SMART

VOLUNTARY SHORT TERM DISABILITY

PLAN (VSTD)

PLAN BOOKLET &
SUMMARY PLAN DESCRIPTION FOR RAIL MEMBERS

Effective April 1, 2026

SMART VOLUNTARY SHORT TERM DISABILITY (VSTD) PLAN

Board of Trustees:

Mr. Jeremy Ferguson
SMART Transportation Division
6060 Rockside Woods Blvd N. Ste. 325
Independence, OH 44131-2378

Mr. Brent Leonard
SMART Transportation Division
6060 Rockside Woods Blvd N. Ste. 325
Independence, OH 44131-2378

Mr. John Daniel
SMART
1750 New York Avenue, NW
Washington, DC 20006-5386

Plan Administrative Office:

SMART VSTD Plan
PO Box 1449
Goodlettsville, Tennessee 37070-1449
Phone: (615) 859-0131 Toll-Free: (844) 880-1071
Fax: (615) 859-0201
www.smart-vstd.com

This VSTD Rail Summary Plan Description describes the SMART Voluntary Short Term Disability Plan (VSTD) and the benefits for Rail 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 to Rail Members on a self-funded basis.

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SCHEDULE OF SHORT TERM DISABILITY BENEFITS

Maximum Weekly Disability Benefit: $480

Minimum Weekly Disability Benefit: $50

Elimination Period: ..... Benefits begin on the
(Waiting Period) 22nd day of disability (except as otherwise provided in the definition of Elimination Period)

Maximum Disability Benefit Period: ..... 34 Weeks

Survivor Death Benefit $4,500

Cost of Coverage: ..... $34.50 per month

24 Hour Coverage for On and Off the Job Injuries and Illnesses

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 want 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 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 30-hours of pay per week; or
2. You began and remained on E-49 status;

You may enroll for Recurring Coverage when you 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 that you are again Actively at Work.

Paying for Coverage

The cost of coverage, as of the effective date of this SPD, is $34.50 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 30- 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 on 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;
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 80% 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:

Step 1. Your Weekly Earnings will be multiplied by 67%.

Step 2. The VSTD will then take the lesser of the amount from Step 1 or $693.

Step 3. Next, the VSTD will add together all the Deductible Sources of Income for which you are eligible, as set forth on the following page.

Step 4. If the amount from Step 3 is less than or equal to the amount from Step 2, your weekly benefit will be $480-. If the amount from Step 3 is more than the amount from Step 2, your weekly benefit will be equal to $480 minus the portion of the Step 3 amount that exceeds the Step 2 amount. However, your weekly benefit as calculated hereunder will not be less than $50, except as outlined in Step 5 below.

Step 5. If salary continuation or accumulated sick leave plan payments plus your weekly benefit as calculated above, along with your Disability Work Earnings, if any, would exceed 100% of your Weekly Earnings, we will subtract the amount in excess of 100% from your weekly benefit payments.

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 Plan will average your Disability Work Earnings over the most recent three weeks to determine if your claims will continue, but the Plan will not terminate your benefits unless the average of your Disability Work Earnings for a three-week period exceeds 80% of your Weekly Earnings.

Deductible Sources of Income

Deductible sources of income is income that is payable as a result of the same disability for which the Plan pays a benefit. You are required to apply for any Deductible Sources of Income for which you may be eligible. You may be required to sign a reimbursement agreement obligating you to reimburse the Plan for any overpayment of benefits made by the Plan due to payments you may receive from these Deductible Sources of Income. You must immediately disclose to the Plan any payments you receive from the Deductible Sources of Income listed below.

The following are all Deductible Sources of Income:

1. The amount that you receive, or are eligible to receive under:
   - A workers' compensation law,
   - An occupational disease law,
   - Any other act or law with similar intent.

2. The amount that you receive, or are eligible to receive, as disability-income payments under any:
   - State-compulsory benefit act or law,
   - Governmental retirement system as a result of your employment with the railroad (including any Railroad Retirement Board benefits),
   - Veteran's Administration or any other foreign or domestic governmental agency,
   - Automobile liability insurance policy,
   - Individual disability income plans which are wholly or partially paid for by your employer,
   - Group insurance plan,
   - Any plan or arrangement of disability coverage, whether or not insured, resulting from your employment by or association with any employer, or resulting from your membership in, or association with, any group, association, union or other organization.

3. The amount that you:
   - Receive as disability payments under any railroad-sponsored retirement plan, and
   - Voluntarily elect to receive as retirement payments under any railroad-sponsored retirement plan,
   - Have satisfied the age and service requirements to receive a Railroad Retirement annuity
   - Are eligible to receive as disability payments under the Social Security Act.

   Disability payments under a retirement plan are benefits that are paid due to disability and that do not reduce the retirement benefit which would have been paid if the disability had not occurred (i.e. ancillary benefits).

   Retirement payments are benefits that are paid based on your railroad employer's contributions to the retirement plan. Disability benefits which reduce the retirement benefit under the retirement plan will also be considered as a retirement payment.

4. The amount you receive as a result of any action brought under Title 46, United States Code Section 688 (The Jones Act).

5. The amount you receive from a third party by judgment, settlement or otherwise.

6. The amount you receive under the mandatory portion of any “no fault” motor vehicle plan.

7. The amount you receive under any salary continuation or accumulated sick leave plans.

8. Commissions, severance allowance, sick pay or any similar employer sponsored paid time off plan where you receive income from the employer, or any salary continuation plan. Any earnings from any work or employment may be used to reduce your weekly benefit payment.

9. Any amounts from partnership or proprietorship draws, or similar draws.

You must apply for disability benefits under the Federal Social Security Act or Railroad Retirement Act if there is a reasonable basis for application. To apply for Social Security benefits or Railroad Retirement benefits means to pursue such benefits until you receive approval from the Social Security Administration or Railroad Retirement Board, or a notice of denial of benefits from an administrative law judge.

Non-Deductible Sources of Income

The Plan will not subtract from your weekly benefit any income you receive from the following:

1. 401(k) plans,
2. Profit sharing plans,
3. Thrift plans,
4. Tax sheltered annuities,
5. Stock ownership plans,
6. Credit disability insurance,
7. Non-qualified plans of deferred compensation,
8. Pension plans for partners,
9. Military pension and disability income plans,
10. Individual disability plans paid for by you,
11. A retirement plan sponsored by SMART,
12. Individual retirement accounts, or
13. Vacation pay.

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 that might otherwise be payable to you.

You must immediately disclose to the Plan the amount of any retroactive payment you may receive from any of the Deductible Sources of Income. 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 14 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 14 days without a break in employment.

In that case, the new claim will be subject to all 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 Deductible Sources of Income or 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 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; or
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 STD 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 the 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 the 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. War or an act of war, declared or undeclared, whether civil or international;
2. 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;
3. Intentionally self-inflicted injury or illness, unless such injury or illness results from a medical condition, including physical or mental health condition;
4. Active participation in a riot or civil commotion;
5. 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;
6. Operating any Motorized Vehicle if:
    - Under the influence of any intoxicant or drug whether or not prescribed by a Physician; or
    - Your blood alcohol concentration is in excess of the legal limit in the state in which the Accident or Injury occurred;
7. 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, except for a period of treatment following voluntary admission to an accredited rehabilitation program (drug or alcohol), subject to the following;
    - A certificate or letter of completion must be submitted to the Plan for this exception to apply.
    - An admission will not be considered voluntary if it is either required by, or in lieu of, employer discipline or is imposed by a court.
    - A program will be considered accredited if it is approved by Medicare, certified or licensed by the applicable state, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or otherwise authorized by law.
8. Loss of professional license, occupational license or certification; or

9. Any Pre-Existing Condition, as further outlined below.

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 12 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 otherwise begin on a date that is at least 12 months from the date that your coverage under the Plan commenced.

Survivor Death Benefit

The Plan will pay a lump-sum Survivor Death Benefit of $4,500 to your eligible survivor if you die while you are receiving, or you would have been eligible to receive, a short-term disability benefit from the Plan if you had not died. This benefit will be paid to your legal spouse at the time of death or, if none, to your surviving children, and if neither your spouse nor children survive you, then to your estate.

CLAIM PROCEDURE

How to Claim Benefits

Written proof of a 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 payments and any notes that have been sent to you with those payments. Registration is not necessary to access the forms.

Whether a claim is flied 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 thereafter. 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 payment payable to you upon receipt and approval of your claim will be paid in a lump sum with your first disability payment.

1. Payment of Claims by Plan:

All claims received by the Plan will be processed for payment as soon as possible. However, no claim will be paid until all information necessary to process the claim has been received.

Once the information required to decide whether a claim is payable has been received, a decision will be made promptly, and you will be notified regarding any benefit payments.

The Plan will send written notice of a claim decision to you within 45 days after it receives proof of loss. If there are special circumstances that require additional 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 the 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 to you within 30 days after it receives the response.

2. Notice of Adverse Benefit Determination:

Upon determination that a claim submitted by or on your behalf is not covered under the Plan, you will be notified in writing within the time frame outlined above regarding the adverse benefit determination. This notice will set forth, in a manner calculated to be understood by you, all of the following information:

(a) The specific reason or reasons for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

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

(d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, after the claimant exhausts the Plan's appeal procedures, including a description of any contractual limitation period that applies to your right to bring an action; and

(e) If the claim is denied because you have failed to establish proof of disability:

(1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

A. The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you (if any);
B. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
C. A disability determination presented by you to the Plan made by the Social Security Administration;

(2) A copy of the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules. guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

The notification will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulations Section 2560.503-1(o).

3. Claimant's Right to Review of an Adverse Benefit Determination:

A claimant whose claim for benefits has been denied under the terms of the Plan and to whom a notice of adverse benefit determination has been issued in accordance with paragraph 2 above will have the right to appeal the adverse benefit determination and will be entitled to a full and fair review of the decision by the Board of Trustees, or by a committee appointed by them. The procedures by which you may appeal the adverse benefit determination and receive a full and fair review of the claim are as described below.

(a) Review Procedure

The procedures hereunder will:

(1) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination in which to appeal the determination;

(2) Provide for an independent review by the Board of Trustees, or their committee. The review will not be conducted by the individual who made the adverse benefit determination that is the subject of the appeal, nor by the subordinate of such individual;

(3) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees or their committee shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(4) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

(5) Provide that the health care professional engaged for purposes of this appeal is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(6) In the event a claim is denied due to failure to establish proof of disability, the Trustees, or a committee appointed by them, will:

A. Prior to issuing an adverse benefit determination on review, provide to you, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you reasonable opportunity to respond prior to that date, and

B. Prior to issuing an adverse benefit determination on review based on a new or additional rationale, provide you, free of charge, the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you reasonable opportunity to respond prior to that date.

(b) Notice of Trustees' Decision

A decision on your appeal will be made by the Trustees or their committee and communicated in writing to you within five days of the decision. The appeal will be reviewed at the meeting of the Trustees or the committee that immediately follows the Plan's receipt of your appeal, unless the appeal is filed within 30 days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the appeal, but in no instance more than 120 days following receipt of the appeal.

(c) Access to Plan Documents

At any time during the course of these appeal proceedings a claimant will be granted access to, and copies of, documents, records and other information relied upon by the Trustees or the committee in making their decision, as requested by you.

(d) Notification of Decision on Appeal

Each claimant whose adverse benefit determination has been appealed to the Trustees will receive notification in writing, within the time period outlined above, of the Trustees' or the committee's decision. Such notification will set forth, in a manner calculated to be understood by you:

(1) The specific reason or reasons for the adverse determination;
(2) Reference to the specific Plan provisions on which the benefit determination is based;
(3) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
(4) A statement describing any additional voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, should the Board of Trustees adopt such procedures, and a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended; and

(5) The following information where applicable —

A. If an internal rule, guideline, practice or procedure was relied upon in making the adverse determination, a statement that such rule, guideline, practice or procedure was relied upon in making the adverse determination and that a copy of the rule, guideline, practice or procedure will be provided free of charge to you upon request; and

B. A statement that you and the Plan may have other voluntary alternative dispute resolution options, although the Plan is not required to offer such options, and that you may contact the local U.S. Department of Labor office or his state insurance regulatory agency to determine what options might be available to the Plan.

(6) If the claim was denied because you failed to establish satisfactory proof of disability:

A. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(i) The views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you (if any);

(ii) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) A disability determination presented by you to the Plan made by the Social Security Administration;

C. A copy of the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

D. The statement required under (4) above will also describe any contractual limitations period that applies to your right to bring such an action, including the calendar date on which the limitations period expires for the claim.

The notification will be provided in a culturally and linguistically appropriate manner in accordance with Department of Labor Regulations Section 2560.503 1(o).

4. Rights Granted Hereunder Are Limited to One Appeal:

In appealing an adverse benefit determination under these procedures, you may choose to make a written appeal, in which event the Plan's administrative manager will present all documents on your behalf, or you may choose to personally appear before the Trustees for the purpose of

presenting an appeal, or designate a representative to appear on his behalf. Claimant appeals rights are limited to one written or personal appeal per denied claim.

5. Compliance with Appeal Procedures:

You may at your own expense have legal representation at any stage of these appeal procedures. The Trustees will interpret Plan provisions in a consistent and equitable manner. You will be required to exhaust these appeals procedures before proceeding to litigation.

6. Limitation of 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 30 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 30 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.

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.

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 30 hours-of pay from a participating rail employer on a scheduled normal work week.

For purposes of eligibility, “dues-paying” means the SMART-TD Member is current on his/her monthly dues to SMART.

If you were paid for less than 30 hours in the week just prior to your Disability, the VSTD will average your number of hours of pay per week over the most recent four weeks while Actively at Work in order to determine if you averaged 30 hours 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.

You must complete the full 21-day Elimination Period within a total period of not more than 35 consecutive days.

The Elimination Period does not apply to a Disability due to a period of treatment following voluntary admission to an accredited rehabilitation program, subject to the requirements provided in Exception #7 of this SPD.

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 and who is 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 form 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:

Lauren P. McDermott
Mooney, Green, Saindon, Murphy & Welch, P.C.
1620 I Street NW, Suite 700
Washington, D.C. 20006

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 Service 27-6365479
Plan Number 506