual benefit payment amount will reflect the net amount after deduction of appropriate taxes. One seventh (1/7) of the weekly benefit is payable for each full day of covered disability, but no benefit is payable for part of a day.

BENEFIT PAYMENT PERIOD

The Weekly Indemnity Benefit will be payable from the "first benefit day" which shall be the eighth consecutive day of disability and shall be payable during the period of continuous disability for a maximum of 20 weeks. One seventh (1/7) of the weekly benefit is payable for each full day of covered disability, but no benefit is payable for part of a day. Successive periods of disability separated by less than two weeks of continuous full time work with the employer will be considered one continuous period of disability unless the later disability is entirely unrelated to the causes of the previous disability and begins after full time work with the employer for at least one full day.

APPLICATION AND TIMELY FILING REQUIREMENT

The Weekly Indemnity Benefit shall be payable only if the covered employee files an application for such benefit on a form available from the office within 60 days of the onset of the disability.

EXCLUSIONS

Weekly Indemnity Benefits are not payable –

1) For any period of disability during which the employee is not under the direct continuous care of a physician, or

2) For any disability which began while he was a retired employee, or

3) For any disability due to:

   a) Intentionally self-inflicted injury, or

   b) Any injury or sickness arising out of employment for compensation or profit whether or not covered by workers compensation or similar acts and whether arising out of self employment or employment by others.

   c) For any disability benefit period during which the covered employee is receiving or entitled to receive payment, reimbursement or benefits for lost wages for any PIP or similar insurance policy.

   d) For any disability commencing prior to January 1, 2003.

SUBROGATION

The Weekly Indemnity Benefit shall be subject to the subrogation provisions of this plan.

HOLIDAY/VACATION BENEFIT

ELIGIBILITY

An eligible employee shall be eligible to receive a Holiday/Vacation benefit only if the Participant earned at least 900 hours during the plan year ending September 30. The Qualifying Period shall be October 1 through September 30 of the year in which benefits are payable. (Example: October 1, 2008 – September 30, 2009 qualifiers will be paid a Holiday/Vacation benefit in December, 2009)

Credits for disability will not count towards this benefit.

BENEFIT PAYABLE

The initial gross benefit payable in the year ending in September 2003 for Participants meeting the eligibility requirement shall be $1,815 plus $25 per 100 hours for which contributions were made or required to be made for performed during the Qualifying Period. The benefit set forth above shall be the gross benefit payable reduced by employee portion of FICA and Medicare taxes, unemployment compensation and other deductions as may be required by law for the year ending September 30, 2003. For all future years the benefit will determined by action of the Board of Trustees and will be reduced by the employee portion of FICA and Medicare taxes, unemployment compensation and other such deductions as may be required by law.

BENEFIT DATE

The benefit provided for hereunder shall be paid to the eligible Plan Participant or in the event of the Participant's death to the beneficiary of the Plan Participant by December 15th or thereabouts.

ALTERNATIVE BENEFIT FOR EMPLOYEES OPTING OUT OF MEDICAL BENEFITS UNDER THIS PLAN – (OPT- OUT BENEFITS)

An Employee who is otherwise eligible for medical benefits under the Plan, may opt out of medical benefits coverage under the Plan upon proof of alternative medical coverage of the Eligible Employee and by filing with the Plan an Opt - Out Request Form. An Eligible Employee who opts out of medical benefits coverage is not eligible for dependent medical benefits coverage.

In the event that an Eligible Employee opts out of medical benefits coverage by the 15th day of a month (by electing the opt out on a form provided by the Plan and delivering the signed Opt Out Form to the Plan or to the Union office) the Plan will pay to the Eligible Employee the sum of $150.00 for the succeeding month and each month thereafter that the Eligible Employee opts out of medical benefits coverage under the Plan. The opt-out payment shall be paid after the end of each Plan Year.

An Eligible Employee who opts out of medical benefits coverage may re-apply for benefits under the Plan by filing an Application to Withdraw from Opt-out.

An Eligible Employee who opts out of medical benefits coverage shall not be eligible for any future benefits under the Plan (except this Opt-out Benefit) until the October 1 following the date Application to Withdraw Opt-out. The Application to Withdraw Opt-out must be received in the Fund Office no later than 30 days prior to the October 1 that the withdrawal of the opt-out is to be effective and is subject to approval by the HMO as to medical benefits.

LIMITATION OF BENEFITS TO THE DESIGNATED PORTION OF PLAN ASSETS

Any provision of this section notwithstanding, all benefits payable hereunder are limited to the assets of the Fund that were based upon contributions from contributing employers for the purpose of providing for this Holiday/Vacation benefit only.

NO VESTED RIGHTS

A Plan Participant shall have no vested right to receive any of the benefits provided for hereunder until the payment date and such vested right, at that time, shall be limited to the benefits in effect as of the payment date.

COORDINATION OF BENEFITS

If a covered person has coverage under another plan, this Plan will coordinate its Medical, Vision and Dental Benefits, with those of the other plan to prevent situations where benefits paid total more than 100% of the charges. Coordination of benefits requires the determination of which plan is primary (the plan which pays first) and which is secondary (the plan which pays second). If this Plan is primary, it will pay its full benefits. If it is secondary, the benefits it would have paid will be reduced to account for the benefits paid by the primary plan. In no event will more than 100% of the total reasonable and customary charges be paid.

The Administrative Manager will determine the primary/secondary plan in the following order:

1. The Plan that does not have a coordination of benefits clause will be primary.

2. If both plans have a coordination of benefits clause, the following rules apply:

    a. The benefits of a plan that covers the patient as an employee are determined before the benefits of a plan that covers the employee as a dependent.

    b. When two or more plans cover the same dependent:

        i. The benefits of the plan of the parent whose birthday falls earlier in the year are determined first.

        ii. If both parents have the same birthday, the benefits of the plan that covered the parent for a longer period of time are determined first.

        iii. Where the dependent is a child of divorced or separated parents, the benefits of the plan that covers the child as a dependent of the custodial parent shall apply first unless there is a court decree that states otherwise.

Medicare coverage will be considered to be primary when determining retiree benefits,

except for the first 29 months of Medicare entitlement because of renal dialysis due to end-stage renal disease. The Plan will be primary for a covered dependent entitled to Medicare because of total disability qualifying for social security benefits. (See Health Coverage for Employees and their Spouses, Age 65 and Older).

The Administrative Manager has the right to exchange claims information with any other organization for the sole purpose of coordinating benefits.

SUBROGATION

If the negligence or wrongful act of a third-party causes the death or injury of a covered person, and benefits are paid or payable by the Plan for such death or injury, the Plan and/or the Trustees will be subrogated to the rights of the covered person and those entitled by law to proceed against such third party, its insurance carrier or in the case of an automobile accident, any uninsured or under-insured motorist coverage available to the covered person to the extent of the benefits paid or payable under the Plan. In addition, in the event that benefits are paid by a third party, its insurance carrier, or in the case of an automobile accident, any uninsured or under-insured motorist, the Plan shall be paid out of the proceeds of such payment any and all benefits paid by the Plan. The Plan specifically disavows any application of the "make whole" doctrine and may therefore exercise a right of subrogation against any and all such proceeds without regard to the nature and characterization of such proceeds or the expenses incurred by the covered person to procure such proceeds (including attorney's fees), without regard to any comparative or contributory negligence on the part of the covered person, and without regard to any ability or inability of the injured person to recover due to limited insurance.
In the event that benefits are paid as a result of any occupational injury or sickness, the Plan and/or Trustees will be subrogated to the rights of the covered person and those entitled by law to proceed against any worker's compensation carrier.

As a condition precedent to receipt of benefits under the Plan, covered persons or any person claiming for him, or through him or for his benefit, may be required to execute documents to protect the interest of the Plan.

The Plan and/or Trustees at its or their option, may:

a. recover from the covered person or any person claiming for him, through him or for his benefit, any and all benefits paid by the Plan out of the proceeds of any settlement, judgment, or other award; and/or

b. proceed directly against the third-party causing the death or injury in its own name or under the name of the covered person or those entitled to use as plaintiff or in the name of the plaintiff for the benefit of the Plan and/or the Trustees; and/or

c. proceed directly against the worker's compensation carrier in its own name or under the name of the covered person or those entitled to make claim for the person or in the name of the claimant for the benefit of the Plan and/or the Trustees; and/or

d. the Plan's subrogation rights of full recovery may be from the third party, any liability or other insurance covering the third party, any uninsured motorist coverage or under-insured motorist insurance providing coverage to the covered person, any medical payments, no-fault, worker's compensation, or school insurance coverage which are paid or payable.

HEALTH COVERAGE FOR EMPLOYEES AND THEIR SPOUSES, AGE 65 OR OLDER

Federal law provides that active employees age 65 or older who are eligible for Medicare because of age may be provided the choice of either their employer-sponsored Plan or Medicare.

At this time, the Tampa Banana Handlers Welfare Fund has agreed to provide group coverage for those working employees and/or their eligible spouses, age 65 or older, who elected this group health Plan as primary payor of their health claims.

This Plan will pay first, subject to any applicable deductibles and co-payments specified by the insurance carrier. Medicare benefits, if applicable, would be secondary. It is possible that the payment paid by this Plan, plus the payment made by Medicare, may not equal the actual charge. However, the combined benefits will in no event exceed 100% of the allowable charges. The primary and secondary payor rules as of the Effective Date of this Plan are as follows:

If the person is age 65 or Older and employed:	The primary payor is the Tampa Banana Handlers Welfare Fund
If the person is age 65 or Older and only the eligible spouse is employed:	The primary payor is the spouse's group health plan
If the person is under 65 and Medicare-eligible solely because of End Stage Renal Disease:	The primary payor is the group health plan of the current or former employer of the employee or family member, for the first 29 months of Medicare eligibility; thereafter, Medicare is primary
If the person is under 65 and Medicare-eligible solely because of disability, or if the eligible spouse is under 65 and Medicare-eligible solely because of disability:	The primary payor is the Tampa Banana Handlers Welfare Fund for the first 24 months the person has received Social Security Disability Benefits; thereafter, Medicare is primary
If the person is age 65 or older, retired, and the eligible spouse, if any, is not the employee, or the spouse is employed but does not have group health coverage:	The primary payor is Medicare

Most workers age 65 and over do not have to pay for Medicare. Part A (basic hospital insurance). Part B (supplementary medical insurance) may be purchased for a low monthly premium. This Plan will coordinate with Medicare, Parts A and B, as if both were in effect.

CLAIMS APPEAL PROCEDURE

Any covered person or beneficiary who applies for benefits under the Plan and is ruled ineligible or not qualified for such benefits in whole or in part, or believes he did not receive the full amount of benefits to which he is entitled, or is otherwise adversely affected by any action of the Trustees acting through the Administrative Manager, shall have the right to request the Board of Trustees to review the matter. The covered person or his duly authorized representative must make such a request in writing, within sixty (60) days after being apprised in writing of such adverse action. Furthermore, upon written request to the Administrative Manager during the sixty (60) day period, covered person (or duly authorized representative) will be extended an opportunity to review pertinent documents relating to the denial and may submit any additional relevant information and/or comments in writing at the Administrator's Office.

The written request for review must be addressed to the Board of Trustees in care of the Administrative Manager and must state (1) the employee's name and address, (2) the fact that the covered person is appealing from a decision of the Fund Office of (the date of the decision appealed from), and (3) the basis of the appeal, i.e., the reason or reasons why the claim should not be denied.

The Board of Trustees will **issue** a written decision affirming, modifying, or setting aside the decision appealed from within sixty (60) days of the receipt by the Administrative Manager of the request for review.

The decision by the Board of Trustees on review will be in writing and will include specific reasons for the decision, as well as specific references to the pertinent plan provisions on which the decision is based. Such a decision by the Board of Trustees will be final and binding. The term "Board of Trustees" means the Board of Trustees of the Plan or a duly authorized committee acting on behalf of the Board of Trustees.

With respect to appeals of urgent care claims, the Board of Trustees shall issue a full and fair written decision within 72 hours from the time the claim is made.

With respect to appeals for pre service claims involving access to medical care or facilities, the Board of Trustees shall issue a full and fair written decision within 30 days of the appeal request of an adverse benefit determination. (The initial determination for pre service claims involving access to medical care or faculties must be made within 15 days.)

HIPAA PRIVACY

THIS PROVISION DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUTCOVERED PERSONS MAY BE USED AND DISCLOSED AND HOW COVERED PERSONS MAY ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is Protected Health Information (PHI)?
Under the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Protected Health Information, or PHI, is health information, including demographic information collected from an individual that:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and:

   a. That identifies the individual; or

   b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

This information cannot be used or disclosed without the Covered Person's written permission except in certain specified circumstances stated in the HIPAA privacy regulations. The Plan is required by law to maintain the privacy of PHI and maintains a privacy policy and safeguards for carrying out its legal duties concerning PHI. The Plan is required to provide timely notice of any changes to its privacy policy to all affected individuals. Individuals have the right to file a complaint with the Plan and/or the Secretary of the Department of Health and Human Services if they believe their privacy rights have been violated. Any complaint filed with the Plan must be in writing and directed to the Plan Administrator. The regulations provide that no individual will be retaliated against for filing a complaint.

What Rights Does a Covered Person Have Regarding Access to or Amendment of PHI?
Upon written request to the Plan, an individual has a right of access to inspect and obtain a copy of PHI about himself/herself in a designated record set for as long as the PHI is maintained in the designated record set except for:

1. Psychotherapy notes;

2. Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding; and

3. Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a to the extent the provision of access to the individual would be prohibited by law, or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

All requests to the Plan for access to PHI must be in writing. The Plan must act on a request for access no later than thirty (30) days after receipt by granting and providing access or providing a written determination as to why access will not be provided. If the PHI requested is not maintained or accessible to the Plan on-site, the Plan may have sixty (60) days to provide the requested access. If the Plan is unable to provide access within these timeframes, the Plan may have an additional thirty (30) days to provide the requested access so long as written notice of the delay and the reasons for it is provided to the requesting individual prior to expiration of the applicable time period. In providing the requested access, the Plan must timely permit an individual to request access to inspect or to obtain a copy of the PHI about the individual that is maintained in a designated record set. If the Plan is asked to provide a photocopy or summary of the PHI, the individual requesting the PHI will be responsible for any reasonable fees incurred by the Plan in producing the same.

The Plan may deny an individual access to PHI in the following circumstances:

1. The PHI is excepted from the right of access;

2. The PHI relates to a correctional facility inmate's request;

3. The PHI is obtained by a covered health care provider in the course of research that includes treatment;

4. The individual's access to the PHI is governed by the Privacy Act and the denial is consistent with the provisions of that Act;

5. The PHI was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information; or

6. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested by an individual or personal representative is reasonably likely to endanger the life or physical safety of the individual or another person referenced in the PHI.

In some of these instances, the individual is given the right to have such denials reviewed and in others the Plan does not need to provide the opportunity for review of the denial. The Plan will provide the opportunity for review of the denial upon receipt of a written request if required to do so by the regulations. Such review will be performed in the manner and within the time periods prescribed in the regulations. Please contact the Plan Administrator if you have questions.

An individual has the right to ask the Plan to amend PHI or a record about the individual in a designated record set for as long as the PHI is maintained in the designated record set. The Plan may deny an individual's request for amendment if it is determined that the PHI or record that is the subject of the request:

1. Was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;

2. Is not part of the designated record set;

3. Would not be available for inspection according to the provisions of the applicable regulations; or

4. Is accurate and complete.

All requests to the Plan for amending PHI must be in writing. The Plan must act on a request for amendment no later than sixty (60) days after receipt by granting the requested amendment or providing a written determination as to why access will not be provided. If the Plan is unable to act on the amendment within these timeframes, the Plan may have an additional thirty (30) days to provide the requested access so long as written notice of the delay and the reasons for it is provided to the requesting individual prior to expiration of the applicable time period. If the request for amendment is granted, the Plan must amend the PHI in the designated record set(s) as requested, must timely inform the individual of the amendment and obtain from that individual relative to other entities who need to be informed of the amendment, and advise those entities and any persons, including business associates, who the Plan knows has the PHI that is the subject of the amendment and may have relied, or could foreseeably rely on such information to the detriment of the individual. If the request for amendment is denied, in whole or in part, the Plan must permit the individual to submit to the Plan a written statement disagreeing with the denial of all or part of a requested amendment and the basis of such disagreement. The Plan may reasonably limit the length of the statement of disagreement. The Plan has the right to prepare a written rebuttal to the individual's statement of disagreement. If such a rebuttal is prepared, a copy of it must be sent to the individual who submitted the statement of disagreement. Where permitted by the regulations, the statement of disagreement and rebuttal will be incorporated into any future disclosures of PHI to which the disagreement relates.

To Whom and Under What Circumstances Will the Plan Disclose PHI?

The Plan does not disclose any nonpublic personal information about Covered Persons or former Covered Persons to anyone, except as permitted by law. The Plan will only disclose PHI:

1. Without a signed written authorization to the Covered Person to whom the PHI pertains (or to a minor child's parent or guardian, if applicable);

2. Without a signed written authorization as required for healthcare operations purposes. The Plan is permitted to disclose PHI, without an additional authorization, for healthcare operations purposes. "Healthcare Operations" includes, but is not

necessarily limited to, any of the following activities of the Plan to the extent that the activities are related to covered functions: quality assessment; case management; care coordination; contacting of health care providers and patients with information about treatment alternatives; reviewing the competence or qualifications of health care professionals; evaluating practitioner and provider performance; health plan performance; 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; ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance); conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and other business management and general administrative activities of the Plan as allowed by law;

3. To an individual who provides the Plan with a written authorization signed by the Covered Person to whom the PHI pertains;

4. As required by state or federal law, regulation or order of a court with jurisdiction.

When, and Under What Circumstances, Will the Plan Sponsor/The Board of Trustees Have Access to PHI?

The Plan Sponsor hereby certifies that the documents providing for the benefits herein have been amended to comply with the regulations by incorporation of the following provisions. The Plan Sponsor agrees
to:

1. Not use or further disclose the information other than as permitted or required by the Plan Documents or as required by law;

2. Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3. Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

5. Make available PHI as required to allow the Covered Person a right of access to his or her PHI as required and permitted by the regulations;

6. Make available PHI for amendment and incorporate any amendments into PHI as required and permitted by the regulations;

7. Make available the information required to provide an accounting of disclosures as required by the regulations;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to any applicable regulatory authority for purposes of determining the Plan's compliance with the law's requirements;

9. If feasible, return or destroy all PHI received from the Plan that the Plan 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, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Ensure that the adequate separation required between the Plan and the Plan Sponsor is established. To fulfill this requirement, the Plan Sponsor will restrict access to nonpublic personal information to the Plan Administrator(s) designated in this Plan Document or employees designated by the Plan Administrator(s) who need to know that information to perform plan administration and healthcare operations functions or assist Covered Persons enrolling and disenrolling from the Plan. The Plan Sponsor will maintain physical, electronic, and procedural safeguards that comply with applicable federal and state regulations to guard such information and to provide the minimum PHI necessary for performance of healthcare operations duties. The Plan Administrator(s) and any employee so designated will be required to maintain the confidentiality of nonpublic personal information and to follow policies the Plan Sponsor establishes to secure such information.

When information is disclosed to entities that perform services or functions on the Plan's behalf, such entities are required to adhere to procedures and practices that maintain the confidentiality of the Covered Person's nonpublic personal information, to use the information only for the limited purpose for which it was shared, and to abide by all applicable privacy laws.

GENERAL PROVISIONS

RECOVERY OF OVERPAYMENTS

Whenever payment have been made by this Plan in excess of the maximum amount of payment necessary under the provisions of this Plan, this Plan shall have the right to offset such overpayments against future benefits payable to the Employee or any of his Dependents whenever the overpayment was made in connection with claims from any family member; or to recover such excess payment from any persons to or with respect to whom such payments were made; or from insurance companies or organizations which owe benefits under any other Plan.

If benefits are paid to or on behalf of any covered person when the basis of such claim is misrepresented or fraudulently presented by either the covered person or a medical provider, the Plan shall have the right to recover all benefits paid by either: 1) a direct recovery from the covered person and/or the medical provider(s); or 2) by reducing all subsequent benefits for such covered person or any other member of the family eligible for benefits until such time as the Plan has made full recovery of the misrepresented or fraudulent amounts.

Such recovery shall also include all costs incurred by the Fund as the result of such claims, including but not limited to medical investigation charges, auditor's fees and attorney's fees, as necessary.

ASSIGNMENT

Benefits payable for expenses incurred on account of hospital, nursing, medical or surgical treatment resulting from a specified injury or period of sickness may be assigned in writing by the covered person to the institution or individual furnishing the respective services for which benefits are payable. The Plan assumes no responsibility for the validity of any assignment, nor will it be liable under any assignment until and unless satisfactory proof of assignment is submitted to the Plan prior to payment of the assigned benefits. Any payment made by the Plan prior to receipt of satisfactory proof of assignment will completely discharge the Plan's obligations to the extent of such payment and the Plan will not be required to see the application of the payment.

Provided, however, except as set forth above, the benefits shall be free from the interference and control of any creditor, and no benefits shall be subject to any assignment or any control of any creditor, and no benefits shall be subject to seizure or sale under any legal, equitable, or any other process, and in the event that any claim or benefit shall, because of any debt incurred by or resulting from any other claim or liability against any Participant or Beneficiary, by reason of any sale, assignment, transfer, encumbrance, anticipation or other disposition made or attempted sale under any legal, equitable or other process, or in any suit or proceeding, become payable, or be liable to become payable, to any person other than the Participant or Beneficiary for whom the same is intended, as provided herein pursuant hereto, the Trustees shall have power to withhold payment of such benefit to such Participant or Beneficiary until such assignment, transfer, encumbrance, anticipation or other disposition, writ or legal process is cancelled or withdrawn in such manner as shall be satisfactory to the Trustees. Until so cancelled or withdrawn, the Trustees shall have the right to use and apply the benefits, as the Trustees may deem best,

directly for the support and maintenance of such Participant or Beneficiary.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim thereunder and to make an autopsy in case of death, where it is not forbidden by law.

THE TRUST AGREEMENT AND COLLECTIVE BARGAINING AGREEMENT

This Plan is established under a Trust agreement pursuant to collective bargaining agreements that are made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependents at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

(1) A copy of the Trust Agreement or collective bargaining agreement, as the case may be.

(2) A complete list of employers sponsoring the Plan.

(3) Information as to whether a particular employer is a sponsor of the Plan. If the employer is a sponsor, then the address must be supplied.

INTERPRETATION, MISREPRESENTATIONS AND AUTHORITY

The Plan Administrator has the sole right to interpret all provisions and procedures of the Plan. Unless such interpretation is arbitrary and capricious, it shall be binding on all persons, participants, employees, dependents, beneficiaries, service providers and institutions.

The provisions of the Plan shall supersede any contrary interpretation whether by the Plan Administrator, the Claims Administrator or any other person. Neither the Plan, nor the Plan Administrator nor the Claims Administrator shall be liable for any benefits other than those specified in the Plan. Neither the Plan Administrator nor the Trustees nor the Claims Administrator nor any other person shall be liable for any misrepresentations made regarding the benefits available under the Plan.

LIMITATION OF ACTIONS

No legal action may be commenced or maintained against the plan (or its Trustees) by any claimant prior to the claimant exhausting the administrative procedures set forth herein (generally 60 days following receipt by the Trustees of a Request for Review or 120 days if the Trustees have extended the period within which a decisional review may be made and written notice has been provided to the claimant).

No legal action may be commenced or maintained unless that action is filed in the appropriate court no more than 180 days following the exhaustion of the administrative procedures set forth herein (generally the earlier of:

1. The date a decision on review was mailed or otherwise furnished to the claimant; and

2. A date that is 120 days following receipt of the request for review by the Trustees.

PLAN AMENDMENT AND/OR TERMINATION

The Board of Trustees has the right to amend and/or terminate the Plan. Circumstances under which the Plan may be terminated include, but are not limited to:

1. When there are no longer sufficient assets to continue the benefits of the Plan. In this regard, the Board of Trustees will first attempt to amend the Plan' s benefits, alter or postpone the method of paying benefits or take other actions consistent with its obligation to maintain the maximum possible benefits within the limits of the Plan's resources;

2. When there are no longer any Employers who are required to make contributions under the appropriate Collective Bargaining Agreement;

3. When the last surviving participant or beneficiary entitled to receive benefits has died;

4. With respect to a particular Employer, when that Employer ceases to be a contributing Employer according to the Plan's Trust Agreement or when that Employer is declared by the Board of Trustees to be in default; or

5. With respect to a particular Employee, when that Employee ceases to be an eligible Employee according to the Plan's Rules and Regulations.

If the Plan were to terminate, the Board of Trustees will, within the limits of the Plan's resources, adopt a plan to discharge all outstanding obligations and to provide that all remaining Plan assets be used in a manner which best carries out the basic purpose for which the Plan was established.

INFORMATION REQUIRED BY
EMPLOYEE RETIREMENT INCOME
SECURITY ACT OF 1974

The following information concerning this Plan is being provided in accordance with government regulations.

PLAN NAME:

TAMPA BANANA HANDLERS WELFARE PLAN

ENTITY WHICH ESTABLISHED AND MAINTAINS THE PLAN:

TAMPA BANANA HANDLERS WELFARE FUND

Address:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

This Plan is maintained pursuant to one or more collective bargaining agreements; a copy of any of the agreements may be obtained by Plan participants or their beneficiaries upon written request to the Administrative Manager or may be inspected at the Administrative Manager's Office during normal business hours.

PLAN NUMBERS:

Employer's Identification No. : **59-0871598**
Plan Number: **501**

TYPE OF PLAN:

Employee Welfare Benefit Plan including:

1. Medical benefits;
2. Death benefits;
3. Accidental Death and Dismemberment benefits;
4. Vision benefits;
5. Dental benefits;
6. Funeral Expense benefits;
7. Weekly Indemnity benefits; and
8. Holiday/Vacation benefits.

TYPE OF ADMINISTRATION

Lincoln National Life Insurance Company insures the **group life** insurance benefits provided by the Plan and administers the payments of life insurance benefits. Their address is:

Lincoln National Life Insurance Company
PO Box 2649
Omaha, NE 68103
1-800-423-2765

United Healthcare insures the **group medical** plan provided by the Plan and administers the payments of medical insurance benefits. Their address is:

United Healthcare
PO Box 740800
Atlanta, GA 30374-0800
1-800-357-0978

ADMINISTRATIVE MANAGER:

The day-to-day administration of the Plan is handled by **National Employee Benefits Administrators, Inc. (NEBA)**, a contract administrator. The address is as follows:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

AGENT FOR SERVICE OF LEGAL PROCESS:

W. Eric Venable, P.A.
7420 N. 56th Street
Suite 380
Tampa, Fl 33617

Service of legal process may also be made upon a Plan Trustee or the Administrative Manager at the address shown herein.

ELIGIBILITY AND BENEFIT PROVISIONS:

All types of benefits for which employees and their eligible dependents are entitled are set forth in the Schedule of Benefits and the Summary of Benefits.

CONTRIBUTIONS:

The amount of employer contributions is determined by the provisions of their collective bargaining agreements with employee representatives.

FUNDING:

Benefits are provided from the Plan's assets, which are held in reserve for payment of premiums for Plan benefits and expenses.

PLAN YEAR:

The year for purposes of maintaining Plan records and reporting to applicable governmental bodies is October 1st through September 30th.

BOARD OF TRUSTEES

L A B O R

LARRY COLEMAN
6316 Magnolia Trails Lane
Gibsonton, FL 33534

TORREY NORMAN
8903 Sandy Plain Drive
Riverview, FL 33569

M A N A G E M E N T

ANDRE DUBOIS
Logistec USA
200 Del Monte Way
Palmetto, FL 34221

W. DARRALD ATWOOD
Logistec USA, Inc.
P.O. Box 9411
New Haven, CT 06534

PIERRE LEFEBVRE
Vice President
Logistec Corp.
360 St. Jacques Street
Suite 1500
Montreal, Quebec H2Y-1P5

STATEMENT OF ERISA RIGHTS

As a participant in the **TAMPA BANANA HANDLERS HEALTH AND WELFARE PLAN**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements. and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 5500 Series) and updated summary plan description The administrator may make a reasonable charge for the copies.

Receive a summary of the plan 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 for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 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, 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.

IMPORTANT INFORMATION REGARDING COBRA

This notice contains important information about your right to COBRA continuation coverage, which is temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you, and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

The Board of Trustees has engaged National Employee Benefits Administrators, Inc. (NEBA) to perform the day to day administrative functions of the Plan, including administration of COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;
(3) Your spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the Plan as a "dependent child".

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), NEBA will provide you and/or your qualified beneficiaries with a COBRA continuation offer.

For the other qualifying events (divorce, or legal separation of the employee and spouse, or a dependent child's losing eligibility as a dependent child), **you** must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways this 18 month period of COBRA continuation coverage may be extended:

Disability extension of 18 month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18 month period of COBRA continuation coverage. This notice should be sent to:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

Second qualifying event extension of 18 month period of continuation coverage

If your family experiences another qualifying period while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36-months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases you must make sure the Plan Administrator is notified of the second qualifying event. This notice must be sent to:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc. (NEBA)
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

If you have questions

If you have questions about your COBRA continuation coverage, you should contact National Employee Benefit Administrators, Inc. or you may contact the nearest Regional or District Office

of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers are available through EBSA's website at www.dol.gov/ebsa

Keep your Plan informed of address changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PROVISIONS RELATING TO COMPLIANCE WITH THE HIPAA PRIVACY RULE

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor to take all actions required to be taken by the Group Health Plan (GHP) in connection with the HIPAA Privacy Rule.

I. Definitions - All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to compliance with the HIPAA Privacy Rule:

A. Plan, also referred to as "GHP", means the Tampa Banana Handlers Welfare Fund.

B. Plan Documents mean the GHP's governing documents and instruments including, but not limited to, the Tampa Banana Handlers Welfare Fund current plan of benefits (Plan) and Restated Agreement and Declaration of Trust (Trust) and as from time to time amended and/or restated.

C. Plan Sponsor means the "Plan Sponsor" as defined at section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B). The Plan Sponsor is the Board of Trustees.

II. The GHP's disclosure of Protected Health Information to the Plan Sponsor – Required Certification of Compliance by Plan Sponsor.

A. Except as provided below with respect to the GHP's disclosure of summary health information, the GHP will (a) disclose Protected Health Information to the Plan Sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or Business Associate with respect to the GHP, only if the GHP has received a certification (signed on behalf of the Plan Sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this provision; and
3. the Plan Sponsor agrees to comply with the Plan provisions as modified by this provision.

III. Permitted disclosure of individuals' Protected Health Information to the Plan Sponsor

A. The GHP (and any business associate acting on behalf of the GHP), or any health insurance issuer servicing the GHP will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with this provision.

B. All disclosures of the Protected Health Information of the GHP's individuals by the GHP's business associate or health insurance issuer, to the Plan Sponsor will comply with the restrictions and requirements of this provision and the "504" provisions.

C. The GHP (and any business associate acting on behalf of the GHP), may not permit a health insurance issuer, to disclose individuals' Protected Health Information to the Plan Sponsor for employment related actions and decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

D. The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Document and permitted by the "504" provisions.

E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the GHP (or from the GHP's business associate or health insurance issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

F. The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

G. The Plan Sponsor will report to the GHP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents and in the "504" provisions, of which the Plan Sponsor becomes aware.

IV. Disclosure of Individuals' Protected Health Information – Disclosure by the Plan Sponsor

A. The Plan Sponsor will make the Protected Health Information of the individuals who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. 164.524.

B. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.S.R. 164.526.

C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.S.R. 164.528.

D. The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from

the GHP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the GHP with the HIPAA Privacy Rule.

E. The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the GHP (or a business associate or health insurance issuer with respect to the GHP) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. The Plan Sponsor will ensure that the required adequate separation, described in paragraph VI below, is established and maintained.

V. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor

A. The GHP, or a business associate or health insurance issuer with respect to the GHP, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:
1. Obtaining premium bids from health plans for providing health coverage under the GHP; or
2. Modifying, amending, or terminating the GHP.

B. The GHP, or a business associate or health insurance issuer with respect to the GHP, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided in the "504" provisions.

VI. Required separation between the GHP and the Plan Sponsor

A. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to or have the potential to access individuals' Protected Health Information received from the GHP or from a business associate or health insurance issuer servicing the GHP. In addition to the Board of Trustees, classes may include, for example:
Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit.

B. This list reflects the employees, classes of employees, or workforce members of

the Plan Sponsor who receive or have the potential to access individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the GHP. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, this provision.

C. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the GHP and will cooperate with the GHP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

STANDARDS FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR:

Protected Health Information (PHI), to include Electronic Protected Health Information (ePHI), as both of those terms are defined in CFR 45 section 160.103 of the implementing regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), shall be disclosed to the Plan Sponsor, and may be used by the Plan Sponsor, only in accordance with the following terms and conditions. As used herein, "Plan Sponsor" shall mean, in accordance with Section 3 (16)(B) of the Employee Retirement and Income Security Act, the Trustees of the Fund jointly and individually, as designated under the terms of the Agreement and Declaration of Trust under which the Fund is established. "Plan" and "Fund" shall mean the Tampa Banana Handlers Welfare Fund.

1. Certification by Trustees. HIPAA requires that PHI will be disclosed to the Trustees only upon receipt of certification made by the Trustees that the Plan Document has been amended to incorporate the appropriate provisions. The Trustees hereby make such certification by execution of this document.

2. Disclosure of PHI to Trustees. The Plan shall disclose PHI in the form of summary health information to the Trustees only to the extent necessary for the Trustees to perform the following functions:

(a) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(b) Modifying, amending or terminating the Plan.

Further, the Plan shall disclose to the Trustees PHI necessary to carry out other plan administrative functions that the plan sponsor performs, such as the review of claims appeals, consistent with the Plan Document and with applicable provisions of HIPAA.

3. Uses and Disclosures of PHI by Trustees. With regard to the use and disclosure of PHI, the Trustees hereby agree to:

(a) Not use or further disclose such information other than as permitted or required by the Plan Document or as required by law;

(b) Ensure that any agents, including any sub-contractors, to whom they provide PHI received from the Plan agree to the same restrictions and conditions that apply to the Trustees with respect to such information and further agree to implement reasonable and appropriate security measures to protect ePHI;

(c) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that they may create, receive, maintain or transmit on behalf of the Plan;

(d) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;

(e) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which they become aware;

(f) Report to the Plan any incident involving the security of ePHI of which they become aware;

(g) Make available PHI to Plan participants in accordance with the separate Participant Privacy Policies and Procedures established by the Trustees;

(h) Make their internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with applicable portions of HIPAA;

(i) If feasible, return or destroy all protected PHI received from the Plan that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which such disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(j) Ensure that the adequate separation required in sub-section 5. Below is established and is supported by reasonable and appropriate security measures.

4. Disclosures between a Health Insurance Issuer or an HMO and the Trustees. No Health Insurance Issuer or HMO with respect to the Plan may disclose PHI to the Trustees except as described under sub-section 2. above and as described in the following sentence. The Plan and any health insurance issuer or HMO with respect to the Plan may disclose to the Trustees information on whether an individual is participating in the Plan, or is in enrolled in or has disenrolled from a Health Insurance Issuer or an HMO offered by the Plan.

5. Adequate Separation between the Plan and the Trustees. PHI will be used only for Plan administration. The Trustees shall not disclose PHI to any person or entity with whom or which the Fund does not have in effect a current "Business Associate" Agreement, and any such disclosures shall be made only in accordance with the terms of such Agreements and of the separate Security Policies and Procedures and Participant Privacy Policies and Procedures established and maintained by the Trustees.

6. Reports of Non-Compliance. Reports of non-compliance by persons or entities described in 5 above with the provisions outlined herein shall be reported to the Plan's "Privacy Official" designated in the separate Participant Privacy Policies and Procedures adopted by the Trustees. Such non-compliance shall be investigated and disposed of in accordance with those policies and procedures.

7. Reports of Security Incidents. Reports of incidents involving the security of ePHI shall be reported to the Plan's "Security Official" designated in the separate Security Policies and Procedures adopted by the Trustees. Such incidents shall be investigated and disposed of in accordance with those policies and procedures.

TAMPA BANANA HANDLERS WELFARE FUND
HIPAA Certificate of Creditable Coverage Procedures

A. Automatic Issuance of a Certificate of Creditable Coverage. The Fund will issue a Certificate of Creditable Coverage automatically as required by federal law including, as follows:

1. Exhaustion of Lifetime Limit. Individuals who lose coverage due to the operation of a lifetime limit on all benefits will receive the Certificate as soon as possible after a claim is denied due to the operation of the lifetime limit.

2. COBRA Events. Individuals who lose coverage due to a COBRA qualifying event will receive the Certificate together with the required COBRA notices. Individuals who lose coverage due to a COBRA qualifying event and elect COBRA coverage will receive two Certificates: one upon the occurrence of the qualifying event and one upon the termination of COBRA.

3. Other Terminations of Coverage. Individuals who lose coverage but do not experience a COBRA qualifying event will receive the Certificate within a reasonable time after coverage ceases or after the expiration of any grace period for nonpayment of premium. For example, an individual who loses coverage upon the termination of COBRA coverage will receive the Certificate within a reasonable time after the termination of COBRA.

B. Requests for Certificates. Individuals may request a Certificate even if the Fund previously provided one, at any time while the participant is covered under the Fund (regardless of whether it is as an active or retired employee) and these requests may be made by phone or in writing (including by facsimile) as set forth below. Individuals may request a Certificate, even if the Fund previously provided one, up to 24 months after the individual's loss of coverage under the Fund and these requests must be in writing (including by facsimile). To request a Certificate an individual must send a request for a Certificate to the Fund administrative office as follows:

Tampa Banana Handlers Welfare Fund
c/o National Employee Benefits Administrators, Inc.
2010 NW 150th Avenue, Suite 100
Pembroke Pines, FL 33028
800-842-5899

C. Delivery of Certificates. The Fund will send the Certificate by first class mail. If the Certificate is addressed and mailed to the participant and the participant's spouse at the participant's last known address, then the notice requirement will be satisfied with regard to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate Certificate will be provided to the dependent at the dependent's last known address.