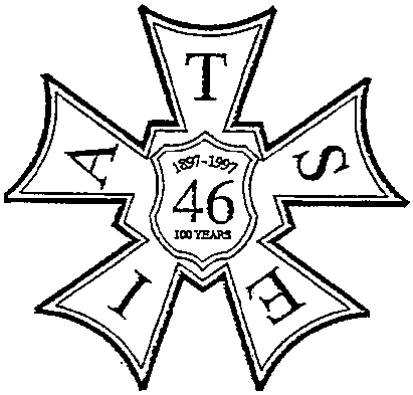
I.A.T.S.E. LOCAL 46 STAGE EMPLOYEES



UNDERSTANDING

YOUR

UNION BENEFIT PLANS

JANUARY, 2006
(revised December 2015)

I.A.T.S.E. LOCAL 46 STAGE EMPLOYEES

UNDERSTANDING YOUR UNION BENEFIT PLANS

Overview

The Trustees of your Union Benefit Plans have developed this booklet to help you understand your benefits, rights and obligations under each benefit Plan.

Six (6) Trustees -Three (3) Union members elected by you and three (3) Employer Representatives oversee the administration of each Benefit Plan. These Trustees have no direct affiliations with your local Union or the International Union. Their sole purpose is to work to ensure that your benefits are secure and the Plan meets all applicable legal requirements..

Current Board of Trustees:

Flexible Plan -Union Representatives:

Patrick Hutchison

Mike Gilbert

Todd Davis

Pension Plan -Union Representatives:

Patrick Hutchison
Mike Gilbert
Todd Davis

Employer Representatives:

Andrew Telles,
Freeman Decorating Company

Nick Stamler,
Geo. E. Fern Decorating Company

Megan Jones,

CP Rigging

This summary creates no rights. Instead, the provisions of the Plan documents govern your benefits. A complete understanding of your rights under the Benefit Plans can only be obtained by referring to the Plan documents. If you have any questions, which are not answered fully in this document, please contact:

I.A.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

I.A.T.S.E. LOCAL 46 STAGE EMPLOYEES

UNDERSTANDING YOUR UNION BENEFIT PLANS

Frequently Asked Questions

Benefits are available under the following I.A.T.S.E. Local 46 Stage Employees Plans:

A. Flexible Benefits Plan (the **Flex Plan).** The Flex Plan has three (3) major components; Health and Welfare, 401 (k) Retirement Savings, Vacation and Sick / HSA Reimbursements.

B. Pension Benefit Plan (the **Pension Plan)**

This section addresses several frequently asked questions regarding your Health and Welfare, 401 (k) Retirement, Vacation and Sick Pay, and Pension Benefits.

Additional information about these benefits can be found in the summary plan descriptions in the appendices to this document. You should review the summaries carefully, so that you understand the provisions of the Benefit Plans. If there is a conflict between the Plans and summaries, the terms of the Plan documents will control. You should direct any questions to your Union Representatives. There are complete Benefit Plan documents on file at the offices of LA.T.S.E. Local 46, which you may review, if you desire. The terms of the Benefit Plans and this document may change at any time.

Flex Plan

Q. **What are the components of the Flex Plan?**
A. Health and Welfare; 401 (k) Retirement Savings, Vacation and Sick / HSA Reimbursements

Health and Welfare Plan

Q. **What can I use my Health and Welfare account for?**
A. The primary purpose of the Flex Plan is to fund participants' major insurance through Employer contributions to the Health and Welfare account. Employer contributions are made according to applicable Collective Bargaining Agreements and allocated among employee Accounts, according to your hours of service.

Q. What other forms of insurance may I select with my Health and Welfare benefit contributions?

A. Additional insurance may be available to you as long as you have funds Available in your Health and Welfare account. We have established payment procedures to facilitate your purchasing coverage under disability, cancer, life insurance, accident, dental, vision and intensive care insurance group policies through the Flex Plan.

Q. Will I be reimbursed for medical expenses not covered under the medical plan?

A. You may be reimbursed for your out-of-pocket medical expenses, through an HSA if you qualify. You may use it for:

* Co-payments and deductibles
* Dental expenses
* Vision expenses
* Hearing related expenses and aids
* Laboratory charges and x-rays
* Hospital and nursing services
* Prescription drug expenses
* Transportation costs to obtain medical care
* Long term care services
* Chiropractic therapy

The general rule of thumb is you may be reimbursed for expenses you could claim as medical expenses, under the Medical Expense Section of IRS Form 1040, Schedule B. Reimbursements are limited to the funds available in your Account. Reimbursements for medical premiums outside of our major medical group policy are not eligible.

Q. When am I eligible to participate?

A. If you are a member in "good standing" with I.A.T.S.E. Local 46, you are eligible to become a Participant in the Health and Welfare plan on the same date you are eligible to have contributions to the Health and Welfare Plan made on your behalf by your Employer. To remain eligible, unless you are a retired or disabled member, you must be employed at least one (1) day, per year, by an Employer who is a party to a I.A.T.S.E. Local 46 Collective Bargaining Agreement.

Q. How much money goes into each Flex Plan account?

A. Your Health and Welfare account balance has to be at least two thousand dollars ($2,000) for the preceding three (3) months, before

you can direct the percentage division of the Employer contributions deposited to your Flex Plan account among the three (3) major components.

Example: After maintaining a balance of at least two thousand dollars ($2,000) in your Health and Welfare account for three (3) months, you , may direct one hundred percent (100%) of the monies deposited in your Flex Plan account to be deposited in your 401 (k) Savings Plan account. This election remains in place until you change it. Or until the balance falls below $2000 at which time the percentage will be reset to 100% H&W.

To change your percentage division of Employer contributions, contact:

Denise Houchin, Plan Administrator
LA.T.S.E.Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

Q. **What if I do not maintain a balance of at least two thousand dollars ($2,000) in my Health and Welfare account?** '

A. If you fail to meet the two thousand dollar ($2,000) threshold or you drop below that amount at any time during the preceding three (3) months the Flex Plan sets the percentage division for you as follows:

One Hundred percent (100%) of your Flex Plan account balance is directed into your Health and Welfare account.

Q. **May I direct all contributions to my Health and Welfare account?**

A. You may opt to have one hundred percent (100%) of Employer contributions directed to your Health and Welfare account in order to pay for your medical insurance–no matter what balance you have in your Account. To change your percentage division of Employer contributions, request an application from Jennifer Black, Plan Administrator, (615) 885-1063.

Q. **Can I self-pay into my Health and Welfare account to keep my insurance?**

A. No, the H&W plan is classified as an HRA (Health Reimbursement Account) the IRS rules pertaining to these type of plans state the funds are to come 100% from the employer.

Q. **What happens to my Health and Welfare benefits if I quit working for I.A.T.S.E. Local 46?**

A. Failure to participate in the Flex Plan, or having no Employer contributions made on your behalf for a period of twelve (12) months, causes any remaining funds in your Accounts to be forfeited. Working just one (1) day a year will prevent purging. This does not apply to retired or disabled members.

Q. **Can I move money from any other account to my Health and Welfare account?**

A. No, you may not transfer funds deposited in one account to another account.

Q. **When may I change my percentage allocation among the three** (3) **benefit accounts?**

A. You may change the percentage allocation of your Employer contributions during the semi-annual election period. The semi-annual election period is held each June and January. Otherwise, you may change your percentage allocation if you have a "qualifying event". Qualifying events include; a change in employment, marriage, divorce, and death. To determine whether you may make benefit elections due to a qualifying event, contact: Jennifer Black, Plan Administrator, who will provide the alternate election form you must execute.

Q. **Who can change my percentage allocation among my accounts?**

A. No changes to your designated percentage allocation will be made, unless you request such changes or your Account balance drops below the required two thousand dollar ($2,000) threshold at which time the Plan administrator will change you percentage allocation back to 100% H&W.

Supplementary Insurance

Q. **How can I enroll for the supplementary insurance coverage that you make available?**

A. Currently, various types of supplemental insurance are offered through group policies with AFLAC, Colonial as well as Blue Cross Blue Shield. You must contact these carriers directly to elect supplementary insurance coverage, the types and coverage amounts of which are determined by you and the carriers. The Flex Plan pays for all supplementary insurance you elect, as long as you have funds available in your Account. Contact; Jennifer Black, Plan Administrator, for more information regarding supplementary insurance benefits.

Q. **Are there limits on my life insurance coverage amounts?**

A. The federal government limits your maximum tax-free life insurance benefit to fifty thousand dollars ($50,000). You may opt to divide this maximum amount (e.g., twenty-five thousand dollars ($25,000) coverage for you and twenty-five dollars ($25,000) for your spouse). Our current medical insurance carrier includes a ten thousand dollar ($50,000) term life policy covering you, the premiums for which are included in your medical premium.

Medical Reimbursements

Q. How do I get reimbursed for my out-of-pocket expenses?

A. All reimbursement for out of pocket expenses will be paid for out of a Health Saving Account (HSA) if you are eligible to participate. Unless you have funds in your H&W account prior to Jan. 2014. Those funds are still available for reimbursement through the H&W plan. You may contact Jennifer Black in the office to get your pre 2014 balance.

Q. **What do I have to do to qualify for the HSA?**

A. You must maintain a two thousand ($2000) balance in your H&W account and participate in a High Deductible Health Insurance Plan (HDHP).

Q. **How much can I contribute to my HSA annually?**

A. The maximum annual contribution is determined by the IRS and depends on whether you have individual coverage or family coverage.

Q. **What medical expenses can I be reimbursed for?**

A. Remember to submit reimbursement requests only for expenses that legally qualify as tax deductible; otherwise, the reimbursement request will not be paid. As Plan Trustees, we confer with our law firm on issues regarding requests for reimbursement.

Q. **How much can I be reimbursed for?**

A. The maximum amount for which you may be reimbursed, per year, is based on your HSA balance. If you are utilizing pre-2014 funds you are limited to a maximum of $7500 annually.

Q. **Do the funds in my HSA carry over from year to year?**

A. Yes, the funds in your HSA carry over from year to year and belong to you. Even if you Retire or no longer work for I.A.T.S.E. Local 46.

401 (K) Retirement Savings Plan

Q. **How do I contribute money to my 401 (k) Retirement Savings account?**

A. Once you become a Participant in the Flex Plan and are able to maintain the $2000 minimum balance in your H&W account you may opt to have a percentage of your Employer contributions directed to a 401 (k) Retirement Savings account.

Q. **What is a 401 (k) Retirement Savings account?**

A. As with any 401 (k) plan, those monies are there to supplement any retirement income received through Social Security and your Union Pension benefit.

Q. **Can I use funds held in my 401 (k) Retirement Savings account for any other purpose?**

A. Funds in your 401 (k) Retirement Savings account are available to you before retirement in limited circumstances, but early withdrawals are subject to a ten percent (10%) penalty. Under federal law, reasons for allowable early withdrawals include:

* Catastrophic illness costs
* First home purchase
* Prevention of foreclosure on your home
* Education expenses for you and members of your immediate Family

Early withdrawals from your Account must be requested on a properly signed and dated form. The Trustees notify the IRS of all such early withdrawals, and you are responsible for any resulting taxes and penalties. You may elect to have the bank that processes the check withhold the ten percent (10%) penalty required on all early withdrawals.

Q. **Must I pay taxes on money distributed from my 401 (k) Retirement Savings account?**

A. Because the 401 (k) Retirement. Savings Plan is tax qualified, your obligation to pay tax on the value of contributions is deferred. For federal tax purposes, 401 (k) Retirement Savings benefits you receive (including earnings on contributions) will be treated as ordinary income in the year in which you receive a distribution from the 401 (k) Retirement Savings Plan. Your Employer may deduct from its taxable income the contributions it makes to the 401 (k) Retirement Savings Plan, each year.

Generally, twenty percent (20%) of your distribution is withheld for payment of federal income taxes, unless you elect a "direct rollover", or the distribution is not eligible for "direct rollover" treatment. If you receive a distribution when you are under the age of fifty nine and one half (59 1/2,), you will be liable for an additional ten percent (10%) tax, unless your distribution is after death, disability or retirement at age fifty-five (55), or later.

Because individual situations vary and federal tax laws change frequently, you should consult with your tax advisor regarding the federal, state and local tax consequences of participating in the 401 (k) Retirement Savings Plan.

Q. **Are there additional penalties for early withdrawals?**

A. Your contributions to the 401 (k) Retirement Savings Plan are suspended for six (6) months, following an early hardship withdrawal. During this period of suspension, you must redirect the Employer contributions that would have been deposited into your 401 (k) Retirement Savings account into other accounts.

Q. **Can I take the funds in my 401 (k) Retirement Savings account with me, if I change employment?**

A. If you terminate employment for any reason other than retirement, death or disability and your 401 (k) Retirement Savings account is one thousand dollars ($1,000), or less you will receive a lump sum payment of your vested benefit following your change of employment. If your vested account balance is greater than one thousand dollars ($1,000), it may be "rolled over" upon your change of employment into your new employer's 401 (k) account or an individual retirement account (IRA). Otherwise, you generally may leave your 401 (k) Retirement Savings account balance intact with us following your change of employment until your subsequent retirement, death or disability.

Q. **When am I eligible for benefits under the 401 (k) Retirement Savings Plan?**

A. You (or your beneficiary), if appropriate may request payments from your 401 (k) Retirement Savings account upon your retirement, death or disability. All applicable taxes are your responsibility.

Vacation and Sick Reimbursements

Q. **How do I get my vacation/sick pay?**

A. On a monthly basis, you may request vacation pay/vacation expenses and any lost pay due to illness. This benefit will be paid directly to you, by filing a properly signed and dated form. If Approved, payment in an amount between one hundred dollars ($100) and your entire vacation/sick account balance are made within ten (10) business days after the end of the month in which the request was submitted.

Note: The "net amount" you will receive will be affected by the fact you are paying both the Employer and employee taxes on this request.

Q. **How do I contribute money to this account?**

A. Once you become a Participant in the Flex Plan and are able to maintain the $2000 minimum balance in your H&W account you may opt to have a portion of the Employer contributions directed to a Vacation Plan account.

Pension Plan

Q. **When am I eligible to participate in the Pension Plan?**

A. You are eligible to participate after you have completed one (1) year of service in which at least eight hundred fifty dollars ($850) has been contributed for you under the Collective Bargaining Agreement with or for the Union. For periods prior to January 1, 2006, you are eligible to participate after you have completed one (1) year of service in which you worked at least seventy-five (75) days under the Collective Bargaining Agreement with or for the Union.

Q. **If I terminate employment with I.A.T.S.E Local 46, can I withdraw funds from my Pension Plan that were contributed on my behalf by my Employer?**

A. The Pension Plan requires you to have completed five (5) years of vesting service to be eligible for a withdrawal from the Pension Plan. You earn a year of vesting service for each year during which at least eight hundred fifty dollars ($850) is contributed for you to the Plan. For periods prior to January 1, 2006, you earn a year of vesting service for each year in which you worked at least one hundred (100) days. Withdrawals from the Plan must be in the form of a monthly benefit at retirement. However, if the present value of your benefit is less than one thousand dollars ($1,000) when you end your employment, you can take the withdrawal as a single lump sum, if you are vested.

Q. **If I am single, may I leave my pension benefit to my children?**

A. No, under the terms of the Pension Plan, only those individuals who are spouses or are legally married to a Participant are eligible beneficiaries.

Q. **Am I eligible for pension benefits if I retire early?**

A. Yes, upon reaching age fifty-five (55) and having completed ten (10) years of service, you are eligible for reduced retirement benefits.

Q. **Can I move funds in my Pension Plan account to another l.A.T.S.E Local 46 benefit account, or vice-versa?**

A. No, because the Pension Plan is a "defined benefit pension plan".

Q. **How much money will I receive when I retire?**

A. Your benefits will depend upon your length of service with I.A.T.S.E. Local 46. You will receive a benefit equal to forty-five dollar ($45) for each year of service prior to 2009, if your contributions were at the maximum contribution level for that year. After 2009 the benefit is equal to twenty two dollars and fifty cent ($22.50) The current maximum contribution level is two thousand two hundred dollars ($2,200). If there is more than ($2,200) contributed you will be paid pro-rata any amount over the max.

Example: Your Employer contributes less than the current maximum of two thousand two hundred dollars ($2,200) on your behalf. If you received our current trade show agreement rate of eight dollars ($8.50), per day, multiplied by one hundred ninety (190) days worked, your Employer contribution would be one thousand six hundred fifty dollars ($1,650). You would receive a credit of .73 of a benefit year for the one thousand six hundred fifty dollars ($1,650) (1,650 divided by 2,200), because you did not meet the maximum possible contribution of one thousand nine hundred dollars ($2,200).

The maximum rate is set by the Pension Board, with directions from the consulting Actua1y firm.

APPENDIX A

I.A.T.S.E. LOCAL 46 STAGE EMPLOYEES

FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION

Introduction

The I.A.T.S.E. Local 46 Stage Employees Flexible Benefits Plan (referred to herein as the "Flex Plan") was established to make health, welfare and retirement savings available to members of l.A.T.S.E. Local 46, who are employed by Employers who have entered into Collective Bargaining Agreements with I.A.T.S.E. Local 46. This summary tells you important information about the Flex Plan.

You should review this summary carefully so that you understand the provisions of the Benefit Plans. If there is a conflict between those Plans and this summary, the terms of the Benefit Plan documents will control. You should direct any questions to your Union Representatives. There are complete Benefit Plan documents on file at the offices of I.A.T.S.E. Local 46, which you may review if you desire. The terms of the Benefit Plan and this document may change at any time.

How the Plan Works

The Flex Plan allows the employees who are covered by the Collective Bargaining Agreements and on whose behalf contributions are required to be made by the contributing Employers to the I.A.T.S.E. Local 46 Stage Employees Health and Welfare Plan and Trust (the "Welfare Plan") and the I.A.T.S.E. Local 46.Stage Employees Savings Plan and Trust (the "Savings Plan") the flexibility to direct which portion of the contributing Employers' contributions will be made to the Welfare Plan and to the 401k/ Savings Plan. You can only receive benefits from a Plan, if you have an account balance in that Plan.

Your Employer will automatically make your contributions to the Flex Plan on your behalf. These amounts will be used to pay for the benefits you have chosen under the Welfare Plan and the Savings Plan. The portion of your benefit wages that are paid to the Flex Plan is not immediately subject to federal income withholding taxes. The taxation of the benefits you receive through the Flex Plan depends on the benefits you elect. Tax matters are discussed below.

Eligibility

You become eligible to participate in the Flex Plan when you maintain an account balance in the Welfare Plan of at least two thousand dollars ($2,000). To direct which portion of your contributions will be made to the Welfare Plan and to the Savings Plan, you must prove to the Administrator that you have health insurance coverage in effect and that your premiums have been paid. If your account balance in the Welfare Plan falls below two thousand dollars ($2,000), your participation in the Flex Plan will be suspended, and amounts that would otherwise be contributed to the Flex Plan on your behalf will be redirected to your Welfare Plan account, until your balance in that account again reaches two thousand dollars ($2,000).

Contributions

Your Employer contributes to your Flex Plan account each pay period. The amount contributed is stated in the Collective Bargaining Agreement. These amounts are contributed to the Welfare Plan and/or Flex Savings Plan in the amounts or percentages you elect each year. You elect the benefits for which the contributions are to be used.

You are required by federal law to make elections for benefits before the Plan Year begins, normally during an open enrollment period. The open enrollment period is determined by the Administrator of the Flex Plan. You must decide at that time how much of your benefit wages should go to each option in the Flex Plan. An election form is provided to you by the Administrator.

You cannot change the elections you have made during an open enrollment period except in limited circumstances. You are permitted to change your elections if there is a change in status. Currently, federal law consider the following events to be examples of a · change in status:

* You get married or divorced
* You have a child or adopt one
* You spouse or child dies
* Your spouse commences or terminates employment
* Your or your spouse's employment status changes in a manner that causes you or your spouse to lose coverage
* You or your spouse taken an unpaid leave of absence
* Your spouse has a change in health coverage
* You or a dependent becomes eligible for coverage under Medicare or;
* Significant changes are made to the benefits available under the Flex Plan

Any election change must be consistent with the reason that such change was permitted.

If you have a change in status, you should contact the Administrator, who will provide you with the required forms for changing your benefit elections. The Administrator may require that you provide proof of a change in status.

For insurance premiums being paid from the Flex Plan, the Administrator may adjust the amount you have elected to contribute for the remainder of the Plan Year, if there is a change in the premium expense, without any action by you.

If the Administrator determines, before or during any Plan Year, that your account balance in the Welfare Plan will fall below two thousand dollars ($2,000) the Administrator shall take such action as the Administrator deems appropriate, which may include a modification of your elections with or without your consent.

For each new Plan Year, you may change the elections that you previously made. If you do not make new elections for the new Plan Year, your elections that were in effect for the prior Plan Year will remain in effect.

Benefits

You can elect benefits under the Welfare Plan and/or the Savings Plan with the benefit wages that are contributed for you to the Flex Plan. The specific benefits available to you are determined by and described in those Plan documents and in Appendices B through D.

Medical Reimbursements

Within the Flex Plan, you can choose to make contributions to an Health Savings Account (HSA) from which you can pay for Medical Expenses described in Section 213 of the Internal Revenue Code that are not covered by your insurance. Examples of expenses include: ·

* Your health or dental insurance deductibles and co-pays
* Chiropractic therapy
* Long-term care services
* Prescription drugs
* Nursing services
* Diagnostics
* Artificial teeth and limbs
* Medical supplies, such as wheelchairs or crutches
* The cost of transportation to obtain medical care
* Prescription nutritional supplements
* Hearing aids
* Hospital services and supplies
* Laboratory charges
* X-rays
* Eyeglasses
* Institutional care expenses

Termination of Participation

Your participation in the Flex Plan will terminate when:

* The Flex Plan itself is terminated

* You cease to be eligible to participate in the Flex Plan, for example; because of a resignation of employment. ·

Claims for Benefits

You must file a written claim for benefits in the manner required by the Administrator when you become eligible to receive payments. If you die or become disabled, proof of death or disability must be submitted to the Administrator in order to receive benefits. It is necessary that you cooperate with the Administrator to prevent any hindrance or delay in the payment of claims. Failure on your part to complete any forms required by the Administrator may delay receipt of your benefits.

Claims must be filed with the Administrator within one hundred eighty (180) days of the date incurred. The Administrator will provide notice of any adverse benefit determination and will tell you if and why any other information is needed to process your claim for benefits. The notice will include the following information:

* The specific reason or reasons for the adverse determination

* Reference to the specific Plan provisions on which the determination was based

* 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

* A description of the Plan's review procedures, and the time limit applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following an adverse benefit determination on review

* 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

This notice will be sent to you within ninety (90) days of your claim, unless special circumstances require an extension of time. If an extension is required, you will be sent a notice telling you why it is needed and the date the Administrator expects to make its' decision. The maximum extension is ninety (90) days. If your claim is denied, you must follow the appeal process that is outlined below to seek reconsideration:

* If you receive notice of denial of benefits, you must appeal to the Administrator in writing within sixty (60) days. If you do not receive a written notice of denial within ninety (90) days after filing your claim for benefits, you may assume that your claim has been denied and may file your written appeal. If you do not file your appeal within sixty (60) days, the original decision of the Administrator will become final.

* The Administrator will review the matter and may, but is not required to, hold a hearing in which you are present. On review, you may use legal assistance and you may examine pertinent Plan documents. You may also submit issues and arguments in writing.

* The Administrator will then re-examine all the facts and come to a final decision as to whether the denial of benefits was justified. You will be notified of the decision within sixty (60) days of the time you submit your written appeal, unless the Administrator determines that a longer period of time is necessary, in which case you will be notified no later than one hundred twenty (120) days, following the receipt of such request. The notice of final decision will include specific reasons for the decision and identify the Plan provisions on which the Administrator relied.

General Provisions

Trust Fund

All contributions to the Flex Plan are held in a trust fund administered and invested by the Trustee according to the Flex Plan and Trust Agreement. The monies in the trust fund, including investment income, must be used exclusively for the benefit of the Plan Participants and their beneficiaries.

Changes in or Termination of the Plan

LA.T.S.E. Local 46 and the Employers intend to continue this Flex Plan indefinitely. However, since future conditions cannot be foreseen, LA.T.S.E. Local 46 and the Employers reserve the right to change or terminate the Plan at any time. Even if the Plan is changed or terminated, no part of the trust fund may be used for any purpose, other than the benefit of Welfare Plan Participants and their beneficiaries. If the Plan is terminated, the trust fund (less any taxes or administrative expenses) will be paid to the Participants according to the balance of their accounts.

Plan Administration Procedures

The Administrator is the administrator of the Plan. I.A.T.S.E. Local 46 and the Employers each appoint members of the Administrator. The Administrator is responsible for making all rules necessary to administer the Plan and for deciding questions concerning your rights under the Plan. Such questions include eligibility, value of accounts and right to benefits. The Administrator is vested with full authority and discretion to interpret and enforce all Plan provisions, including making determinations as to eligibility for benefits. Benefits under the Welfare Plan will be paid only if the Administrator decides in its' discretion that the applicant is entitled to them. All decisions of the Administrator are final, binding and conclusive on all persons.

If you have questions regarding the Plan, you can contact the Administrator at the following:

Administrator of the I.A.T.S.E. Local 46 Stage Employees Flex Plan
c/o LA.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1063
Facsimile: (615) 885-5165

A Trustee has been appointed to hold the assets under the trust and to facilitate the investment of assets under the trust. The Trustee is:

First State Trust Co

Wilmington, DE 19803

Other Information You Should Know

No Insurance of Minimum Plan Benefits

Benefits under the Plan are paid out of the trust. Your benefits under the Plan are determined by the size of your Account balance. Therefore, the trust fund is not insured by the Pension Benefit Guarantee Corporation, the agency established by ERISA to provide minimum pension insurance for some type of retirement plans.

Plan Year: January I to December 31

Plan Number: 501

APPENDIX B

HEALTH AND WELFARE

SUMMARY PLAN DESCRIPTION

Introduction

The LA.T.S.E. Local 46 Stage Employees Health and Welfare Plan and Trust (the "Welfare Plan") was established effective January 1, 1981, in order to make certain health and welfare benefits available to members of LA.T.S.E. Local 46 Stage Employees. The Welfare Plan provides medical, dental, disability, vacation and sick pay benefits.

This summary is intended to provide an explanation of how the Welfare Plan works. However, should any conflict arise between this summary and the provisions of the Welfare Plan, or if any provision is not described in this summary or is only partially described, the terms of the Welfare Plan document will govern.

You should read this summary carefully. If you have any questions, ask the Administrator for an answer.

How the Plan Works

The benefits provided under the Welfare Plan are made available to you through the LA.T.S.E. Local 46 Flexible Benefits Plan (the "Flex Plan"). You should refer to the Plan description of the Flex Plan for a summary of how the Flex Plan works. Amounts directed to the Welfare Plan through the Flex Plan will be used to pay for the benefits you can choose under the benefit options described below.

Eligibility

If you are a member in "good standing" of LA.T.S.E. Local 46, you are eligible to become a Participant in the Welfare Plan on the same day you are eligible to have contributions to the Welfare Plan made on your behalf by your Employer. See "Employer Contributions", below. To remain eligible, you must be employed one (I) day, per year, by an Employer under a LA.T.S.E. Local 46 Collective Bargaining Agreement, with the exception of those members who are retired or disabled, as described more fully in the Welfare Plan document.

Eligible Dependents

Eligible dependents are your spouse, unmarried children under the age of nineteen (19), children under the age of twenty-three (23), who are full time students in an accredited school, and dependents who are physically or mentally incapable of self-support.

Benefits

Funds that have been contributed for you may be used for any of the benefit options listed below. The premium for each one selected will be paid directly or reimbursed to you from an Account maintained in your name. Detailed descriptions of each policy's coverage are included in the schedule of benefits that is provided by the respective insurance companies. I.A.T.S.E. Local 46 and your employer may change insurance carriers or the options available to you at any time. The benefit options currently available are:

* Major medical insurance (with optional group term life insurance), with Blue Cross/ Blue Shield

* Cancer and/or intensive care insurance with American Family Life Assurance

* Accident, sickness, disability and group term life insurance with Colonial Life & Accident Insurance Company

* Medical Expense Payments: You may be eligible to participate in an Health Savings Account (HSA) if you at able to maintain a two thousand ($2000) balance in your H&W account and participate in a High Deductible Health Plan (HDHP). The HSA is funded through contributions made to your Flex Account.

* Dental and Vision insurance with Blue Cross/Blue Shield.

Contributions and Accounts

Employer Contributions

Your Employer will make contributions on your behalf to the Flex Plan, based on its' Collective Bargaining Agreement with I.A.T.S.E. Local 46. A portion of these contributions are allocated to your Account in the Welfare Plan.

Your Contributions

Employer contributions are based on the number of hours you work with I.A.T.S.E. Local 46. If your hours are low for a period, there may not be enough money in your Welfare Plan account to pay the premium for health insurance coverage you have elected. If this happens, the Administrator will notify you and you will be given the opportunity to continue participation via COBRA. If you do not pay the amount needed when you have been notified of the cost, the policy may lapse or be cancelled, according to the terms of the policy. You cannot make a contribution to the Flex Plan or to the Savings Plan.

Benefit Payments

The Welfare Plan will pay your insurance premiums directly from your Account to the insurance company.

If you choose to use part of your Employer's contribution to make contributions to a HSA. You must submit your transfer of funds on the forms provided by the Administrator.

Death Benefit

In the event of your death, any money left in your Account (after all premiums and fees due on your behalf have been paid from your Account) will be paid to your beneficiary. You must indicate who your beneficiary will be on the forms provided by the Administrator.

Forfeiture of Account

Except in certain cases involving your retirement, disability or approved leave of absence, if no contributions are made to the Welfare Plan on your behalf during a Plan Year, then at the end of that Plan Year, the balance in your Account will be forfeited. Forfeited employee account balances are used first to pay the administrative expenses of operating the Plan and then are divided up among the remaining Active Participants' Accounts.

Claims for Benefits

You must file a written claim for benefits in the manner required by the Administrator when you become eligible to receive payments. If you die or become disabled, proof of death or disability must be submitted to the Administrator in order to receive benefits. It is necessary that you cooperate with the Administrator to prevent any hindrance or delay in the payment of claims. Failure on your part to complete any forms required by the Administrator may delay receipt of your benefits.

Claims must be filed with the Administrator within one hundred eighty (180) days of the date incurred.. The Administrator will provide notice of any adverse benefit determination and will tell you if and why any other information is needed to process your claim for benefits. The notice will include the following information:

* The specific reason or reasons for the adverse determination
* Reference to the specific Plan provisions. on which the determination was based
* 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

* A description of the Plan's review procedures, and the time limit applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following an adverse benefits determination on review

* 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

This notice will be sent to you within ninety (90) days of your claim, unless special circumstances require an extension of time. If an extension is required, you will be sent a notice telling you why it is needed and the date the Administrator expects to make its' decision. The maximum extension is ninety (90) days. If your claim is denied, you must follow the appeal process that is outlined below to seek reconsideration:

* If you receive notice of denial of benefits, you must appeal to the Administrator in writing within sixty (60) days. If you do not receive a written notice of denial within ninety (90) days, after filing your claim for benefits, you may assume that your claim has been denied and may file your written appeal. If you do not file your appeal within sixty (60) days, the original decision of the Administrator will become final

* The Administrator will review the matter and may, but is not required to, hold a hearing in which you are present. On review, you may use legal assistance and you may ·examine pertinent Plan documents. You may also submit issues and arguments in writing

* The Administrator will then re-examine all the facts and come to a final decision, as to whether the denial of benefits was justified. You will be notified of the decision within sixty (60) days of the time you submit your written appeal, unless the Administrator determines that a longer period of time is necessary, in which case you will be notified no later than one hundred twenty (120) days, following the receipt of such request. The notice of final decision will include specific reasons for the decision and identify the Plan provisions on which the Administrator relied.

General Provisions

Trust Fund

All contributions to the Welfare Plan are held in a trust fund administered and invested by the Trustee, according to the Welfare Plan and Trust Agreement. The money in the trust fund, including investment income, must be used exclusively for the benefit of Plan Participants and their beneficiaries.

Changes in or Termination of the Plan

I.A.T.S.E. Local 46 and the Employers intend to continue this Welfare Plan indefinitely. However, since future conditions cannot be foreseen, I.A.T.S.E. Local 46 and the Employers reserve the right to change or terminate the Plan at any time. Even if the Plan is changed or terminated, no part of the trust fund may be used for any purpose other than the benefit of Welfare Plan Participants and their beneficiaries. If the Plan is terminated, the trust fund (less any taxes or administrative expenses) will be paid to the Participants according to the balance of their Accounts.

Plan Administration Procedures

The Administrator is the administrator of the Plan. LA.T.S.E. Local 46 and the Employers each appoint members of the Administrator. The Administrator is responsible for making all rules necessary to administer the Plan and for deciding questions concerning your rights under the Plan. Such questions include eligibility, value of accounts and right to benefits. The Administrator is vested with full authority and discretion to interpret and enforce all Plan provisions, including making determinations as to eligibility for benefits. Benefits under the Welfare Plan will be paid only if the Administrator decides in its' discretion that the applicant is entitled to them. All decisions of the Administrator are final, binding and conclusive on all persons.

If you have questions regarding the Plan, you can contact the Administrator at the following:

Administration of l.A.T.S.E. Local 46 Stage Employees Health and Welfare Plan and Trust
c/o LA.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

A Trustee has been appointed to hold the assets under the trust and to facilitate the investment of assets under the trust. The Trustee is:

First State Trust Co.

Wilmington, DE.

Other Information You Should Know

No Insurance of Minimum Plan Benefits.

Benefits under the Plan are paid out of the Trust. Your benefits under the Plan are determined by the size of your Account balance. Therefore, the trust fund is not insured by the Pension Benefit Guarantee Corporation, the agency established by ERISA to provide minimum pension insurance for some types of retirement plans.

Plan Year: January 1 to December 31

Plan Number: 501

APPENDIX C

VACATION AND SICK REIMBURSEMENTS

SUMMARY PLAN DESCRIPTION

Introduction

The I.A.T.S.E. Local 46 Stage Employees Health and Welfare Plan and Trust (the "Welfare Plan") was established effective January 1, 1981, in order to make certain health and welfare benefits available to members of I.A.T.S.E. Local 46. The Welfare Plan provides; medical, dental, disability, vacation and sick pay benefits.

This summary is intended to provide an explanation of how the Welfare Plan works. However, should any conflict arise between this summary and the provisions of the Welfare Plan, or if any provision is not described in this summary or is only partially described, the terms of the Welfare Plan document will govern.

You should read this summary carefully. If you have any questions, ask the Administrator for an answer.

How the Plan Works

The benefits provided under the Welfare Plan are made available to you through the I.A.T.S.E. Local 46 Flexible Benefits Plan (the "Flex Plan"). You should refer to the Plan description of the Flex Plan for a summary of how the Flex Plan works. Amounts directed to the Welfare Plan through the Flex Plan will be used to pay for the benefits you can choose under the benefit options described below.

Eligibility

If you are a member in "good standing" of I.A.T.S.E. Local 46, you are eligible to become a participant in the Welfare Plan on the same day you are eligible to have contributions to the Welfare Plan made on your behalf by your Employer. See "Employer Contributions", below. To remain eligible, you must be employed one (1) day, per year, by an Employer under an I.A.T.S.E. Local 46 Collective Bargaining Agreement, with the exception of those members who are retired or disabled, as described more fully in the Welfare Plan document.

Eligible Dependents

Eligible dependents are your spouse, unmarried children, under the age of nineteen (19), children under the age of twenty-three (23) who are full time students in an accredited school, and dependents who are physically or mentally incapable of self-support.

Benefits

Detailed descriptions of each policy's coverage are included in the schedule of benefits that is provided by the respective insurance companies. I.A.T.S.E. Local 46 and your Employer may change the benefits available to you at any time. The benefits currently available are:

* Vacation benefits or expenses
* Unable to work, due to sickness or injury
* Health Savings Account (HSA).

Forfeiture of Account

Except in certain cases involving your retirement, disability or approved leave of absence, if no contributions are made to the Welfare Plan on your behalf during a Plan Year, then at the end of that Plan Year the balance in your Account will be forfeited. Forfeited employee account balances are used first to pay the administrative expenses of operating the Plan and then are divided up among the remaining Participants' Accounts.

Claims for Benefits

You must file a written claim for benefits in the manner required by the Administrator when you become eligible to receive payments. If you die or become disabled, proof of death or disability must be submitted to the Administrator in order to receive benefits. It is necessary that you cooperate with the Administrator to prevent any hindrance or delay in the payment of claims. Failure on your part to complete any forms required by the Administrator may delay receipt of your benefits.

Claims must be filed with the Administrator within one hundred eighty (180) days of the date incurred. The Administrator will provide notice of any adverse benefit determination and will tell you if and why any other information is needed to process your claim for benefits. The notice will include the following information:

* The specific reason or reasons for the adverse determination

* Reference to the specific Plan provisions on which the determination was based

* 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

* A description of the Plan's review procedures, and the time limit applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following an adverse benefits determination on review

* 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

This notice will be sent to you within ninety (90) days of your claim, unless special circumstances require an extension of time. If an extension is required, you will be sent a notice telling you why it is needed and the date the Administrator expects to make its' decision. The maximum extension is ninety (90) days. If your claim is denied, you must follow the appeal process that is outlined below to seek reconsideration:

* If you receive notice of denial of benefits, you must appeal to the Administrator in writing within sixty (60) days. If you do not receive a written notice of denial within ninety (90) days, after filing your claim for benefits, you may assume that your claim has been denied and may file your written appeal. If you do not file your appeal within sixty (60) days, the original decision of the Administrator will become final

* The Administrator will review the matter and may, but is not required to, hold a hearing in which you are present. On review, you may use legal assistance and you may examine pertinent Plan documents. You may also submit issues and arguments in writing

* The Administrator will then re-examine all the facts and come to a final decision, as to whether the denial of benefits was justified. You will be notified of the decision within sixty (60) days of the time you submit your written appeal, unless the Administrator determines that a longer period of time is necessary, in which case you will be notified no later than one hundred twenty (120) days, following the receipt of such request. The notice of final decision will include specific reasons for the decision and identify the Plan provisions on which the Administrator relied.

General Provisions

Changes in or Termination of the Plan

I.A.T.S.E. Local 46 and the Employers intend to continue this Welfare Plan indefinitely. However, since future conditions cannot be foreseen, I.A.T.S.E. Local 46 and the Employers reserve the right to change or terminate the Plan at any time. Even if the Plan is changed or terminated, no part of the trust fund may be used for any purpose other than the benefit of Welfare Plan Participants and their beneficiaries. If the Plan is terminated, the trust fund (less any taxes or administrative expenses) will be paid to the Participants according to the balance of their accounts.

Plan Administration Procedures

The Administrator is the administrator of the Plan. I.A.T.S.E. Local 46 and the Employers each appoint members of the Administrator. The Administrator is responsible for making all rules necessary to administer the Plan and for deciding questions concerning your rights under the Plan. Such questions include eligibility, value of accounts and right to benefits. The Administrator is vested with full authority and discretion to interpret and enforce all plan provisions, including making determinations as to eligibility for benefits. Benefits under the Welfare Plan will be paid only if the Administrator decides in its' discretion that the applicant is entitled to them. All decisions of the Administrator are final, binding and conclusive on all persons.

If you have questions regarding the Plan, you can contact the Administrator at the following:

Administration of l.A.T.S.E. Local 46 Stage Employees Health and Welfare Plan and Trust
c/o l.A.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

A Trustee has been appointed to hold the assets under the trust and to facilitate the investment of assets under the trust. The Trustee is:

First State Trust Co.

Wilmington, DE.

Other Information You Should Know

No Insurance of Minimum Plan Benefits.

Benefits under the Plan are paid out of the Trust. Your benefits under the Plan are determined by the size of your Account balance. Therefore, the trust fund is not insured by the Pension Benefit Guarantee Corporation, the agency established by ERISA to provide minimum pension insurance for some types of retirement plans.

Plan Year: January 1 to December 31

Plan Number: 501

APPENDIX D

401 (K) RETIREMENT SAVINGS PLAN

SUMMARY PLAN DESCRIPTION

Introduction

This is a summary of your benefits, rights and obligations under the I.A.T.S.E. Local 46 Stage Employees Saving Plan (the "Plan"). The Plan is funded through a trust fund, known as the I.A.T.S.E. Local 46 Stage Employees Savings Plan Trust (the 'Trust"). This summary is designed to answer your questions about how the Plan and Trust work. A table of contents at the front of this summary will help you find the answers to particular questions. Cross-references, examples and a glossary have been included to help you understand the explanations of the Plan. Capitalized terms are defined in this document.

The Plan was established effective June 4, 1992, to provide certain retirement benefits to members of l.A.T.S.E. Local 46, whose Collective Bargaining Agreement requires the Employer to contribute a portion of their wages to a retirement plan on their behalf. This Plan is provided through the Flex Plan. Any such contributions to the Plan on your behalf are made on a pre-tax basis. You may name a beneficiary to receive your Plan benefits, if you should die.

This summary is intended to comply with the summary plan description requirements of the Employee _Retirement Income Security Act of 1974 ("ERISA") and the regulations issued there under by the United States Department of Labor. It is not a complete description of all the provisions of the Plan. This summary creates no rights. Instead, the provisions of the Plan and the trust documents govern all benefits and control over any statement in this summary and any other written document or oral statement that concerns the Plan. A complete understanding of your rights under the Plan and trust can only be obtained by referring to the Plan and trust documents.

As is more fully explained below, the Plan and the trust may be amended or terminated at any time. All statements in this summary are subject to change at any time, according to changes made to the Plan and the trust. The statements contained in this summary are intended to only apply to the Plan, as it exists at the time this summary is printed.

How the Plan Works

The Plan was established by LA.T.S.E. Local 46 to help provide for your future economic security. If you are eligible, contributions to the Plan will be made on your behalf as further explained below. Contributions are invested under the trust, as described below.

LA.T.S.E. Local 46 and the Employers have established the Plan with the intention of maintaining it indefinitely. Nonetheless, LA.T.S.E. Local 46 and the Employers have collectively retained the right to amend or terminate the Plan at any time. The benefits you have accrued on the date of such amendment or termination cannot be reduced. The Plan can be amended by the Administrator. Any amendment must be in writing that is approved or ratified by the Administrator. Notice of the Plan's amendment or termination is not required to be given before it is effective.

Eligibility

Generally, you become a Participant if you are a regular employee of an Employer whose Collective Bargaining Agreement with LA.T.S.E. Local 46 calls for your Employer to make contributions to the Plan on your behalf. These contributions are referred to as "pay deferral contributions". You may check with LA.T.S.E. Local 46 to learn how these rules apply to you.

You may elect to make a "rollover contribution" to the Plan before you are otherwise eligible to become a Participant in the Plan.

After you have become a Participant in the Plan, your "pay deferral contributions" will commence after you complete the enrollment process that is established by the Administrator. To make a "rollover contribution" to the Plan, you must follow the procedures established by the Administrator.

Contributions and Accounts

All contributions to the Plan will be credited to a bookkeeping "Account" in the trust. Your benefit in the Plan will be determined by the amount in this Account. You will be given a form to complete in order to name a beneficiary to receive any benefits payable after your death. If you are married, your surviving spouse will automatically be your beneficiary, unless your spouse has consented in writing to your designation of someone else as your beneficiary. For your spouse's consent to be effective, his or her signature must be witnessed by a member of the Administrator or a notary public. You will also be asked to file your current address and that of your beneficiary with the Administrator.

There are two (2) ways that contributions can be made to the Plan:

Pay Deferral Contributions. If required by your Collective Bargaining Agreement, contributions of the percentage or dollar amount of your wages set forth in the Collective Bargaining Agreement will be made to the Plan on your behalf, each pay period. These "pay deferral contributions", and earnings on investments under the trust, are not taxed for federal income tax purposes, until the time you actually receive a distribution from the Plan.

Rollover Contributions. If you were a participant in another tax-qualified plan, you may transfer amounts under that plan to the Plan, with the consent of the Administrator, if certain legal requirements are satisfied. Rollover contributions can be made after you commence employment, whether or not your Employer is making "pay deferral contributions" on your behalf. There are three (3) types of rollovers:

* **Rollover of Distribution.** If you have received a distribution from a tax-qualified plan of a previous employer, you may generally roll the amounts over to the Plan within sixty (60) days of the date you received the distribution. If the Trustee of your prior plan withheld taxes on your distribution, you may be permitted to add other funds to the net payment you received so that one hundred percent (100%) of your distribution is rolled into the Plan.

* **Direct Rollover.** In most cases, amounts that you can receive from another tax-qualified plan may be directly rolled over to the Plan. You should ask the Administrator of the other plan for instructions on making a "direct rollover" to the Plan. The Trustee of the prior plan will not be required to withhold taxes on your distribution, if you use the "direct rollover" method.

* **IRA Rollover.** Amounts held in an individual retirement account ("IRA") that were received in a distribution from a tax-qualified plan of a previous Employer, including a "direct rollover", can be rolled into the Plan, if no other amounts have been commingled in the IRA with the Plan distribution.

You should contact the Administrator, if you desire to make a rollover into the Plan.

Legal Limits on Contributions to Your Account

There are several IRS limitations on contributions to the Plan. First, the amount of all contributions and forfeitures (if any) that can be allocated to your Account in a Plan Year is the lesser of (i) one hundred percent (100%) of your annual pay, or (ii) forty-two thousand dollars ($42,000) (subject to cost of living adjustments by the IRS). Second, the federal government limits the amount of "pay deferral contributions" that can be made each year by any Participant. This limit is eighteen thousand dollars ($18,000) for 2015 (subject to cost of living adjustments by the IRS). Third, IRS regulations limit the amount of contributions that your Employer may deduct for tax purposes. Contributions to the Plan may not exceed this deduction limit, generally fifteen percent (15%) of all compensation.

If you are a "Highly Compensated Employee" your "pay deferral contributions" may be limited in accordance with IRS nondiscrimination rules. The Administrator may unilaterally reduce your "pay deferral contribution" election for all or part of a Plan Year, in order to avoid violating these nondiscrimination rules. If excess contributions do occur, the Administrator may refund them to you as taxable compensation.

Benefits

Your benefits under the Plan will consist of payments to you or, if you die, to your beneficiary of the full amount of your Account balance in the Plan. Your Account balance includes the amounts allocated to you due to contributions and any related earnings or losses in investments. Your benefits will rise or fall according to the investment performance of the trust. See "Benefit Payments" below for information regarding when and how your benefits will be paid.

Generally, you are entitled to receive your Plan benefits when you retire, become disabled, die or terminate employment. To obtain benefits that are payable before age sixty- two (62), you or your beneficiary must first file a claim for benefits in the manner prescribed by the Administrator.

If you retire, die or become disabled, payment of your benefits will begin as soon as administratively feasible after the date that payment of your benefit is approved. Normal retirement age is sixty-two (62). If you terminate employment for any other reason and your Account is one thousand dollars ($1,000) or less, you will receive a lump sum payment as soon as administratively feasible after termination. Ifyour Account is greater than one thousand dollars ($1,000), you may request payment at any time. Otherwise, your Account will continue to be invested through the trust until you reach age sixty-two (62). When you reach age sixty-two (62), your benefits will be paid out as soon as administratively feasible after the date that payment of your benefit is approved. While your Account balance remains in the Plan, it will continue to share in the earnings and losses of the trust.

Your Account may remain in the Plan past age sixty-two (62), if you are still employed by your Employer. Payment of your Account must begin no later than April 1", following the calendar year in which you attain age seventy and one half (70 1/2*)* or, if later, the year that you terminate employment. You may also obtain a distribution in certain other circumstances while you are employed, as explained below.

Benefit Payments

When you become eligible for a distribution from the Plan, your benefit will automatically be paid in the manner you or your beneficiary select. In the alternative, you may elect a "direct rollover". A rollover is a payment of your Plan benefits to an IRA or another tax-qualified employer retirement plan. A "direct rollover" is a payment of your distribution by the Trustee directly to the Trustee of another tax-qualified plan or an IRA. If you decide you do not want a "direct rollover", your distribution may be subject to federal income tax withholding at the rate of twenty percent (20%).

You or your beneficiary may select to receive your distribution from the Plan under one of the following methods:

* By payment in a single lump sum

* By payment in time period installments -in level monthly, quarterly, semi-annual or annual installments, over a specified period of years, not in excess of twenty (20) years; provided, however, that no installment period may be selected which would result in a periodic payment of less than fifty dollars ($50.00). Upon your death, after distributions commence under this option, your beneficiary, if then living, may similarly elect to receive installments over not more than five (5) years or in a lump sum, and upon the beneficiary's subsequent death, the balance, if any, of your Account shall be paid in a lump sum to the estate of the beneficiary. Any expenses incurred as a result of the selection of this option are charged to your Account.

* By payment in level dollar installments – in level monthly, quarterly, semi-annual or annual installments of the amounts selected by you or your beneficiary, payable until there is no balance remaining. The total annual amount of any such installments must equal not less than ten percent (10%) of your Account; provided, however, that no installment period may be selected which would result in a periodic payment of less than fifty dollars ($50.00). Upon your death after distributions commence under this option, your beneficiary shall receive the balance in your Account, in a lump sum. Any expenses incurred as a result of the selection of this option are charged to your Account.

If you die, your Account will be paid to the beneficiary you have named. If you have not named a beneficiary, any benefits due will be paid to your spouse, your children or your estate, in that order. If your beneficiary is someone other than your surviving spouse, however, your spouse must give written consent to your beneficiary designation. Your spouse's signature on the consent must be witnessed by a member of the Administrator or a notary public. Your beneficiary (and, in certain case, the representative of your estate) will be allowed to select from the methods of payment described above.

If you or your beneficiary become mentally incompetent, or if your beneficiary is a minor child, the Administrator may pay your share of the trust or any benefits payable after your death to a guardian, a relative, or a friend to be used for your benefit or your beneficiary's benefit.

Federal Taxation of Benefits

The Plan was established by I.A.T.S.E. Local 46 as a retirement plan that is qualified under Section 40l(a) of the Internal Revenue Code. As the Plan is tax-qualified, your obligation to pay tax on the value of contributions made by you or your Employer is deferred. For federal tax purposes, Plan benefits you receive (including earnings on contributions) will be treated as ordinary income in the year in which you receive a distribution from the Plan. The amount of your "pay deferral contributions" will, however, be subject to Social Security taxes in the year deferred. Your Employer may deduct from its' taxable income the contributions it makes to the Plan, each year.

Generally, twenty percent (20%) of your distribution is withheld for payment of federal income taxes unless you elect a "direct rollover", or the distribution is not eligible for "direct rollover" treatment. Your actual tax rate may be different than the twenty percent (20%) withholding rate. If you receive a distribution when you are under the age of fifty nine and one half (59 1/2), you will be liable for an additional ten percent (10%) tax, unless your distribution is after death, disability or retirement at the age of fifty-five (55) or later.

This is a brief summary of the federal income tax consequences applicable to contributions under the Plan. You will also receive general tax information at the time you are eligible for a distribution from the Plan. Because individual situations vary and federal tax laws change frequently, you should consult with your tax advisor regarding the federal, state and local tax consequences of participation in the Plan.

Benefit Withdrawals During Employment

You may make a withdrawal while you are employed, if the withdrawal is due to financial hardship. To qualify for a hardship withdrawal, you must have an immediate and heavy financial need and have no other reasonably available resources with which to meet that need. The Administrator will determine at its' discretion whether and to what extent such a hardship withdrawal may be made. The types of needs that can qualify for a hardship withdrawal include; certain medical expenses, purchase of your principal residence (but excluding regular mortgage payments), payment of college education for you and certain family members, and avoiding eviction or foreclosure on your principal residence. Distribution of "pay deferral contributions" are taxable and may be subject to a ten percent (10%) penalty tax, if you are under the age of fifty nine and one half (59 1/2). If you make a hardship withdrawal, you may not make "pay deferral contributions" to the Plan for the six (6) month period following the hardship withdrawal.

Claims for Benefits

Initial Claims

You do not have to file a claim for benefits, if you terminate employment and the balance of your Account is less than one thousand dollars ($1,000). Otherwise, you must file a written claim for benefits as prescribed by the Administrator when you become eligible to receive payments. If you die or become disabled, proof of death or disability must be submitted to the Administrator in order to receive benefits. However, if you do not file a claim for benefits, the Administrator will notify you at your last known address that you are entitled to receive benefits when it so determines this fact. It is important to keep your address current with LA.T.S.E. Local 46, even after you retire or terminate employment.

Appeals

The Administrator will send you a written explanation if it denies your claim for benefits, setting forth the specific reason or reasons for the denial, specific reference to pertinent Plan provisions upon which the denial is based and an explanation of your rights with regard to the claims review procedure. The Administrator will also tell you if and why any other information is needed to process your claim for benefits. This notice will be sent to you within ninety (90) days of your claim, unless special circumstances require an extension of time. If an extension is required, you will be sent a notice telling you why it is needed and the date the Administrator expects to make its' decision. This information may be provided to you electronically. The maximum extension is ninety (90) days. For your convenience, the appeal process is outlined below:

* After you receive notice of denial of benefits, you must appeal to the Administrator in writing within sixty (60) days. If you do not receive a written notice of denial within ninety (90) days after filing your claim for benefits, you may assume that your claim has been denied and may file your written appeal. If you do not file your appeal within sixty (60) days, the original decision of the Administrator will become final.

* You may include in your written appeal any reasons for appeal and any information to support your right to benefits. You may use legal assistance in preparing the written appeal and you may examine any related Plan documents. You may also review pertinent documents.

* The Administrator will then re-examine all the facts and come to a final decision, as to whether the denial of benefits was justified. You will be notified of the decision within sixty (60) days of the time you submit your written appeal, unless the Administrator determines that a longer period of time is necessary, in which case you will be notified no later than one hundred twenty (120) days, following the receipt of such request. The notice of final decision will include specific reasons for the decision and identify the Plan provisions on which the Committee relied.

Reduced or Lost Benefits

Under certain circumstances, your benefits may be reduced or suspended.

Unclaimed Accounts. If you or your beneficiary fail to make a claim for benefits, or if you and your and beneficiary have not provided a current address to the Administrator after payment becomes due, the Administrator will attempt to locate you under IRS procedures. If you cannot be located within the time prescribed by law for abandonment of property to the state, your Account will be treated as a forfeiture to the Plan.

Withdrawals. If you have made any withdrawals, your benefits will not include those amounts.

Investment Losses. Your benefits under the Plan are determined solely by the amounts in your Account at the time you become entitled to payment. Your benefits will be reduced, if the Trust experiences investment losses.

General Provisions

Changes in or Termination of the Plan

As stated above, I.A.T.S.E. Local 46 and the Employers intend to continue the Plan, but may change or terminate the Plan at any time. You will be notified of any important changes.

Plan Administration Procedures

The Administrator is the administrator of the Plan. LA.T.S.E. Local 46 and the Employers each appoint members of the Administrator. The Administrator is responsible for making all rules necessary to administer the Plan and for deciding questions concerning your rights under the Plan. Such questions include eligibility, value of accounts and right to benefits. The Administrator is vested with full authority and discretion to interpret and enforce all Plan provisions, including making determinations as to eligibility for benefits. Benefits under the Welfare Plan will be paid only if the Administrator decides in its' discretion that the applicant is entitled to them. All decisions of the Administrator are final, binding and conclusive on all persons.

If you have questions regarding the Plan, you can contact the Administrator at the following:

Administration of l.A.T.S.E. Local 46 Stage Employees Savings Plan
c/o LA.T.S.E Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

An Investment Committee may be appointed to administer the investments of the Plan and to interact with the investment advisors to the Plan and the Trustee. If no Committee is appointed; then the Administrator shall serve as the Investment Committee. The Investment Committee has many of the same authorities as the Administrator, but its' role is limited to matters directly involving the investment of the Plan assets. The Investment Committee may be contacted in the same manner as the Administrator.

A Trustee has been appointed to hold Plan assets under the trust and to facilitate the investment of assets under the trust. The Trustee is:

First State Trust Co.

Wilmington, DE. 19803

Other Information You Should Know

No insurance of minimum Plan benefits.

Benefits under the Plan are paid out of the trust. Your benefits under the Plan are determined by the size of your Account balance. Therefore, the trust fund is not insured by the Pension Benefit Guarantee Corporation, the agency established by ERISA to provide minimum pension insurance for some types of retirement plans.

Plan Year: January 1 to December 31

Plan Number: 002

APPENDIX E

PENSION PLAN

SUMMARY PLAN DESCRIPTION

Introduction

This is a summary of your benefits, rights and obligations under the I.A.T.S.E. Local 46 Pension Plan and Trust (the "Plan"). This summary is designed to answer your questions about how the Plan works.

This summary is intended to comply with the summary plan description requirements of ERISA and the regulations issued there under by the United States Department of Labor. It is not a complete description of all the provisions of the Plan. This summary creates no rights. Instead, the provisions of the documents govern all benefits and control over any statement in this summary and any other written document or oral statement that concerns the Plan. A complete understanding of your rights under the Plan can be obtained only by referring to the Plan documents.

As is more fully explained below, the Plan may be amended or terminated at any time. All statements in this summary are subject to change at any time, according to changes made in the Plan. The statements contained in this summary are intended to only apply to the Plan, as it exists at the time this summary is printed.

How the Plan Works

This Plan is a "defined benefit pension plan". Defined benefit pension plans specify how the amount of your retirement benefit will be calculated. Your Plan is intended to be a qualified retirement plan under the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. Because the Plan is a "defined benefit plan", the Pension Benefit Guarantee Corporation guarantees limited benefit payments (see "Plan Termination").

This Plan is maintained subject to a Collective Bargaining Agreement between the Union and participating Employers. A copy of any such agreement may be obtained, upon written request, to the Board of Trustees or applicable Employer. A list of Employers participating under the Plan and their addresses is maintained by the Board. You may obtain information from the Board, regarding participating Employers and contact information at the following address:

Administrator of the I.A.T.S.E. Local 46 Stage Employees Pension Plan
c/o I.A.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

The Plan is funded through Employer contributions. The amount of Employer contributions and the employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreement.

Eligibility

You are eligible to enter the Plan, after you have completed one (1) year in which at least six hundred dollars ($800) is contributed on your behalf under the Collective Bargaining Agreement with the Union or for the Union. For periods prior to January 1, 2006, you are eligible to enter the Plan after you have completed one (1) year in which you work at least seventy-five (75) days under the Collective Bargaining Agreement with the Union or for the Union. Entry occurs on the first of January or July, after the one (1) year entry period.

You will stop being a participant if you:

* Quit Work
* Cease working under the Collective Bargaining Agreement with or for the Union
* Have less than eight hundred ($800) dollars contributed to the Plan for you during the year

If your participation ends, you can return to the Plan after you again complete one (1) year of service in which at least eight hundred ($800) dollars is contributed on your behalf under the Collective Bargaining Agreement with the Union or for the Union.

Benefits

Normal Retirement Benefit

Normal retirement occurs at age sixty-five (65). Upon retirement, you will receive a monthly benefit equal to twenty-two dollars and fifty cents ($22.50) multiplied by your years of credited service.

Early Retirement Benefit

You are eligible for early retirement benefits, if you are at least age fifty-five (55) and have ten (I0) years of service when you retire. Early retirement benefits are calculated under the same formula.

Early retirement benefits in the amount described above can begin at age sixty-two (62). You may, however, choose to receive an actuarially reduced benefit beginning before age sixty-two (62). The amount of the actuarial reduction varies by age; the earlier you retire before reaching age sixty-two (62), the more your benefit is reduced. The reduction is approximately eighteen percent (18%) at age sixty (60),and as much as forty-seven percent (47%) at age fifty-five (55).

Death Benefit

If you die while married and are eligible for normal retirement, early retirement or vested benefit, your spouse will be eligible to receive a monthly death benefit. No death benefit is paid if you are not married at the time of your death.

Your spouse will receive the same benefit that would have been paid if you had retired on the day before your death, begun to receive a joint or fifty percent (50%) survivor retirement benefit, and then died. If you are not eligible for early or normal retirement when you die, benefit payment will not begin until the date on which you would have reached early or normal retirement age.

When you become eligible to begin receiving retirement benefits, you may elect a form of payment that will continue after your death. You may elect a joint and survivor annuity, where a portion of your benefit (either fifty percent (50%), seventy-five percent (75%) or one hundred percent (100%), as you elect), will continue to your beneficiary after your death. This beneficiary must be selected before payments begin and cannot be changed once payments have begun. The reduction in your benefit for this option will depend on your age and the age of your beneficiary.

You may also elect a form of payment where payments will continue to your beneficiary if you die before the end of the "guarantee period". The "guarantee period" is either sixty (60), one hundred twenty (120) or one hundred eighty (180) months, as you elect. If you die before the end of the "guarantee period", payments will continue to your beneficiary until the end of the period. For this type of benefit, you may elect any individual or entity (e.g., a charity) as your beneficiary. If you are married, your spouse must agree in writing to allow someone else to be your beneficiary. Your spouse's signature on the consent form must be witnessed by a member of the Administrator, or notary public.

Service **Credit**

You earn one (1) full year of service credit for each year in which contributions are made for you to the Plan totaling one thousand nine hundred dollars ($1,900). For periods prior to January 1, 2006, you earn one (I) full year of service credit for each year in which you are credited with the "highest daily amount", the amount that could be contributed for a participant under the highest negotiated agreement contribution rate for two hundred (200) days. One hundred fifty (150) days, prior to January 1, 1996.

For periods prior to January 1, 2006, you cannot earn more than one (1) year of service credit during a calendar year. Beginning January 1, 2006, you can earn more than one (1) year of service during a calendar year, if more than the one thousand nine hundred dollars ($1,900) is contributed for you during the Plan Year.

If you are credited with less than the maximum contribution amount for any year, you will be credited with a proportionately lower benefit amount for that year. However, for the Plan Years beginning on or after January 1, 2006, you will not earn any benefits for Plan Years during which contributions made for you total less than six hundred dollars ($600). However, if contributions made for you total less than six hundred dollars ($600) in the year you retire (either normal retirement or early retirement), you will receive a partial benefit amount for that year, based on your contributions for the year divided by the maximum amount for the year.

Vesting

If you quit work before you reach early retirement age, you will not be entitled to any benefits, unless you are vested. To be vested you must have been credited with at least five (5) years of vesting service.

To earn one (1) year of vesting service you must have at least eight hundred dollars ($800) contributed on your behalf during the year (for periods prior to January 1, 2006, you must have worked at least one hundred (100) days during the year). Contributions in excess of eight hundred dollars ($800) (on days in excess of one hundred (100) for periods prior to January 1, 2006) are not counted for vesting purposes. You can have two (2) or more years combined to total eight hundred dollars ($800) in contributions (or one hundred (100) days worked) for a credit of one (1) year, if you were considered a Participant of the Plan during those years.

Benefit Payments

Joint and Survivor Annuity. If you are married when you begin to receive retirement benefits, your monthly benefits will be lower, usually by about twelve percent (12%) than the formula amount described above, but will be paid as a ".joint and fifty percent (50%) survivor annuity". This means that if you die, your spouse will receive a death benefit equal to one half (l/2) the amount you were receiving before you died, for the rest of your spouse's life. If you prefer to receive a different payment form and to drop or change the survivor death benefit, you may elect the other form of payment, if your spouse agrees, Your spouse must sign (in person) if you elect to not utilize the joint and survivor annuity. You may choose from the following optional forms of payment:

* Joint and survivor annuity with fifty percent (50%), seventy-five percent (75%) or one hundred percent (100%) continuing to your spouse after your death; or

* Life annuity with a guarantee of sixty (60), one hundred twenty (120) or one hundred eighty (180) payments, if you die before the end of the "guarantee period"

Lump Sum. If the benefit you have earned is worth five thousand dollars ($5,000) or less when you quit working, you can choose to have the value of your benefit paid in a single sum. If the value of the benefit you have earned is less than one thousand dollars ($1,000), the value of your benefit will be paid in a single lump sum.

You must have accumulated five (5)years of service credit to receive a lump sum payment.

Claims for Benefits

The Board of Trustees has established two (2) sets of procedures for presenting claims for benefits. One (1) set of procedures is for retirement benefits, death benefits and general claims. The other set of procedures is for disability benefits only.

FAILURE TO FOLLOW THE PROCEDURES EXPLAINED IN THIS SECTION WITHIN THE REQUIRED TIME PERIODS WILL RESULT IN THE LOSS OF YOUR RIGHT TO SUE IN COURT.

Retirement Benefits, Death Benefits and General Claims

If you have a general claim or want to begin payment of retirement or death benefits, you, your beneficiary or an authorized representative should notify the Board and the Plan Administrator will provide you with the necessary forms. (For retirement, you should request the forms about twelve (12) months before your expected retirement date).

The Plan Administrator will review the claim based on the terms of the Plan and will apply the rules of the Plan consistently to similarly situated claimants. If the claim is wholly or partially denied, the Plan Administrator must notify the claimant of the adverse decision within a reasonable period of time, but no later than ninety (90) days after the Plan Administrator receives your completed claim form. If the Plan Administrator determines that an extension of the time for processing the claim is needed, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the ninety (90) day period, after the filing of the claim. The extended period may not exceed one hundred eighty (180) days, after the date of the filing of the claim.

A notice of a benefit denial will be provided in written electronic form. The notice will provide the following information, written in a manner to be understood by the claimant:

* The specific reason or reasons for the denial

* Reference to the specific Plan provisions on which the denial is based

* A description of any additional information necessary for the claim to be granted and, an explanation of why such information is necessary

* A description of the Plan's claim review procedures, the time limit under the procedure and a statement regarding the claimant's right to bring a civil action under ERISA 502 (a) following a benefit denial appeal

* A statement that the claimant will lose his or her right to sue, if the claimant fails to file a timely appeal with the Board

Upon receipt of the notice above, the claimant may appeal to the Board. The claimant has sixty (60) days, following receipt of the notice of the denial, in which to file an appeal of the decision. The claimant may submit written comments, documents, records and other information related to the benefit claim on appeal.

The claimant may request, free of charge, access to and copies of all documents, records and other information relevant to the benefit claim (a document, record, or other information is·considered relevant to the claim if it; (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; or (iii) demonstrates compliance in making the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated claimants). The review on appeal will consider all comments, documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination.

The Board must notify the claimant of the appeals decision (whether adverse or not) within a reasonable period of time, but no later than sixty (60) days after the Plan's receipt of the appeal.

If the Board determines that an extension of time for processing the claim is needed, the Board must notify the claimant of the reasons for the extension and the extended due date before the end of the sixty (60) day period after the filing of the appeal. The extended period may not exceed one hundred twenty (120) days, after the date of the filing of the appeal.

Notice of a benefit determination on appeal must be provided in written or electronic form. If the claim is denied, the notice must provide the following information, written in a manner to be understood by the claimant:

* The specific reasons for the benefit denial

* Reference to the specific Plan provisions on which the determination was based

* A statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim (a document, record, or other information is considered relevant to the claim if it; (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; or (iii) demonstrates compliance in make the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated claimants).

Disability Benefits

If you have a claim regarding a disability, you, your beneficiary or an authorized representative should notify the Board and the Plan Administrator will provide you with the necessary forms.

The Plan Administrator will review the claim based on the terms of the Plan and will apply the rules of the Plan consistently to similarly situated claimants. If the claim is wholly or partially denied, the Plan Administrator must notify the claimant of the adverse decision within a reasonable period of time, but no later than forty-five (45) days after the Plan Administrator receives your completed claim form. If the Plan Administrator determines that an extension of the time for processing the claim is needed, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the forty-five (45) day period, after the filing of the claim. The extended period may not exceed seventy-five (75) days, after the date of the filing of the claim. If the Plan Administrator determines that a second extension of time for processing the claim is needed, due to matters beyond the control of the Plan, the Plan Administrator must notify the claimant of the reasons for the extension and the extended due date before the end of the seventy-five (75) day period after the filing of the claim. The second extended period may not exceed one hundred five (105) days, after the date of the filing of the claim. Any notice of extension must explain to the claimant the standards on which an entitlement to a disability benefit under the Plan is based and the unresolved issues that prevent a decision on the claim and must describe any additional information that is needed to resolve the issues and give the claimant forty-five (45) days from the date of the receipt of the notice to submit the information. If additional information is requested, the time period for making a benefit decision is tolled from the date on which the notice is sent to the claimant until the date the claimant responds to the request.

A notice of a benefit denial will be provided in written or electronic form. The notice will provide the following information, written in a manner to be understood by the claimant:

* The specific reason or reasons for the denial
* Reference to the specific Plan provisions on which the denial is based
* A description of any additional information necessary for the claim to be granted and, an explanation of why such information is necessary
* A description of the Plan's claim review procedures, the time limits under the procedure and a statement regarding the claimant's right to bring civil action under ERISA 502(a) following a benefit denial on appeal
* A statement that the claimant will lose his/her right to sue if the claimant fails to file a timely appeal with the Board; and

* If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant, upon request

Upon receipt of the notice described above, the claimant may appeal to the Board for a review. The claimant has one hundred eighty (180) days following receipt of the notice of the denial in which to file an appeal of the decision. The claimant may submit written comments, documents, records and other information related to the benefit claim on appeal.

The claimant may request, free of charge, access to and copies of all documents, records and other information relevant to the benefit claim (a document, record, or other information is considered relevant to the claim if it; (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; or (iii) demonstrates compliance in make the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated claimants). The review on appeal will consider all comments, documents, records and other information submitted by the claimant, without regard to whether such information was submitted or considered in the initial benefit determination. The review on appeal must not defer to the initial adverse benefit determination and may not be conducted by the individual who made the initial adverse determination nor the subordinate of such individual. In deciding an appeal of any benefit determination that is based in whole or in part on a medical judgment, the Board must consult with a health care professional, who has appropriate training and experience in the field of medicine involved in the medical judgment ("health care professional" includes a physician or other health care professional licensed, accredited, or certified to perform specified health services under state law). The health care professional engaged with respect to the review of the claim on appeal may not be an individual who was consulted in connection with the initial adverse benefit decision nor the subordinate of such individual. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim (even if the advice was not relied upon in the benefit determination) must be identified.

The Board must notify the claimant of the appeals decision (whether adverse or not) within a reasonable period of time, but no later than forty-five (45) days after the Plan's receipt of the appeal. If the Board determines that an extension of the time for processing the claim is needed, the Board must notify the claimant of the reasons for the extension and the extended due date before the end of the sixty (60) day period, after the filing of the appeal. The extended period may not exceed ninety (90) days, after the date of the filing of the appeal.

Notice of a benefit determination on appeal must be provided in written or electronic form. If the claim is denied, the notice must provide the following information, written in a manner to be understood by the claimant:

* The specific reason or reasons for the benefit denial

* Reference to the specific Plan provisions on which the determination was based

* A statement that the claimant is entitled to receive, upon request and free of charge, access to and copies of all documents, records and other information relevant to the benefit claim (a document, record, or other information is considered relevant to the claim if it; (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; or (iii) demonstrates compliance in make the benefit decision with the requirement that the benefit determinations must follow the terms of the Plan and be consistent when applied to similarly situated claimants).

* If applicable, a copy of the internal rule, guideline or protocol that was relied upon to make the adverse determination or a statement that such rule was relied upon and that a copy of such rule will be provided free of charge to the claimant, upon request; and

* If the benefit denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge to the claimant, upon request

General Provisions

Change in or Termination of the Plan

I.A.T.S.E. Local 46 and the Employers intend to continue this Pension Plan indefinitely. However, since future conditions cannot be foreseen, I.A.T.S.E. Local 46 and the Employers reserve the right to change or terminate the Plan at any time. In case of Plan termination, your benefit rights become fully vested, to the extent funded, and any assets held by the Plan in excess of those needed to provide all Plan Participants their accrued benefits may be returned to the Union.

Benefits under *this* Plan are insured by the Pension Benefit Guaranty Corporation (the "PBGC"), a federal insurance agency. If the Plan terminates without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their Plan, but some people may lose certain benefits.

The PBGC guarantee generally covers (i) normal and early retirement benefits; (ii) disability benefits, if you become disabled before the Plan terminates; and (iii) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (i) benefits greater than the maximum guaranteed amount set by Jaw for the year in which the Plan terminates; (ii) some or all of benefit increases and new benefits based on Plan provisions that have been in place for fewer than five (5) years, at the time the Plan terminates; (iii) benefits that are not vested, because you have not worked long enough for the employer; (iv) benefits for which you have not met all of the requirements at the time the Plan terminates; (v) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the Plan's normal retirement age; and (vi) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you still may receive some of those benefits from the PBGC, depending on how much money your Plan has and on how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask your Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026, or call (202) 326-4000 (not a toll free number). TTY/TDD users may call the federal relay service toll free at 1-800-877-8339 and ask to be connected to (202) 326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the internet at: http://www.pbgc.gov.

Plan Administration Procedures

The Administrator is the administrator of the Plan. I.A.T.S.E. Local 46 and the Employers each appoint members of the Administrator. The Administrator is responsible for making all rules necessary to administer the Plan and for deciding questions concerning your rights under the Plan. Such questions include eligibility, value of accounts and rights to benefits. The Administrator is vested with full authority and discretion to interpret and enforce all Plan provisions, including making determinations as to eligibility for benefits. Benefits under the Plan will be paid only if the Administrator decides in its' discretion that the applicant is entitled to them. All decisions of the Administrator are final, binding and conclusive on all persons.

If you have questions regarding the Plan, you can contact the Administrator at the following:

Administrator of the LA.T.S.E. Local 46 Pension Plan
c/o I.A.T.S.E. Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

A Trustee has been appointed to hold the assets under the trust and to facilitate the investment of assets under the trust. The Trustee is:

First State Trust Co.

Wilmington, DE. 19803

Other Information You Should Know

Plan Year: January 1 to December 31.

Plan Number: 001

APPENDIX F

ADDITIONAL INFORMATION AND STATEMENT OF ERISA RIGHTS

ADDITIONAL INFORMATION

Employer Identification Number: 62-10181087

Beneficiaries. If you desire to change your beneficiary designation, you may do so by completing and filing the forms available by contacting the Administrator. Your last choice of beneficiary remains on file and will be deemed to be your designation, provided your spouse has consented to the designation. Thus, you should review your choice of beneficiary if you become divorced, married, or if your beneficiary dies. If you are married, your spouse is automatically your primary beneficiary. If you want to choose a beneficiary other than your spouse, written consent from your spouse will be necessary. Your spouse's signature on the consent form must be witnessed by a member of the Administrator, or notary public.

No Assignment of Benefits. For your protection, your benefits under the Plan cannot be sold or assigned and are not subject to garnishment or attachment until they are actually paid to you or your beneficiary. However, the Administrator may be required to use some or all of your benefits to pay court ordered alimony, child support, or other transfer of assets directly to a spouse, former spouse, child or other dependent. This type of court order is known as a "qualified domestic relations order". The court order must follow a certain form and contain certain information. If it does not, the Administrator will not honor it. The Administrator, in its' discretion, will determine whether or not the court order must be followed. If you are contemplating a divorce, you may wish to contact the Administrator to ensure that the proper information is contained in the court order.

Plan Documents. This summary is provided for your information, but is not the legal and official document that constitutes the LA.T.S.E. Local 46 Pension Plan. Although every attempt has been made to accurately explain the Plan, as it exists on the date of this summary, the terms of the Plan documents control over this summary. If you wish to examine the Plan documents, you may contact the Administrator and arrange to see a copy during business hours. You may obtain a copy of any of these documents by sending a written request to the Administrator. A reasonable copying fee may be charged.

Agent For Service of Legal Process. The name and address of the designated agent for service of legal process is:

Administrator of the l.A.T.S.E. Local 46 Pension Plan
c/o l.A.T.S.E Local 46
211 Donelson Pike, Suite 202
Nashville, TN. 37214
Telephone: (615) 885-1058
Facsimile: (615) 885-5165

Service of legal process may also be made upon the Trustee of the Plan, or the Administrator.

Statement of ERISA Rights:

Flex Plan; Health and Welfare Plan; Vacation and Sick Reimbursements

As a Participant in the Plan, you are entitled to certain rights and protection under ERISA. ERISA provides that all Plan Participants shall be entitled to:

* Examine without charge, at the office of the Plan Administrator and at other specified locations, such as worksites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the United States Department of Labor, such as detailed annual reports and Plan descriptions, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

* Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for 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.

In addition to creating rights for the Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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, including l.A.T.S.E. Local 46, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (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 one hundred ten dollars ($110), per 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 federal court, after exhausting your administrative remedies. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, you may file suit in a federal court. The court will decide who should pay court cost and legal fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these cost and fees, for example, if it finds that 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, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under BRISA by calling the publications hotline of the Employee Benefits Security Administration.

Statement Of ERISA Rights:

401 (k) Retirement Savings; Pension Plan

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

* Examine, without charge, at the office of the Joint Board and at other specified locations, all documents governing the Plan, including trust agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan and the United States Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

* Obtain, upon written request to the Joint Board, copies of documents covering . 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 Board may make a reasonable charge for the copies.

* Receive a summary of the Plan's annual financial report. The Joint Board is required, by law, to furnish each Participant with a copy of this summary annual report.

* Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested by you in writing and is not required to be given more than once, every twelve (12) months. The Plan must provide the statement free of charge.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan members, 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 members and beneficiaries. No one, including your employer, may fire you or otherwise discriminate against you in any way solely to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights:

If your claim for a benefit is denied, 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 materials from the Plan and do not receive them within thirty (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 one hundred ten dollars ($110), per 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, that is denied or ignored, in whole or in part, you may file suit in a federal court, after exhausting your administrative remedies. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a "domestic relations order of a medical child support order", you may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor or you may file suit in a federal court. The court will decide who should pay court cost and fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these cost and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions:

If you have any questions about this Plan, you should contact the Joint Board. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Joint Board, you should contact the nearest area office of the Pension and Welfare Benefits Administration, United States Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, United States Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.