American Postal Workers Accident Benefit Association
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR DISABILITY AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS
As Revised January 2019

I. INTRODUCTION

This document comprises the plan document and summary plan description required by the Employee Retirement Income Security Act ("ERISA") for the American Postal Workers Accident Benefit Association Plan (the "Plan"). This document supersedes the disability and accidental death and dismemberment benefits described in the Certificate of Benefits in the American Postal Workers Accident Benefit Association Plan, Constitution, By-Laws, Ritual & Certificate of Benefits dated August 2006, and in any other source.

II. ELIGIBILITY

Members and their covered spouses may select coverage under the Value Plan or the Advantage Plan. In addition, Members covered by the Value Plan or the Advantage Plan may elect supplemental death benefit coverage under the PLUS Plan. The Plus Plan may also be obtained as a stand-alone benefit. Members and their covered spouses may elect different levels of coverage under the Plan. Members (employed and retired) shall have the option to change Plan coverage once each calendar year.

- **Members** – Those eligible for membership in the APW-ABA are: Any active or retired member of the APWU*, and their spouse; Any Associate member of the APWU*, and their spouse; Any career bargaining unit employee employed by the APW-ABA or the APWU*, and their spouse; **Eligible members of the APWU Auxiliary as determined by union affiliation and/or family relationship to APWU members.** *APWU shall be recognized as the American Postal Workers Union, AFL-CIO or any other name the APWU may hereafter assume and/or the members of any entity with which said union may merge. To participate, you must submit an application to the Home Office, and coverage will become effective on the first pay period ABA premiums are received. If you are a member of a 100% Local or State, you are automatically enrolled (no application is required), and coverage will become effective the date your membership in the 100% Local or State becomes effective.

If you are a Value Plan member (on dues check-off or payroll deduction) in a non-pay status, you will be covered by the ABA for up to 90 days. If you continue in a non-pay status after 90 days, you must submit your premiums to the ABA in order to remain in good standing.

If you are an Advantage Plan member (on dues check-off or payroll deduction) in a non-pay status, you will be covered at the Value Plan rate for up to 90 days and will only be responsible for paying the difference between the Value and Advantage Plan rate. If you choose not to pay the difference, you will receive benefits at the Value Plan rate in the event of an accident. After 90 days you must submit your full premium to the ABA in order to remain a member in good standing.

If your spouse is an ABA member (and not a member of the APWU) there is no 90 day grace period for their ABA Benefits. In order for the spouse to remain in good standing their premiums must be submitted beginning the first Pay Period in the non-pay status.

If you are a PLUS member in a non-pay status you must submit ABA Plus premiums beginning the first Pay Period in a non-pay status to be considered a member in good standing.

The above also applies to retirees who desire to continue paying full dues to the APWU National and Local.

These premiums must be paid in advance for the upcoming year. If you have any questions, please call the ABA home office at 603-330-0282.

Any payment of claims filed for benefits by any member in a non-pay status will be reduced by the amount of said back ABA dues prior to payment(s) being sent to the member.

If you are a current employee, you are eligible for supplemental death benefit coverage under the PLUS Plan. If you and your spouse are both active postal employees and members in good standing, you may each obtain PLUS Plan coverage, provided that you apply for separate deductions on dues check-off. If you are a PLUS Plan Member in a non-pay status, you must submit premiums beginning the first pay period in a non-pay status.

- **Spouses** – Your spouse is eligible to participate in the Plan if you are a Member in good standing. You are responsible for payment of dues and premiums for your spouse's coverage. Spousal coverage will terminate when you cease to be a Member, or when your marriage is terminated by reason other than death. If you become fully disabled and benefits cease, or if you die, your surviving spouse may elect to continue as a Member and be responsible for all premiums. If your spouse participates in the Plan (and is not a member of the APWU), and you are in a non-pay status, your spouse's premiums must continue to be submitted to the Home Office while you are in non-pay status beginning the first pay period in the non-pay status.

If your spouse does not participate in the Plan, he or she automatically will be covered by the accidental death benefit described in the Family Benefit Provision in the Benefits section of this document if you are a Member in good standing.

- **Retirees** – You are eligible to participate in the Plan (including the PLUS Plan up to a $50,000 benefit option) if you are a member, including an associate member, of the American Postal Workers Union, AFL-CIO, in good standing, and leave the U.S. Postal Service by regular retirement or disability retirement. PLUS coverage may be elected as a stand-alone benefit, or in addition to coverage under the Value Plan or Advantage Plan.

Spouses of Retirees – Your spouse is eligible to enroll or continue participation in the Plan (including the PLUS Plan up to a $50,000 benefit option) on or after your retirement regardless of whether he or she was enrolled at the time of your retirement. Plus Plan coverage may be continued as a stand-alone benefit, or in addition to coverage under the Value Plan or Advantage Plan. If you die, your surviving spouse may elect to continue as a Member and be responsible for submitting all premiums to the Home Office. If your spouse does not participate in the Plan, he or she automatically will be covered by the accidental death benefit described in the Family Benefit Provision in the Benefits section of this document if you are a Member in good standing.

Coverage will become effective on the date ABA premiums are received.

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium. Coverage will continue in force during this grace period. If you fail to pay premiums after the grace period expires, your coverage will be suspended without notice. You may restore coverage within 60 days by bringing your premiums current. If you fail to restore coverage within 60 days, your coverage will terminate. If coverage is reinstated, it will apply only to accidents sustained after the date of reinstatement.

- **Dependents** – Unmarried dependent children (up to and including age 26) are automatically covered by the accidental death benefit described in the Family Benefit Provision in the Benefits section of this document if you are a Member in good standing.
- **Honorary Members** – You are eligible to participate in the Plan if you have been elected to honorary membership. The Accident Benefit Association will pay premiums for all honorary Members.

III. WHEN COVERAGE ENDS

Your coverage under the Plan will terminate if:

- You cease to be a Member in good standing.
- You fail to pay premiums.
- The Plan is terminated.
- You leave the U.S. Postal Service and do not retain membership with the American Postal Workers Union, AFL-CIO or associate membership.

IV. COST OF COVERAGE

Premiums will be reviewed and adjusted, if necessary, on an annual basis.

V. BENEFITS

Generally, the Plan provides benefits for a disabling injury or death resulting directly and exclusively from an accident of external cause, and which is independent and exclusive of other causes and must be identifiable as to time and place of occurrence and body part or function of the body affected.

LOSS	VALUE PLAN	ADVANTAGE PLAN
Disability Provision*		
Loss of time (for which you are totally disabled and unable to work any type of duty, not exceeding 52 weeks/365 days, including recurrence within 52 weeks after the date of a previously compensated accident)	$12 per day	$24 per day
Dismemberment Provisions		
Loss of 1 finger (at least to first joint)	$500	$2,000
Loss of a thumb (at least to first joint)	$750	$3,000
Loss of 2 or more fingers (at least to first joint)	$1,000	$4,000
Loss of 1 thumb and 1 or more fingers (at least to first joint)	$1,500	$6,000
Loss of sight of 1 eye (to at least industrial blindness level)	$3,000	$12,000

LOSS	VALUE PLAN	ADVANTAGE PLAN
Loss of sight of both eyes (to at least industrial blindness level)	$6,000	$24,000
Loss of 1 arm (at or above wrist)	$1,500	$6,000
Loss of both arms (at or above wrist)	$6,000	$24,000
Loss of 1 leg (at or above ankle)	$2,000	$8,000
Loss of both legs (at or above ankle)	$6,000	$24,000
Loss of 1 arm and 1 leg (at or above wrist/ankle)	$6,000	$24,000
Accidental Death Provision		
Death due to an accident	$6,000	$24,000
Family Benefit Provision		
Death of spouse (provided spouse is not covered as an ABA Member)	$2,000	$2,000
Death of unmarried dependent child (up to and including age 26)	$2,000	$2,000
PLUS Plan Provision (supplemental coverage)		
Death due to an accident – $20,000, $30,000, $40,000, $50,000, $75,000, $100,000, $125,000, $150,000 benefit option (includes Value Plan or Advantage Plan death benefit; if applicable)		
Death due to an accident of retiree or spouse of retiree – up to $50,000 benefit option (includes Value Plan or Advantage Plan death benefit; if applicable)		

*Daily disability benefit payments under the Disability Provision shall be offset by any lump sum payments made under the Dismemberment Provisions.

These rates begin on the first day of total disability and end the day you return to any type of work, or your doctor releases you for work, whichever occurs first.

Retirees are eligible for benefits if medical documentation is submitted verifying that the retiree has suffered a disabling injury resulting from an accident of external force, is totally disabled and requires assistance in performing normal daily life functions.

Benefit Exclusions and Limitations

Benefits will not be paid under the following circumstances or for the following conditions:

1. Disability while in a nursing home or medical facility.
2. You retired from the U.S. Postal Service on a disability and the accident relates directly to the disability for which you retired.
3. Loss of time beginning more than 60 days after the date of the accident (unless justified by medical evidence) or continuing after you can perform any type of work.
4. Death, loss of sight, or any dismemberment resulting more than 180 days after the date of the accident.
5. Death or Disability contributed to or caused by illness, disease, physical defect, or bodily infirmity.
6. Disability caused by lifting, stress, strain, over-exertion or repetitive motion.
7. ny member of the armed forces of the United States, or in a hostile action or while a member of any organization, military or other, bearing arms (except active duty in peacetime as a reservist in the armed forces of the United States for not more than 30 successive days).
8. Injuries received during the commission of a crime for which a term of imprisonment could be imposed.
9. Death or disability from intentionally self-inflicted injuries, or disability from attempted suicide.
10. Death resulting from any willful or malicious killing of a Member by a beneficiary.
11. Death or disability caused by any poison or drug intentionally abused.
12. Death or disability as the result of any surgical operation (except when surgical treatment was made necessary by an accident).
13. Death or disability as the result of administration of any anesthetic (except when the anesthetic was made necessary by an accident).
14. Death or disability caused by or contributed to by appendicitis, seizures, epilepsy, mental infirmity (including emotional distress, post traumatic stress and depression), bacterial infection (except when an infection occurs through an accidental cut or wound), pregnancy, arthritis, diabetes, heat prostration, sunstroke, sunburn, or cancer.
15. Death or disability resulting from any hostile action defined as "weapons of mass destruction" including but not limited to biological, chemical, or nuclear weapons.
16. Death or disability as a result of any treatment or therapy intended to cure or alleviate mental or bodily ills.
17. Death or disability resulting from an accident to a Member who is under the influence of alcohol, narcotics or other drugs unless administered on the advice of a physician.
18. Death or disability caused by herniorrhaphy on all types of hernias shall be compensated one time at $400 for Value Plan and $600 for Advantage Plan, provided that repair be made within 52 weeks after diagnosis and recommendation for surgery by a physician. Recurrent hernias will not be compensated.
19. Injuries due to an accident of the spine (including the muscle and nerve system relating to the spine) cannot exceed a lifetime total of 90 days. Benefits for disabilities caused due to an accident resulting in herniated, ruptured or fractured discs cannot exceed a lifetime total of 180 days. Parted or severed spinal cords shall not be subject to these limitations.
20. Benefits for Disability due to fracture of the hip shall not exceed $1,500 for Value Plan and $3,000 for Advantage Plan. Benefits for Death due to fracture of the hip under both the Value Plan and Advantage Plan shall not exceed $3,000.
21. Loss of time for which you are totally disabled and unable to work any type of duty, exceeding 52 weeks/365 days, including recurrence within 52 weeks after the date of a previously compensated accident.
22. Pre-existing or recurring conditions.
23. If you change coverage options, you will not be allowed additional payment of benefits if you have been paid the maximum days or benefit under your former option.

Beneficiaries

You should designate your beneficiary as soon as possible after you become a Member, on the form provided by the Plan Administrator. You should update your beneficiary designation whenever warranted by a change in your personal circumstances. The right to change a beneficiary is reserved for the Member. The consent of the beneficiary or beneficiaries is not required to end coverage, to change beneficiaries, or for any other changes. A change of beneficiary becomes effective when recorded in the home office of the Plan Sponsor.

Benefit Payments

Benefits (including dismemberment and disability benefits, if you die before payment is made) will be paid to your beneficiary (or in equal shares to your beneficiaries) living at your death, in accordance with the most recent beneficiary designation on file. Payments will be made to primary beneficiaries, or if no primary beneficiary is living at your death, to contingent beneficiaries (if any).

If no named beneficiary survives you, or if you have not named a beneficiary, or if the beneficiary is disqualified from receiving benefits, benefits will be paid in the following order: (1) to your surviving spouse; if none, then (2) to your surviving children in equal shares; if none, then (3) to your parent or parents, in equal shares if both are living; if none, then (4) to your executor or the administrator of your estate.

If your death benefit beneficiary is a minor or cannot give a valid release for any payment due, and until the beneficiary's appointed guardian, or conservator, or committee makes a claim, we will make payments to one of the following: (a) the beneficiary, (b) any relative by blood or marriage of the beneficiary, or (c) any other person or institute that has assumed the custody and main support of the beneficiary. Payments may be to the person selected above at our option as follows: (1) we will pay $100 after your death, and then in installments of not more than $50 each month until the amount of the benefit is exhausted.

Benefits payable under the Family Benefit Provision will be paid to you only. You must be living at the time of payment to receive benefits under the Family Benefit Provision.

VI. CLAIMS

Death and Dismemberment Benefits

- **Submitting Claims** – Death and dismemberment claims must be filed with Sun Life and Health Insurance Company ("Sun Life") through the Home Office. The Plan Administrator will furnish a claim form upon request. There is no cost or fee for filing a claim. All claims for death and dismemberment benefits will be determined by Sun Life. Claims for death benefits (including benefits for spouses and dependents) must be filed within 1 year of the date of death. Claims for death benefits must include a copy of the certified death certificate and, if performed, a copy of the autopsy and/or medical examiners report (including the toxicology report). Claims for dismemberment benefits must be filed within 90 days after the day you return to work.

- **Denial of Claims** – If your claim for death or dismemberment benefits is denied in whole or in part, Sun Life will notify you within 90 days of receipt of the claim. If Sun Life needs more time to review your claim, it may take up to an additional 90 days, but will notify you in writing, within the first 90 day period, of the circumstances requiring the extension and the date by which a decision will be made.
- **Appeal of Claims** – If your claim for death or dismemberment benefits is denied, you may appeal to Sun Life to have your claim reconsidered for payment. Your appeal must be filed within 180 days of the day you receive notice that your claim has been denied. You may submit written comments, documents, records, and any other information you believe is relevant to your claim. These submissions will be taken into account when determining the final disposition of your claim regardless of whether they were submitted or considered in the initial benefit determination. You may request, at no charge to you, reasonable access to and copies of all documents, records and other information relevant to your claim. You will be notified of the decision of Sun Life within 60 days after the receipt of your appeal. If Sun Life determines that additional time is necessary, you will be notified in writing within the initial 60-day period of the special circumstances requiring the extension and the date by which Sun Life expects to resolve your claim. In no event will the extension exceed 60 days. The decision of Sun Life shall be final and binding upon all parties.

Disability Benefits

- **Submitting Claims** – Disability claims by both active and retired members must be filed with the Claims Administrator. The Plan Administrator will furnish a claim form upon request. There is no cost or fee for filing a claim. All claims for benefits will be determined by the Claims Administrator. Claims for disability benefits must be filed within 90 days after the day you return to work or are released by your doctor, whichever occurs first. If you experience a "prolonged disability" (defined as a disability which lasts 30 days or longer), you may make a claim for partial payments, but not sooner than each 30 day period.
- **Denial of Claims by the Claims Administrator** – If your disability claim is denied in whole or in part, the Claims Administrator will notify you within 45 days of the day it receives your claim. If the Claims Administrator needs more time to review your claim, he or she may take up to an additional 30 days, but will notify you in writing, within the first 45-day period, of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If, due to circumstances outside the control of the Plan, a decision cannot be made within the additional 30-day period, another 30-day extension may be taken, but the Claims Administrator will again notify you in writing of the reason for the extension and the date by which a decision will be made.
- **First Appeal to the National Director** – If your disability claim is denied by the Claims Administrator, you may appeal to the National Director to have your claim reconsidered for payment. Your appeal must be filed within 180 days of the day you receive notice that your claim has been denied by the Claims Administrator. You may submit written comments, documents, records, and any other information you believe is relevant to your claim. These submissions will be taken into account when determining the final disposition of your claim regardless of whether they were submitted or considered in the initial benefit determination. You may request, at no charge to you, reasonable access to and copies of all documents, records and other information relevant to your claim. If the advice of any medical or vocational expert was obtained on behalf of the Plan in connection with your claim, such experts will be identified, regardless of whether their advice was relied upon in denying your claim. The review by the National Director will not afford deference to the initial claim denial. The review will not include the Claims Administrator, nor any individual who is the subordinate of the Claims Administrator. If the denial of your claim was based in whole or in part on a medical judgment, the National Director will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be an individual who was consulted in connection with the initial denial of your claim, nor will it be a subordinate of that individual. You will be notified of the decision of the National Director within 45 days after the receipt of your appeal. If the National Director determines that additional time is necessary, you will be notified in writing within the initial 45-day period of the special circumstances requiring the extension and the date by which the National Director expects to resolve your claim. In no event will the extension exceed 45 days.
- **Second Appeal to the Committee** – If your disability claim is denied by the National Director, you may appeal to the Committee on Claims of the Board of Directors (the "Committee") to have your claim reconsidered for payment. Your appeal must be filed within 180 days of the day you receive notice that your claim has been denied by the National Director. You may submit written comments, documents, records, and any other information you believe is relevant to your claim. These submissions will be taken into account when determining the final disposition of your claim regardless of whether they were submitted or considered in the initial benefit determination. You may request, at no charge to you, reasonable access to and copies of all documents, records and other information relevant to your claim. If the advice of any medical or vocational expert was obtained on behalf of the Plan in connection with your claim, such experts will be identified, regardless of whether their advice was relied upon in denying your claim. The review by the Committee will not afford deference to the initial claim denial. The review will not include the Claims Administrator, the National Director, nor any individual who is the subordinate of the Claims Administrator or National Director. If the denial of your claim was based in whole or in part on a medical judgment, the Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not be an individual who was consulted in connection with the initial denial of your claim, nor will it be a subordinate of that individual. You will be notified of the decision of the Committee within 45 days after the receipt of your appeal. If the Committee determines that additional time is necessary, you will be notified in writing within the initial 45-day period of the special circumstances requiring the extension and the date by which the Committee expects to resolve your claim. In no event will the extension exceed 45 days. The decision of the Committee shall be final and binding upon all parties, unless you voluntarily elect to appeal to the Board of Directors.
- **Voluntary Third Appeal to the Board of Directors** – If your disability claim is denied by the Committee, you may, but are not required to, appeal to the Board of Directors to have your claim reconsidered for payment. You may appeal to the Board of Directors only after you have appealed to the National Director and to the Committee. Your appeal must be filed within 180 days of the day you receive notice that your claim has been denied by the Committee. Any statute of limitations or other defense based on timeliness is tolled during the time that your appeal to the Board of Directors is pending, and the Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to appeal to the Board of Directors. If you elect to appeal to the Board of Directors, the decision of the Board of Directors shall be final and binding upon all parties. Additional information about appealing to the Board of Directors is available upon written request to the Plan Administrator.

VII. AMENDMENT AND TERMINATION

The Plan may be amended or deleted by written action of the Board of Directors when, in its judgment, such action shall be necessary. The Board of Directors expressly reserves the right to amend any benefits hereunder and eligibility rules for all benefits. The Board's determination concerning the administration, application, and interpretation of the Plan shall be binding on all persons subject to the provisions contained in the Plan.

VIII. PLAN ADMINISTRATION

- **Named Fiduciary** – The persons serving on the Board of Directors shall be the named fiduciaries for purposes of ERISA.
- **Authority of the Board of Directors** – The Board of Directors has the authority to delegate and/or determine any question arising in connection with the administration, interpretation and application of the language in the Plan, including any question regarding eligibility for benefits and the right to participate as a Member. A majority of members of the Board of Directors at the time of office may perform any act which the Plan authorizes or requires the Board of Directors to do, and the action of such majority of the Board members expressed by a vote at a meeting, or in writing without a meeting, shall constitute the action of the Board of Directors and shall have the same effect for all purposes as if assented to by all the Board members at the time in office. In administration of the Plan, the Board of Directors may: (1) employ agents to carry out non-fiduciary responsibilities; (2) employ agents to carry out fiduciary duties (other than Trustee responsibilities defined in ERISA Section 405(c)(3)); (3) consult with counsel; (4) appoint an investment manager (as defined by ERISA Section 3(38)) to manage, including the power to acquire and dispose of, all or any past of the assets of the Plan; (5) provide for the allocation of fiduciary responsibilities (other than Trustee responsibilities defined in ERISA Section 405(c)(3)) among Board members; (6) purchase such liability and casualty insurance as it deems appropriate, and (7) such other actions it deems appropriate, in its sole discretion, to administer the Plan. The Board of Directors shall be entitled to rely upon all tables, valuations, certificates and reports furnished by an actuary selected by the Board of Directors, and upon all opinions given by any legal counsel selected by the Board of Directors, and the Board of Directors and each member thereof shall be fully protected with respect to any action taken or suffered by them in good faith in reliance upon such actuary, accountant or counsel. The Plan Sponsor shall indemnify

the Board of Directors and each member thereof, to the extent permitted by applicable law, against all loss, liability and expense occasioned by any act, or omission to act, taken or determined upon by it, him or her, except any such act or omission which is due to willful misconduct, fraud or bad faith.

- **Applicable Law** – The provisions of the Plan shall be construed, administered and enforced according to the laws of the United States of America, insofar as they may be applicable, and otherwise according to the laws of the state of New Hampshire. Accidental death & dismemberment benefits may be subject to state insurance laws.
- **Plan Assets** – The assets of the Plan are to be held in trust and invested by the Board of Directors for the benefit of Members. The Board of Directors' duties and responsibilities are set forth in the ABA Constitution and the Plan. All contributions to the Plan shall be committed in trust in accordance with the ABA Constitution and the Plan, to be held, managed and disposed of by the Board of Directors in accordance with the ABA Constitution and the Plan. No Member or former Member shall have any legal or equitable right or interest in the funds received or held under the Plan, or in any assets of the Plan, except as expressly provided for in the Plan, and no Member shall be deemed to possess a right to share in any monies except as herein provided.
- **Funding Policy** – The Board of Directors shall adopt a funding policy and methods and shall review such funding policy and method on a semi-annual basis. If the Board appoints an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan, authority over and responsibility for the management of the assets to designate shall be the responsibility of the investment manager or managers.
- **Legal Action** – No action at law or in equity shall be brought to recover hereunder prior to the expiration of 180 days after written proof of loss has been furnished in accordance with requirements of the Plan. No such action shall be brought after the expiration of three years and sixty days after the time written proof of loss is required to be furnished, nor shall it be brought unless you have exhausted all of your rights under the Plan. Notwithstanding the foregoing time periods, this Plan shall not extend the statute of limitations period of any jurisdiction which shall further limit the time periods for legally making claims against the Plan for benefits. Claims not noticed, proved, or prosecuted as above provided will be forfeited. Nothing in this provision shall abridge your rights under ERISA.

IX. STATEMENT OF ERISA RIGHTS

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 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 Plan 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 Plan. The people who operate the 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 may 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 Plan 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.

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.

X. PLAN INFORMATION

Plan Name
American Postal Workers Accident Benefit Association Plan

Plan Sponsor
American Postal Workers Accident Benefit Association

Plan Sponsor's EIN
02-0181885

Plan Number
501

Type of Plan
Disability and Accidental Death & Dismemberment Plan

Type of Administration
Self-Administration and Insurer Administration

Plan Administrator
American Postal Workers Accident Benefit Association
Board of Directors
P.O. Box 120
Rochester, NH 03866
(603) 330-0282

Agent for Service of Legal Process
Service of legal process may be made on the Plan Administrator.

Sources of Contributions
Member premiums are collected and deposited into a general fund. The fund shall be for the sole purpose of paying the expenses of the Plan.

Disability benefits are self-funded. Member premiums are collected and deposited into a general fund. Accidental death & dismemberment benefits are underwritten by:

Sun Life and Health Insurance Company
175 Addison Road
Windsor, CT 06095

A copy of the accidental death & dismemberment certificate is available at no charge by writing to the Plan Administrator. Accidental death & dismemberment benefits may be subject to state insurance laws.

Plan Year
January 1-December 31

Claims Administrator
For Death and Dismemberment Claims:
Sun Life and Health Insurance Company
175 Addison Road
Windsor, CT 06095
For Disability Claims:
Claims Administrator
American Postal Workers Accident Benefit Association
P.O. Box 120
Rochester, NH 03866
(603) 330-0282