



SMART

VOLUNTARY SHORT TERM DISABILITY

PLAN (VSTD)

**PLAN BOOKLET &
SUMMARY PLAN DESCRIPTION**

FOR BUS MEMBERS

Effective April 1, 2021

SMART VOLUNTARY SHORT TERM DISABILITY (VSTD) PLAN

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This VSTD Bus Summary Plan Description describes the SMART Voluntary Short Term Disability Plan (VSTD) and the benefits for Bus Members. The VSTD is sponsored by SMART. This document together with the VSTD Plan Document describes the short term disability (STD) benefits that the VSTD provides on a self-funded basis.

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SCHEDULE OF SHORT TERM DISABILITY BENEFITS

Maximum Weekly Benefit:	\$240
Minimum Weekly Benefit:	\$20
Elimination Period:	Benefits begin on the
(Waiting Period)	22 nd day of disability
Maximum Benefit Period:	52 Weeks
Cost of Coverage:	\$26 per month

For Non-Occupational (Off-the-Job) Injuries and Illnesses Only

ELIGIBILITY AND ENROLLMENT

Obtaining Coverage

To qualify to participate in the VSTD, you must be an Eligible Member and be Actively at Work (see Definitions).

Enrollment

You are automatically enrolled for coverage if you become an Eligible Member and do not waive coverage.

Initial coverage is automatic regardless of your health conditions.

If you waive coverage you must apply for coverage by submitting a Late Entry Application along with information regarding any current or past health conditions, and your application may not necessarily be approved.

Automatic Enrollment/Opting Out

As explained above, you are automatically enrolled for coverage when you become an Eligible Member. However, you may opt out of the coverage at any time during your first 30 days of work and not have to pay contributions to the Plan. The SMART Transportation Division (TD) automatically enrolls everyone to ensure that those who wants STD coverage receives it without having to qualify under a Late Entry Application. To opt out of coverage, simply complete the waiver form, available on the SMART website at smart-union.org, and mail it to the address indicated on the form. If the TD does not receive a Waiver form from you by the end of your first 30 days of work (your Eligibility Waiting Period), you will be enrolled for coverage and the contributions will be automatically deducted from your pay on a post-tax basis.

Terminating Coverage

If you do not opt out, but subsequently request to terminate your coverage, your coverage will be terminated on the last day of the month in which the request was received by the VSTD administrative office.

Recurring Coverage

If your coverage last ended solely because:

1. You became and remained employed for less than 20-hours-worth of pay per week; or
2. You began and remained on E-49 status;

You may enroll for Recurring Coverage when you once again become an Eligible Member. In that case, your recurring coverage will begin on the first of the month in which you again become an Eligible Member; you are not required to submit a Late Entry Application.

Delayed Effective Date of your Coverage

If you are not Actively at Work on the date your coverage would otherwise begin, your coverage begins on the date you are again Actively at Work.

Paying for Coverage

The cost of this coverage, as of the effective date of this SPD, is \$26 per month. Once you are enrolled, this amount will be automatically deducted from your paycheck on a post-tax basis. The cost of STD coverage is subject to change at any time at the sole discretion of the Trustees of the VSTD, upon prior notification to you.

When Coverage Ends

Your coverage will end on the earliest of:

1. The date your employment terminates. For the purpose of this provision, employment terminates when you are no longer Actively at Work, unless due to Disability;
2. The date of your death;
3. The date your weekly benefit payments end, if you are not again Actively at Work the following day;
4. The date on which – for reasons other than E-49 status or working for less than 20-hours-worth of pay per week – you cease to be an Eligible Member as defined in this Booklet;
5. The end of the month in which you request in writing that your coverage be terminated;
6. The date you cease to be Actively at Work; or
7. The date payment for coverage is not received in your behalf.

BENEFIT PROVISIONS

Determining Disability

Disabled and Disability under the Plan mean that because of your Injury or Illness, all of the following are true:

1. You are unable to do the Material and Substantial Duties of Your Own Occupation; and
2. You are receiving Regular Care from a Physician for that Injury or Illness; and
3. Your Disability Work Earnings, if any, are less than or equal to 99% of Your Weekly Earnings.

Your Disability must start while you are covered under the Plan.

Your loss of earnings must be a direct result of your Injury or Illness. You will not be considered Disabled from an occupation solely due to:

1. Loss, suspension, restriction or failure to maintain a professional license, occupational license, permit or certification; or
2. Loss of earnings due to economic factors such as, but not limited to, recession, job elimination, job restructuring, temporary layoffs, pay cuts and job-sharing; or
3. You are no longer Actively at Work because you tested positive for drugs or alcohol.

When Benefits Are Payable

STD benefits will be payable for a period of Disability, if:

1. The Disability starts while you are covered under the Plan and Actively at Work; and
2. The Disability continues during and past the Elimination Period; and
3. The Plan receives a timely application for benefits.

The Weekly Benefit, Elimination Period and Maximum Benefit Period are listed in the Schedule of Benefits.

Calculating Your Benefit

Your weekly benefit will be calculated as follows:

Part A.

If you are Disabled and not working, or Disabled and working and your Disability Work Earnings are less than 20% of your Weekly Earnings, your weekly benefit payment is the Maximum Weekly Benefit as shown in the Schedule of Benefits, except that if the sum of the weekly benefit payment and your Disability Work Earnings exceed 100% of your Weekly Earnings, the VSTD will subtract the amount in excess of 100% from your Weekly Benefit Payment.

Part B.

If you are Disabled and working, and your Disability Work Earnings are at least 20% but less than or equal to 99% of your Weekly Earnings, your weekly benefit payment will be the lesser of:

1. The amount of the Maximum Weekly Benefit as shown in the Schedule of Benefits; or
2. Your Weekly Earnings minus any Disability Work Earnings you receive during the period of Disability.

Part C.

If you are Disabled and working, and your Disability Work Earnings equal or exceed your Weekly Earnings, your weekly benefit payment will be equal to the minimum weekly benefit listed below.

The minimum weekly benefit payment is \$20.

Any benefit payable for less than a week will be prorated based on a 7-day week. The prorated amount may be less than the Minimum Weekly Benefit.

If your Disability Work Earnings fluctuate by more than 20% from week to week, the VSTD will average your Disability Work Earnings over the most recent three weeks to determine if your claim should continue but the VSTD will not terminate your claim unless the average of your Disability Work Earnings for a three-week period exceeds 99% of your Weekly Earnings.

Recovery of Overpayment

The Plan has the right to recover any amount that it determines to be an overpayment. This includes any prior or current overpayment from any past, current or new payable claims under the Plan. An overpayment occurs if the Plan determines that:

1. The total amount paid on your claim is more than the total amount then due to you under the Plan; or
2. Payment made by the Plan should have been made under another plan.

If an overpayment occurs, you have an obligation to reimburse the Plan in full within 60 days of written notice to you.

If the Plan does not receive reimbursement in full within 60 days, it may use any available legal means to collect the overpayment, including but not limited to one or both of the following:

1. Taking legal action; and/or
2. Stopping or reducing any future payments under the Plan which might otherwise be payable to you.

The Plan has the right to obtain any information it may require relating to your eligibility for, application for, or receipt of Deductible Sources of Income. You must provide the Plan with a signed authorization to obtain such information upon the Plan's request.

Recurrent Disability

If you have a recurrent Disability that is related or due to the same cause(s) as a prior covered Disability, and after the prior Disability ended you returned to Actively at Work status for 13 days or less, the Plan will treat your Disability as part of your prior claim and you do not have to complete another Elimination Period. Your weekly benefit payment will be based on your Weekly Earnings as of the date of your initial claim and your Disability will be subject to the same terms and conditions of the Plan as your prior claim.

Your Disability will be treated as a new claim if your current Disability:

1. Is unrelated to your prior Disability; or
2. After your prior Disability ended, you returned to Actively at Work status for more than 13 consecutive days.

The new claim will be subject to all of the provisions of the Plan and you will be required to satisfy a new Elimination Period.

If a period of Disability is extended by a new condition while you are receiving weekly benefit payments, then the extension of the period of Disability will be treated as a part of the same continuous period of Disability, subject to the same Maximum Benefit Period.

When Benefits End

Weekly benefit payments will end on the earliest of the date:

1. You are no longer Disabled;
2. You are no longer receiving, accepting or following Regular Care from a Physician;
3. The Maximum Benefit Period outlined in the Schedule of Benefits ends;
4. Preceding the date of your death;
5. The Plan requests proof that you are still Disabled and does not receive proof of Disability within 31 days of the request;
6. The Plan requests details about your Disability Work Earnings, including your tax returns, and you do not provide the information within 31 days of the request;
7. The Plan asks you to be examined by:
 - A Physician, or
 - A healthcare professional,And if you do not reasonably cooperate with the examiner or you unreasonably decline to be examined;
8. Your Disability Work Earnings exceed the amount allowable under the Plan;
9. You are confined to a penal or correctional institution;
10. You or your Physician fail to submit any medical or psychiatric information reasonably requested by the Plan,

Waiver of Payments for Coverage

The VSTD will waive the monthly payments required of you for this coverage for any period during which you are Disabled and your Disability Work Earnings are less than 20% of your Weekly Earnings, provided that you are receiving benefits under the Plan on the day that the monthly payments are due.

The VSTD will continue to waive your payments until the due date that falls on or next follows the first of the following to occur:

1. The date you are no longer Disabled;
2. The date your Disability Work Earnings equal 20% or more of your Weekly Earnings;
3. The end of the Maximum Benefit period listed in the Schedule of Benefits; or
4. The date your coverage under the Plan ends.

If you return to work and are an Eligible Member on the date payment waiver ends, your coverage will be continued subject to payment of the required payments. If you are not an Eligible Member on the date payment waiver ends, your coverage will end.

Exclusions

The Plan will not cover any disabilities or loss caused by, resulting from, or related to any of the following:

1. Your disability if result of an occupational injury;
2. War or an act of war, declared or undeclared, whether civil or international;
3. Service in the armed forces, military reserves or National Guard of any country or international authority, or in a civilian unit serving with such forces;
4. Intentionally self-inflicted injury or illness, unless such injury or illness results from a medical condition, including physical or mental health condition,
5. Active participation in a riot or civil commotion;
6. Participating in, committing or attempting to commit a felony, or engaging in an illegal occupation. This exclusion applies even if you plead to a lesser charge or no contest;
7. Operating any Motorized Vehicle if:
 - a. Under the influence of any intoxicant or drug whether or not prescribed by a physician; or
 - b. Your blood alcohol concentration is in excess of the legal limit in the state in which the Accident or Injury occurred;
8. Any Accident, Injury or Illness caused by, resulting from, or related to your being under the voluntary influence of any illicit drug, narcotic, intoxicant (including alcohol) or chemical;
9. Loss of professional license, occupational license or certification;
10. Any Pre-Existing Condition, as further outlined below; or
11. Any Illness or Injury caused by or during employment for wage or profit.

In addition, the Plan will not pay a benefit for any period for which any of the following applies:

1. You are no longer receiving accepting or following Regular Care from a Physician, except for a period for which the Physician certifies that treatment is not warranted;
2. You have applied for benefits under fraudulent circumstances and these circumstances result in a conviction of fraud;
3. You unreasonably fail to submit to an Independent Medical Exam requested by the Plan;
4. You are confined to a penal or correctional institution;
5. Disability results from cosmetic or reconstructive surgery, except for complications arising from such surgery, or surgery necessary to correct a deformity caused by Illness or accidental Injury; or

6. You or your Physician fail to provide any medical or any psychiatric records that the Plan reasonably requests.

Pre-Existing Condition Exclusion

No benefit will be payable for any Disability which is caused by, contributed to by, or results from a Pre-Existing Condition.

A "Pre-Existing Condition" is an Injury or Illness for which you did, or an ordinarily prudent person would have done, any of the following within 3 months prior to the date on which you became covered under the Plan whether or not that condition is diagnosed or misdiagnosed during that period of time:

1. Visited or consulted a Physician, Hospital or Medical Facility; or
2. Took clinical tests or received treatment. This includes (but is not limited to) taking pills, injections or other medication to treat any condition.

This exclusion will not apply if the first benefit payment would begin on a date that is at least 6months from the date that your coverage under the Plan commenced.

CLAIM PROCEDURE

How to Claim Benefits

Written proof of claim for disability benefits is required to be eligible to receive benefits under the Plan. You should file your claim within 90 days after a covered loss starts, or as soon afterward as is reasonably possible. You may request a claim form by calling the administration office of the Plan at 1-844-880-1071. Claims forms are also available online at www.smart-vstd.com. Once you have been approved for a benefit, you can register and view your payment and any notes that have been sent to you with those payments. Registration is not necessary to access the forms.

Whether a claim is filed as soon as reasonably possible shall be determined by the VSTD in each case and shall require, at a minimum, that there were extenuating circumstances that prevented filing within the 90-day period. Forgetting or not realizing that you are covered by the Plan does not constitute extenuating circumstances.

You must notify the Plan immediately if you return to work in any capacity.

Proof of Disability

Written proof of Disability must be given to the Plan within 90 days after the Disability commences. Your failure to furnish the proof within that time will not invalidate or reduce the claim if the proof is given as soon as reasonably possible. Proof of Disability must include information from your Physician about your condition. You must authorize the release of your medical information and give the Plan any other information and items that it reasonably requests to support your claim.

Filing Claim Forms

The claim form contains instructions as to how it should be completed and where it should be sent. Be sure to fully complete your portion of the form. Unanswered questions may delay the processing of your claim.

Proof of Continuing Disability

From time to time you must provide proof satisfactory to the Plan at your expense that you are still Disabled. The Plan will request this proof at reasonable intervals. That proof must be provided within 30 days, or as soon as reasonably possible thereafter. The Plan will stop benefit payments to you if you do not give satisfactory proof that you are still Disabled. The Plan may require you to provide the name and address of any Hospital or Medical Facility where you received treatment, including all attending Physicians, and to give written authorization to obtain additional medical information, including, but not limited to, complete copies of medical records. The Plan may investigate your claim at any time.

Proof of Financial Loss

The Plan has the right to require written proof of financial loss. This includes, but is not limited to:

1. Statements of Weekly Earnings and other written proof of your pre-Disability income;
2. Statements of income received from other sources while you are claiming benefits under the Plan,
3. Evidence that due application has been made for all other available benefits;
4. Tax returns and worksheets, tax statements and accountant's statements; and
5. Any other proof that the Plan may reasonably require.

Payment of benefits is contingent upon proof of financial loss satisfactory to the Plan.

Payment of Claims

Upon receiving the required proof of Disability and the fully completed claim form, the Plan will send you a weekly benefit check for the duration of your Disability, subject to the Maximum Benefit Period. Any retroactive benefits payable to you upon receipt and approval of your claim will be paid in a lump sum with your first disability check.

Notice of Claim Decisions

The Plan will send you written notice of a claim decision within 45 days after it receives proof of your loss. If there are special circumstances that require more time, the Plan will send you a written notice within this time frame that an additional 30 days is needed. If more time is still needed to make a claim determination, the Plan will send you written notice during this initial 30-day extension stating the special circumstances that require an additional 30 days. If the Plan requests additional information, you will have 45 days to respond to the request, and the Plan will send written notice of its claim decision within 30 days after it receives your response.

If the claim is wholly or partly denied, the notice will include:

1. Reasons for the denial;

2. Reference to specific Plan provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that the Plan review its decision; and
5. A description of the review procedures, and time limits, and notice to you of your right to bring a civil action.

Reconsideration of a Denied Claim

You may request that the Plan's Appeal Committee review a denial of all or part of your claim. This request must be in writing and must be received by the Plan no more than 180 days after you receive notice of the claim decision. As part of this review, you may:

1. Send the Plan written comments;
2. Review any information relating to your claim; and
3. Provide the Plan with other information or proof in support of your claim.

The Appeal Committee will review your claim at the next quarterly meeting, or if your request is received within the 30-day preceding the date of the meeting, in which case it will be considered at the next quarterly meeting. The decision of the Committee will be sent to you as soon as possible following the meeting, but no later than five days after the determination is made. That letter will include references to specific Plan provisions, rules or guidelines on which the decision was based, and notice to you of your right to bring a civil action.

Legal Actions

No legal action can be taken until 60 days after written proof of loss has been given as outlined herein. No legal action can be taken more than 3 years after written proof of loss was required as outlined herein. Legal action with respect to a claim that has been denied, in whole or in part, is contingent upon first having obtained the Plan's reconsideration of that claim in accordance with the Plan's procedures as explained herein.

Medical Examinations

The Plan may require that you undergo an Independent Medical Exam at reasonable intervals, at the Plan's expense. No benefits will be paid beyond any date that:

- Proof that you remain Disabled is not provided when requested by the Plan; or
- You do not allow a Physician to examine you when required by the Plan.

The Plan may require you to be examined at its expense by one or more Physicians, health care professionals, or vocational evaluators of its choice. The Plan may require examination at any time and as often as reasonably necessary. The examination may include such testing as the Plan determines necessary to administer the terms and conditions of the Plan, including but not limited to medical testing and vocational testing. The Plan will deny or stop benefit payments if you decline to be examined or if you do not cooperate with the examiner. Additionally, the Plan reserves the right to have you interviewed by its authorized representative.

DEFINITIONS

Where the following terms are used in this SPD, unless specified otherwise, they have the meaning explained here. Any capitalized terms that are not defined have the meaning ascribed to them elsewhere in the SPD.

Accident or Accidental means accidental bodily Injury which is sustained independently of disease, Illness or bodily infirmity.

Actively at Work means that you are performing the normal duties of your Own Occupation and working your normal hours. You must be paid for at least 20 hours on a permanent full-time basis and must be paid regular earnings.

You must perform the normal duties of your Own Occupation at your employer's usual place of business, except for duties of a kind that must be done elsewhere. Within 90 days of the last day that you performed your normal duties and worked your normal hours, you must be examined by a Physician and determined to be disabled as of that last date.

You are not considered Actively at Work when you are off work or paid below a minimum of 20 hours' worth of pay a week due to Illness, Injury, Leave of Absence, strike, layoff, or a reason that causes you to be placed on E-49 status. Paid days off will count as active workdays if you were fully capable of performing normal duties of your Own Occupation during the paid days off, provided that you were Actively at Work on the last working day prior to the paid days off. Appeals Committee means the person appointed by the Trustees to hear, adjudicate reconsiderations of denied claims.

Annual Earnings mean whichever one of the following is applicable to you:

- If, on the start of your Disability, you are covered and Actively at Work – Annual Earnings means the annualized gross base earnings you received from your employer during the period of coverage (not to exceed 12 months) that preceded your Disability.
- If, on the start of your Disability, you are covered but not Actively at Work – Annual Earnings means the annualized gross base earnings you received from your employer during the period of coverage while you were Actively at Work (not to exceed 12 months) that preceded your Disability.

Appeals Committee means the persons appointed by the Trustees to hear and adjudicate Participant appeal of denied claims.

Disability Work Earnings means any weekly earnings that you receive while you are Disabled and working.

Eligible Member means a dues-paying member of the SMART TD Actively at work for at least 20 hours' worth of pay from a participating bus employer on a scheduled normal work week.

If you were paid for less than 20 hours' worth of pay in the week just prior to your Disability, the VSTD may average your number of hours' worth of pay per week over the most recent four

weeks while Actively at Work in order to determine if you averaged 20 hours' worth of pay per week and therefore remained an Eligible Member when the Disability began.

Eligibility Waiting Period means the continuous length of time that you must serve in an eligible class to reach your eligibility date and begin your coverage.

Elimination Period means the period of continuous Disability that must be satisfied before you are eligible to receive benefits under the VSTD. The Elimination Period is shown in the Schedule of Benefits and begins on the first day that you meet the definition of Disability.

If you return to full-time work for 5 or less days during the Elimination Period, those days will interrupt the Elimination Period. However, the Disability will be treated as continuous if it is due to the same or a related condition. Only those days during which you are Disabled will be used to satisfy the Elimination Period. Therefore, you must complete the full 30-day Elimination Period within a total period of not more than 35 consecutive days.

Hospital or Medical Facility means a facility accredited by JCAHO (Joint Commission on Accreditation of Health Care Organizations) duly licensed by the state to provide medical evaluation and treatment of patients under the direction of an active staff of licensed Physicians.

Illness means a sickness or disease and will include pregnancy. Disability resulting from the sickness or disease must begin while you are covered under the VSTD for Short Term Disability.

Independent Medical Exam means an examination by a Physician of the appropriate specialty for your condition performed at the Plan's expense.

Injury means bodily injury resulting directly from an Accident and independent of all other causes, and which produces, at the time of the Accident, objective symptoms. The Injury must occur, and Disability must begin while you are covered under the VSTD for Short Term Disability.

Material and Substantial Duties means duties that:

- Are normally required for the performance of your Own Occupation; and
- Cannot be reasonably omitted or modified, except that the Plan will consider you able to perform the Material and Substantial duties if you are working or have the capability to work your normal scheduled work hours.

Own Occupation means the occupation that you regularly perform and for which you are covered under the Plan immediately prior to the date your Disability begins.

Physician means:

- A person licensed to practice medicine in the jurisdiction where such services are performed; or
- Any other person whose services must be treated as a Physician's according to applicable law. Such person must be licensed in the jurisdiction where they perform the

service and must act within the scope of that license and must also be certified and/or registered if required by such jurisdiction.

Physician does not include you or any member of your immediate family.

Regular Care means:

- You are under the continuing care of and personally visit a Physician as frequently as is medically required according to standard medical practice, to effectively diagnose, manage and treat your disabling condition(s); and
- You are receiving appropriate treatment and care of your disabling conditions(s) that conforms with standard medical practice by a Physician whose specialty and clinical experience is appropriate for your disabling condition(s) according to standard medical practice.

TD or SMART TD means the Transportation Division of SMART.

Weekly Earnings means your Annual Earnings divided by 52.

RIGHTS OF VSTD PARTICIPANTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at your worksite all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and 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's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

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 participant and beneficiaries. No one, including your employer or 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 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

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

ADDITIONAL INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Name and Address of the Plan Administrator as Defined by ERISA

Your Plan is maintained and administered by a Board of Trustees. A list of the Trustees as of the date this booklet was prepared is contained in the front of this booklet. All decisions made by the Board of Trustees are final and binding.

Source of Contributions

The Plan is funded by payments ("assessments") made by Eligible Members. The amounts of the assessments are established periodically by the Trustees.

The Plan's assets may be invested to produce additional income to the Plan.

Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings are accumulated in a trust fund. Benefits are provided through the fund.

Agent for Service of Legal Process

Every effort will be made by the Trustees of this Plan to resolve any disagreements with participants promptly and equitably. It is recognized, however, that on occasion, some participants may feel that it is necessary for them to take legal action. Service of legal papers may be made on:

Marc H. Rifkind
Slevin & Hart, P.C.
1625 Massachusetts Ave., N.W., Suite 450
Washington, D.C. 20036

Legal papers may also be served on the Trustees collectively or individually.

Plan Identification Numbers

When filing various reports with the Department of Labor and the Internal Revenue Service, certain numbers are used to properly identify the Plan including:

Employer Identification Number (EIN)
Assigned by the Internal Revenue Service27-6365479
Plan Number506