IBEW LOCAL 1245
INJURED WORKERS PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

Effective: **February 1, 2021**

IBEW LOCAL 1245
INJURED WORKERS PLAN

BOARD OF TRUSTEES

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ADMINISTRATIVE MANAGER/CLAIMS PROCESSOR

IBEW Local 1245 Injured Workers Plan
c/o IBEW Local 1245
30 Orange Tree Circle
Vacaville, CA 95687

TO ALL PARTICIPANTS AND BENEFICIARIES:

This Summary Plan Description ("SPD") and Plan Document has been prepared to provide you with details of the coverage through the IBEW Local 1245 Injured Workers Plan ("Injured Workers Plan" or "Plan"), how you qualify for benefits, and under what circumstances you may not be eligible. The booklet also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

This booklet summarizes the most important features of the Injured Workers Plan. No general explanation can adequately give you all the details of your Plan. This general explanation does not change or expand or otherwise interpret the provisions of any rules and regulations adopted by the Plan in coordination with the terms of this SPD and Plan Document.

Only the Board of Trustees of the Plan has the authority to answer questions about eligibility and benefits provided through the Fund, or to interpret the Rules and Regulations. No Union representative, individual Trustee, or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Trustees and is acting on their behalf. The Trustees have delegated the routine day to day administration of the Fund. Any questions regarding benefits or any other matters relating to claims processing should be directed to the Claims Processor. Any questions regarding eligibility or any other matters related to the Plan should be directed to the Claims Processor.

Please read this booklet carefully so that you will know the benefits to which you and the members of your family are entitled. We suggest you put this booklet in a safe place along with other valuable papers. You will receive benefit updates and other changes to the Plan periodically. You need to insert these notices into this booklet in order to maintain a complete and current list of your benefits and requirements.

When you first become eligible for benefits, you should receive an enrollment package which includes forms for you to complete and return to the Administrative Manager. These enrollment forms are vital to the proper administration of your claims for benefits under this Plan. You must provide the Claims Processor with an updated Enrollment Form whenever you change your address or wish to change your beneficiary.

Sincerely,
BOARD OF TRUSTEES

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SCHEDULE OF BENEFITS

This Schedule of Benefits provides you and your beneficiaries with a summary of the benefits covered under the Injured Workers Plan. The Amounts listed in the Schedule of Benefits reflect the amount that the Plan covers unless noted otherwise. For a complete description of the benefits covered, review the Work Related Disability Benefits, Non Work Related Disability Benefits, Covid-19 Related Disability Benefits, Death Benefits and Parental Leave Benefits sections on Pages 3-7 of the Plan document.

A.	Disability Benefits		
	1)	Initial Disability Benefit (for disabilities lasting more than ten (10) days but less than thirty (30) days)	$2,000.00
	2)	Secondary Disability Benefit (for disabilities lasting more than twenty-nine (29) days but less than ninety (90) days)	$5,000.00[1]
	3)	Final Disability Benefit (for disabilities lasting at least ninety (90) days)	$5,000.00[2]
B.	Non-Work Disability Related Benefits:		
	1)	Initial Disability Benefit (for disabilities lasting more than ten (10) days but less than thirty (30) days)	$2,000.00
	2)	Secondary Disability Benefit (for disabilities lasting more than twenty-nine (29) days but less than ninety (90) days)	$5,000.00
	3)	Final Disability Benefit (for disabilities lasting at least ninety (90) days)	$5,000.00
C.	COVID-19 Related Disability Benefits		$2,000.00
D.	Death Benefit (For Work Related Deaths Only)		$50,000.00
E.	Parental Leave Benefits		
	1)	Parental Leave Benefits of $400/week for up to 6 weeks for the birth or placement of a child for adoption or foster care.	

RULES OF ELIGIBILITY FOR PARTICIPANTS

[1] This lump-sum benefit shall be in addition to any Initial Disability Benefit paid to the Participant.
[2] This lump-sum benefit shall be in addition to any Initial and Secondary Disability Benefits paid to the Participant.

Initial Eligibility

You will become initially eligible on the first day of the benefit month following the eligibility month in which you first accumulate at least 125 credited hours of employment for which a contribution is required to be made to the Injured Workers Fund on your behalf. The date on which you become initially eligible is called your initial eligibility date.

Continuation of Eligibility

Once you have met the initial eligibility rules, you will remain eligible for coverage for each month in which you have contributions made for at least 100 hours of work (performed in the prior month) or 450 hours of work (performed in the six (6) months prior).

Reinstatement of Eligibility

If you fail to maintain your eligibility by meeting the hourly requirements, you will not again become eligible in this Fund until you satisfy the Initial Eligibility Requirements of this section, as set forth above.

Continuation of Eligibility Under the Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires your employer to provide you with up to twelve (12) weeks of unpaid leave during any twelve (12) month period for specified family and medical reasons, if you are eligible. During this period, your employer must provide health coverage for you on the same terms and conditions that you would receive if you continued to work.

To be eligible for leave under FMLA, you must work for the same contributing employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your employer is obligated to provide Family and Medical leave only if your employer employs 50 or more employees each working day during 20 or more work weeks during the current or preceding calendar year.

During any period for which you are eligible for FMLA leave, you shall remain eligible for benefits from the Injured Workers Plan.

Termination of Participant's Coverage

A Participant's coverage under any benefit provision shall terminate upon any of the following:

1. Termination of the Plan, or

2. The Participant ceases to be eligible for participation in the Plan, or

3. Plan modification to terminate coverage in the Participant's classification, or

4. Plan modification to terminate a specific type of coverage under the Plan, or

5. On the date the Participant enters the Armed Forces on full-time active duty, or

6. On the date a Participant materially misrepresents information provided to the Injured Workers Plan (or any related insurance provider) or commits fraud or forgery.

DISABILITY BENEFITS

ELIGIBILITY FOR WORK RELATED DISABILITY INCOME

To be eligible for Work Related Disability Benefits, you must meet the following requirements:

1. You must be totally disabled (be completely unable to perform each and every duty of your occupation or employment) as a result of an occupational bodily injury or sickness, which is related to you performing work with an employer signatory to the California Outside Line Construction Agreement; and

2. You must be eligible and covered under the Plan on the date your disability begins; and

3. Your disability must begin and you must see a doctor about the disability within fifteen (15) days after the last day you worked for an Employer. You must provide a doctor's certification to the Plan stating that you are totally disabled for at least ten (10) days. The initial doctor's certification must include 1) an indication that the disability is due to an occupational bodily injury or sickness, which is related to you performing work with an employer signatory to the California Outside Line Construction Agreement, 2) the nature of the disability (i.e. diagnosis), 3) the anticipated length of the disability, 4) the estimated return to work date, and 5) the date when the doctor first saw you for the medical treatment associated with the disability. Any subsequent certifications must include 1) the current nature of disability, 2) the anticipated length of disability, and 3) any new estimated return to work date.

ELIGIBILITY FOR NON-WORK RELATED DISABILITY INCOME

To be eligible for Disability Benefits, you must meet the following requirements:

1. You must be totally disabled (be completely unable to perform each and every duty of your occupation or employment); and

2. You must be eligible and covered under the Plan on the date your disability begins; and

3. Your disability must begin and you must see a doctor about the disability within fifteen (15) days after the last day you worked for an Employer. You must provide a doctor's certification to the Plan stating that you are totally disabled for at least ten (10) days. The initial doctor's certification must include 1) the nature of the disability (i.e. diagnosis), 2) the anticipated length of the disability, 3) the estimated return to work

date, and 4) the date when the doctor first saw you for the medical treatment associated with the disability. Any subsequent certifications must include 1) the current nature of disability, 2) the anticipated length of disability, and 3) any new estimated return to work date.

AMOUNT OF BENEFIT

The amount of your work-related or non-work related disability benefit is shown in the Schedule of Benefits set forth on page 1 in the Schedule of Benefits section.

PERIOD OF PAYMENT/WHEN BENEFITS START

Work-Related Benefits are payable as follows:

A) Initial Work-Related Disability Benefits – You shall be paid a lump-sum amount of $2,000.00 for any disability lasting at least ten (10) days but less than thirty (30) days.
B) Secondary Work-Related Disability Benefits – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting more than twenty-nine (29) days but less than ninety (90) days. Said payment shall be in addition to any Initial Disability Benefit payment made to you.
C) Final Work-Related Disability Benefit – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting at least ninety (90) days. Said payment shall be in addition to any Initial and Secondary Disability Benefit Payments made to you.

A disability will not be considered to have started until the first day you are actually examined or treated by a doctor or legally qualified physician.

Non-Work Related Benefits are payable as follows:

A) Initial Non Work-Related Disability Benefits – You shall be paid a lump-sum amount of $2,000.00 for any disability lasting at least ten (10) days but less than thirty (30) days.
B) Secondary Non Work-Related Disability Benefits – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting more than twenty-nine (29) days but less than ninety (90) days. Said payment shall be in addition to any Initial Disability Benefit payment made to you.
C) Final Non Work-Related Disability Benefit – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting at least ninety (90) days. Said payment shall be in addition to any Initial and Secondary Disability Benefit payments made to you.

A disability will not be considered to have started until the first day you are actually examined or treated by a doctor or legally qualified physician.

SUCCESSIVE PERIODS OF DISABILITY

Two or more periods of disability due to the same or related causes will be considered one period of disability unless you return to full-time work for a continuous period of at least thirty (30) days between the periods of disability. Successive periods of disability separated by less than thirty (30) days of active full-time work will be considered one period of disability unless the second disability is entirely unrelated to the causes of the first disability and begins after you return to full-time work for at least one full day.

EXCLUSIONS AND LIMITATIONS

With the exception of Covid-19 Related Disability Benefits, no disability benefits are paid for any disability which results from a sickness or injury for which you are not under the direct care of a doctor or other legally qualified physician.

ELIGIBILITY FOR COVID-19 RELATED DISABILITY INCOME

To be eligible for COVID-19 Related Disability Benefits, you must meet the following requirements:

1. You must test positive for COVID-19.
2. You must be directed to self-isolate and not work for at least 10 days because of such test result; and
3. You must be covered under the Plan on the date you tested positive for COVID-19.

If your positive COVID-19 test results in a disability that lasts more than 29 days, and if you are otherwise eligible, you may apply for Secondary or Final Disability Benefits for either Work Related Disability Benefits or a Non-Work Related Disability Benefits, whichever may apply. However, once you receive a COVID-19 Related Disability Benefit, you will not be eligible for an Initial Disability Benefit for either Work Related Disability Benefits or a Non-Work Related Disability Benefits.

DEATH BENEFIT (FOR WORK RELATED DEATHS ONLY)

If you die due to an occupational bodily injury or sickness, resulting from you performing work with an employer pursuant to the California Outside Line Construction Agreement, a lump-sum Death Benefit, in the amount of $50,000.00, will be paid to your designated Beneficiary (as designated on your most recent completed Beneficiary Designation Form). **The Beneficiary Designation Form for the Death Benefit shall be the Designation Beneficiary Form – USA completed by the Participant and utilized for death benefits from the IBEW Pension Benefit Fund**. However, no Death Benefit can be paid directly to a minor. This benefit is solely payable as a result of the death of a Participant and does not apply to the death of any Surviving Dependents or other Beneficiaries.

In its determination of any eligibility for a death benefit, the Plan and the Board of Trustees may require submission of a final decision from a Court, administrative agency or court or other tribunal (WCAB for example) which determined that your death occurred as a result of you performing work with an employer pursuant to the California Outside Line Construction Agreement during a time period when you were eligible for benefits under the Plan.

DESIGNATION OF A BENEFICIARY

A Beneficiary can only be designated by a Participant on a Beneficiary Designation Form that is approved by the Trustees. In the case of your death, your named beneficiary will receive the Death Benefit amount. You may name anyone you want as your beneficiary, but ***it is extremely important that you name someone***. The Plan must receive your signed Beneficiary Designation Form prior to your death in order for it to be a proper designation. The Board of Trustees also allows the designation of a contingent beneficiary who will be eligible to receive the Death Benefit in the event that your designated Beneficiary is not living at the time of your death.

You may change your Beneficiary at any time by filling out a new Beneficiary Designation Form, which is available from the office of the Administrative Manager and Claims Processor. A completed Beneficiary Designation Form indicating your named Beneficiary must be on file with the Administrative Manager to avoid disputes regarding your proper Beneficiary. A dispute about the identity of your proper Beneficiary has the potential to delay payment of the Death Benefit.

If you did not designate a Beneficiary or there is no surviving designated Beneficiary for all or part of your Death Benefit payable under this Plan, the benefits shall be paid, at the discretion of the Trustees, as follows:

1. To your legal spouse, if any;

2. If you have no legal spouse at the time of your death, to your other Surviving Dependents, if any, in equal amounts; or

3. To your estate, if you have no Surviving Dependent.

Payment in the manner provided in this Section shall, to the extent thereof, release the Fund from all liability.

PARENTAL LEAVE BENEFITS

The Plan will provide parental leave benefits to you for up to six (6) weeks of parental leave for the birth or placement of a child for adoption or foster care, provided that you provide appropriate documentation to evidence such event. The appropriate documentation includes a birth certificate, adoption paperwork, or a court order or agency paperwork for foster care. If you elect to take time off before the birth of a child, you must provide a doctor's note that documents the pregnancy and the anticipated due date.

The Plan will provide $400 a week for up to a six (6) week period, made in monthly installments. You may commence the parental leave benefits up to two (2) weeks prior to the birth or placement of child for adoption or foster care once you stop working for an Employer. The parental leave benefit is only available for you and not available for your spouse or children. You may apply for the parental leave benefit through an Application form provided by the Plan upon request.

ELIGIBILITY FOR PARENTAL LEAVE BENEFITS

To be eligible for Parental Leave Benefits, you must meet the following requirements:

1. You must be taking a leave of absence from work for the birth or placement of a child for adoption or foster care; and

2. You must be covered under the Plan on the date such leave begins.

AMOUNT OF BENEFIT

The amount of your Parental Leave Benefit is shown in the Schedule of Benefits set forth on page 1 in the Schedule of Benefits section.

PERIOD OF PAYMENT/WHEN BENEFITS START

Parental leave benefits are payable on a monthly basis.

WORKERS' COMPENSATION BENEFITS

The disability benefits provided for herein shall supplement any Workers Compensation Benefits you are entitled to but are not intended to replace such benefits.

GENERAL EXCLUSIONS

The Plan does not provide benefits for:

1. Any injury, ailment, condition, disease, disorder, illness, or death that occurs as a result of insurrection or act of war, declared or undeclared, or during the commission of a felony by the covered Participant.
2. A loss incurred while engaged in military service for any country.
3. Losses incurred in connection with intentionally self-inflicted injuries or sickness, unless such injuries or sickness are a result of a medical condition (including both physical and mental conditions), or the intentional abuse or misuse of any drug, poison, or fumes taken or inhaled.

HOW TO FILE A BENEFIT CLAIM WITH THE ADMINISTRATIVE MANAGER

All claims must be submitted by you to the Plan on an Application for Benefits provided to you by the Claims Processor.

A claim is not filed until it is received by the Claims Processor. The Claims Processor will process your claim within forty-five (45) days of the date it is filed in the case of a disability claim, and in the case of other benefit claims, within ninety (90) days of the date such claim is filed.

For claims other than disability benefits, the ninety (90) day period may be extended by the Plan for up to ninety (90) days, provided that the Claims Processor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you or your authorized representative, prior to the expiration of the initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

For disability claims, the 45 day period may be extended by the Plan for up to thirty (30) days, provided that the Claims Processor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you or your authorized representative, prior to the expiration of the initial period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Processor determines that a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Claims Processor notifies you or your authorized representative, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. If additional information is needed to process your claim, the Plan may request additional information from you or the provider. You and your provider will have at least forty-five (45) days to submit the additional information.

The period of time with which a benefit determination is required to be made, for both disability benefits and non-disability benefits under the Plan, will begin at the time the claim is filed in accordance with the reasonable procedures of the Plan, without regard to whether all information necessary to make a benefit determination accompanies the filing. For disability claims, if additional information is necessary to make a benefit determination, the period of time for making the benefit determination shall be tolled from the date that additional information is requested until you or your authorized representative responds to the request for additional information.

If your claim is not eligible for payment under the Plan, you will be notified by the Fund's Claims Processor that the claim is denied in whole or part with an explanation of the

reasons for the denial. This notification which is called a Notice of Adverse Benefit Determination and will be provided in the form of an Explanation of Benefits (EOB) which shall be in writing and will contain the following:

- The specific reasons for the adverse benefit determination;

- The specific reference to the sections of the Plan or Summary Plan Description provisions on which the adverse benefit determination was based;

- A description of any additional materials or information necessary for you to perfect your claim and an explanation of why such materials or information is necessary;

- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claims for benefits.

In addition to the above, for cases of an adverse benefit determination for disability benefits the Explanation of Benefits (EOB) will contain:

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

    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; and
    - The views of medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

- In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

PROOF OF CLAIMS

Written proof of claims for payment of benefits should be submitted as soon as you become disabled. **All claims must be filed within one hundred eighty (180) days from initial the date of disability (for disability benefit and parental leave claims) or within one (1) year from the date of death (for death benefit claims) and if they are not submitted, they will be denied as untimely.**

No action at law or in equity shall be brought to recover on your claim prior to the exhaustion of the reasonable claims and appeals procedures set forth in this Section.

PHYSICAL EXAMINATION

The Plan at its own expense shall have the right and opportunity to examine an individual for whom benefits are being claimed under this Plan when and as often as the Trustees may reasonably require while a claim is pending. The Trustees have the right to ask for an autopsy in the case of death, provided this is not forbidden by law.

REVIEW PROCEDURE FOR CLAIMS UNDER THE FUND

You or your authorized representative may appeal the decision by the Claims Processor to deny any claim for disability or death benefits, in whole or part. If you are not handling your own claim, then an "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization.

APPEALS

You may file a written notice of appeal for benefits to the Board of Trustees at any time within sixty (60) days (for all benefit claims other than disability claims) and one hundred eighty (180) days (for disability claims) after the mailing of the Notice of Adverse Benefit Determination. The written notice only needs to state your name, address, social security number, phone number, and the fact that you are appealing from the decision of the Plan's Claims Processor, giving the date of the Notice. The Appeal should be addressed as follows:

Board of Trustees
IBEW Local 1245 Injured Workers Plan
c/o IBEW Local 1245
30 Orange Tree Circle
Vacaville, CA 95687
Telephone: (707) 452-2700

During the appeals process, you will also be afforded access to, and copies of, all documents, records, and other information relevant to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional comments, documents, records, and other information prior to any determination on your appeal.

If an appeal requires medical judgment, the Board of Trustees shall consult an appropriate health professional or medical or vocational expert who has appropriate training or experience in the field of

medicine involved in the medical judgment and will disclose the identity of such individual to you. The healthcare professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, or the subordinate of any such individual. The health professional may conduct an independent medical records review and/or independent medical examination to determine whether you are eligible for the applied benefits.

In the event that you file a timely appeal with the Board of Trustees:

- The Plan will not assert a failure to exhaust administrative remedies.
- The Plan will provide you with a statement that using this procedure will have no effect on your right to receive other benefits under this Plan.
- The Plan will provide you with a statement that you have the right to have a personal representative with regard to your claim.
- The Plan will provide you with a notice of any circumstances which may impair the impartiality of the Board of Trustees.
- The Plan will not impose any fees or costs on you as part of this appeal process.

The Board of Trustees will consider your appeal of a claim as soon as possible after receipt of your request. The Trustees' review of your appeal shall take into account all comments, documents, records, and other information submitted by you, or your authorized representative, relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Such review shall not afford deference to the initial adverse benefit determination and shall be conducted by the Board of Trustees, comprised of individuals who did not make the initial adverse benefit determination that is the subject of the appeal and who are not subordinates of the individual making such initial determination.

The Board of Trustees, as Plan Administrator, is vested with all powers necessary to enable it to review all appeals of adverse benefit determinations and to determine all questions that may arise thereunder, including, but not limited to, all questions relating to the eligibility of Participants to participate in the Plan, benefits covered by the Plan, and the amount of any benefit to which a Participant may become entitled to hereunder. In so acting, the Trustees shall have full and complete authority and discretion to construe, interpret, and apply all provision of the Plan. Specifically, the Trustees shall have full and complete authority and discretion to make any determination of disability and other determinations or findings of fact regarding any claims and appeals of any benefit determinations. The decision of the Trustees shall set forth specific reasons for their conclusion, shall be written in a manner calculated to be understood by you and shall make reference to the pertinent Plan provisions upon which the decision is based. This decision shall be final and binding upon you, except to the extent that you may choose to pursue any rights provided for by ERISA Section 502(a) following an adverse benefit determination on appeal.

For all appeals related to claims other than disability, the Board of Trustees will issue a decision within 60 days. When reasons beyond the Plan's control so require, the Board of Trustees is entitled to one 60-day extension for disability claims on appeal. In the event that an extension is warranted, the Plan shall provide you with notice that the extension is needed prior to the expiration of the initial time period and shall inform you as to the reason for the extension.

For all appeals related to disability claims, the Board of Trustees will issue a decision within 45 days. When reasons beyond the Plan's control so require, the Board of Trustees is entitled to one 45-day extension for disability claims on appeal. In the event that an extension is warranted, the Plan shall provide the claimant with notice that the extension is needed prior to the expiration of the initial time period and shall inform you as to the reason for the extension.

You will be notified of the decision of the Board of Trustees within five (5) days of when any determination is made.

If the Plan determines to uphold an adverse benefit decision for disability benefits on review, the Plan Administrator shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan. This evidence will be provided as soon as possible and sufficiently in advance of the 45 days of the date in which your appeal was received to give you a reasonable opportunity to respond prior to the 45 day deadline after the appeal was received.

Before the Plan issues a Notice of Denial for upholding an adverse benefit decision for disability benefits, based on new or additional rationale from the initial adverse benefit decision, the Plan Administrator shall provide you, free of charge, with the rationale, as soon as possible and sufficiently in advance of the 45-days deadline after the appeal was received.

In the event that the denial is upheld on appeal, you will receive a written Notice which includes the following information:

- The specific reason or reasons for the adverse benefit determination upon appeal;

- A specific reference to the sections of the Plan or Summary Plan Description upon which the denial was based;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

- A statement describing any voluntary appeal procedures offered by the Plan, including your right to obtain the information about such procedures at no cost, and a notice of your right to file a lawsuit under ERISA Section 502(a).

    - The following statement "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation." One way to find out what may be available is to contact your local U.S. Department of Labor office.

In addition to the above, for appeals that uphold an adverse benefit determination for disability benefits, the written Notice will contain:

- A discussion of the decision, including an explanation of the basis for disagreeing or agreeing with the following:
    - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
    - A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

The decision by the Board of Trustees upon review of your appeal is final and binding. Once you have exhausted your appeal rights, you have the right to file a lawsuit in federal court.

SUBROGATION AND REIMBURSEMENT

The Plan will take advantage of its right to subrogation if you or your Surviving Dependent is paid benefits by the Plan due to any injury or illness that arises out of the acts or omissions of any person or entity or which arise under any no-fault coverage (for the purpose of this provision, collectively referred to as “Other Coverage”).

The term Covered Person as used in this Section on Subrogation and Reimbursement shall include the Participant (with respect to Disability benefits), a Surviving Dependent or Beneficiary (with respect to Death benefits) or anyone acting for, or on behalf of, a Covered Person.

Any person who receives benefits or is eligible to receive benefits under the Plan must agree in writing (1) to reimburse the Plan to the extent any benefit payments are recovered from the proceeds of any judgment or settlement on account of any illness, injury, or condition for which an employer or other third party (or their respective insurers) may be liable, regardless of whether such recovery is less than the actual loss suffered by the personal; (2) to waive any argument or contention that any action by the Trustees in state court is pre-empted by federal law; and (3) to assign to the Trustees the person’s right of action against the employer or other third party (or their respective insurers) to the extent benefits have been paid or may be paid in the future. In addition, any person

eligible for benefits, to receive any benefits and to maintain eligibility under the Plan, must (i) notify the Trustees of the Plan within thirty (30) days after making a claim against an employer or other third party (or their respective insurers) relating to an incident leading to damages, benefits and/or other compensation, of the fact and nature of such claim; (ii) furnish any information or assistance and execute any documents that the Trustees may require; and (iii) take no action that may prejudice or interfere with such rights.

Whether or not the preceding requirements are satisfied, the Trustees shall (1) be automatically assigned such person's right of action against the employer or other third party (or their respective insurers) to recover benefits that have been paid or may be paid in the future; (2) have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover all benefits that have been paid or may be paid in the future; (3) be reimbursed fully from the proceeds of any judgment, settlement, or other resolution of any action or proceeding to recover benefits that have been paid or may be paid in the future, regardless of whether the total amount of such recovery is less than the actual loss suffered by the person; and (4) have an automatic first lien upon any recovery to the extent of benefits paid, or in the future, may be paid. In all four instances set forth above in this paragraph, the Trustees shall have such rights regardless of whether the total amount of such recovery is less than the actual loss suffered by the person.

In the event the Plan has a subrogated interest or right of recovery, no Covered Person shall release any party, person, corporation, entity, insurance company, insurance policies, or funds that may be liable or obligated to the Covered Person for the acts or omissions of any person or entity without the written approval of the Plan.

If any person does not comply with any of the foregoing requirements the Plan may suspend that person's ongoing eligibility for benefits and refuse to process pending or future claims until such time that he or she is in compliance with such requirements. Specifically, if any Participant or Surviving Dependent enters into any settlement of his/her claim(s) pursuant to a state workers' compensation law or based upon personal injury (whether or not a lawsuit is filed) that does not include complete and final resolution (immediately upon effectuation of such settlement) of the Plan's lien claim and/or subrogation claim, the Plan may suspend the person's ongoing eligibility for benefits and refuse to process or pay pending or future claims until the Plan has recouped an amount equal to the value of any such claims.

The information in this section applies to any no fault insurance recoveries and all proceedings and actions, including but not limited to proceedings under state and actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

In the event a Covered Person pursues a claim against any person, entity, or Other Coverage, the Covered Person agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event a Covered Person does not pursue a claim against any person, entity, or Other Coverage, the Plan shall have the right to pursue, sue, compromise, or settle any such claims in the Covered Person's name and to execute any and all documents necessary to pursue said claim in the Covered Person's name.

The Plan will not pay or be responsible for, without the written consent of the Board of Trustees, any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage. The Plan's subrogation interest and the Plan's reimbursement interest shall not be subject to offset for any fees or costs associated with a Covered Person pursuing a claim against a third party or any other coverage.

The Plan expressly disavows the application of legal theories such as the "collateral source", the "make-whole" doctrine and the "common fund" doctrine to the extent that they may prevent or limit the Welfare Plan's recovery from any payment a person with eligibility receives from a third party (or its insurer). The Plan's reimbursement will not be reduced to pay any portion of the attorney's fees and costs associated with the person with eligibility or beneficiary's legal recovery.

In the event a Covered Person settles, recovers, or is reimbursed by any person, entity, or Other Coverage, the Covered Person shall hold any such money in trust for the benefit of the Plan. In fact, any monies recovered by a Covered Person from a third-party are deemed to be held in trust for the benefit of the Plan. If a Covered Person fails to reimburse the Plan in accordance with this provision, the Covered Person shall be liable to the Plan for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. Each Covered Person also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights under this Plan.

If the Plan should provide benefits to you or your Surviving Dependent or Beneficiary, and, for whatever reason, such payment is not required under the terms of this Plan, the Plan shall have the right to offset any future benefit payments to either you or your Surviving Dependent or Beneficiary, in the amount of any overpayment or erroneous payment. The Plan may recover such an overpayment or erroneous payment in any other lawful manner as well. The recipient of such overpayment or erroneous payment shall refund to the Plan the overpaid amount and any related interest income, whether the error was based upon mistake, fraud or misrepresentation or whether the error was that of the Plan or the individual recipient of the payment. In both instances (overpayment or erroneous payments), the Plan and Trust Fund shall be entitled to an equitable lien upon such benefits and payments and such monies shall be held in constructive trust for the benefit of the Plan and Trust Fund by the recipient of the payment, whether the initial recipient or a subsequent recipient of such funds.

IMPORTANT INFORMATION ABOUT THE FUND

This booklet describes the disability, parental leave and death benefits available to you and your beneficiaries under the Plan, known as the IBEW Local 1245 Injured Workers Fund.

The Board of Trustees is responsible for the operation of the Plan and acts as Plan Administrator. It is responsible for reporting Plan information to government agencies and disclosing the same information to Plan Participants and beneficiaries.

You can contact the Board of Trustees at the address and telephone number below:

Board of Trustees
IBEW Local 1245 Injured Workers Fund
c/o IBEW Local 1245
30 Orange Tree Circle
Vacaville, CA 95687
Telephone: (707) 452-2700

The Trustees of the Plan are as follows:

Scott Hudelson
30 Orangetree Circle
Vacaville, CA 95687

Grant Todd
30 Orange Tree Circle
Vacaville, CA 95687

Robert D. MacLauchlan
30 Orange Tree Circle
Vacaville, CA 95687

Service of legal process may also be made upon the Board of Trustees or any individual Trustee.

The Plan Sponsor: Upon written request, Participants and beneficiaries may receive from the Administrative Manager or Claims Processor, information as to whether an Employer or Employee Organization is a sponsor of the Plan and if so, the appropriate address. Additionally, upon written request, the Administrative Manager will provide you with information as to whether a particular employer is contributing to the Fund on behalf of Participants working under a collective bargaining agreement. A copy of any such collective bargaining agreement may also be obtained by participants and beneficiaries upon written request to the Administrative Manager, and is available for examination by participants and beneficiaries.

Plan Number: The Plan number assigned to the Trust is 001. The Employer Identification Number assigned by the Internal Revenue Service is 35-2308172.

Plan Year: The Plan Year is the Fund's fiscal year, which is the period of October 1 through September 30. The records of the Fund are kept on the basis of the Fund's fiscal year; however, benefits are paid on the basis of a calendar year.

The Injured Workers Plan is maintained for the purposes of providing disability, death and parental leave benefits. All benefits are self-insured and administered by the IBEW Local 1245 Injured Workers Fund.

IMPORTANT

Benefits offered by the IBEW Local 1245 Injured Workers Fund are not guaranteed to the Participants or beneficiaries covered by the Fund.

The Trustees of the Fund reserve a full, absolute, and discretionary right to amend, modify, suspend, withdraw, discontinue, or terminate the Fund in whole or part at any time for any or all of the Participants. Although the Trustees hope to maintain the present level of benefits and to improve upon them, if possible, a primary concern of the Trustees is to protect the financial soundness of the Fund at all times. To do so may require Plan changes from time to time. Therefore, any benefits or persons covered by the Plan are not guaranteed. The benefits set forth herein shall not constitute a vested benefit under federal or state law and shall not be transferable or payable to you or any other person or entity.

If the Plan ends, monies remaining in the Fund to the extent possible would be used in the following order according to the priority required by any applicable law and the provisions stated in this Plan Document, to:

- pay reasonable administrative expenses;
- provide benefits and premium payments to Participants; and
- pay any other expenses that are deemed to be in the interest of the Plan.

No Funds can be returned to any employer.

Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under the Internal Revenue Service rules and regulations. These rules and regulations may change and, as a result, the Trustees may find it necessary to change the Plan provisions so that the Trust does not lose its tax exempt status. In the event of a change that would result in the reduction of any benefit provided by the Plan, the Trustees will endeavor to provide notice of the change to the Participants prior to initiating such change.

All benefits under the Plan shall be payable through employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan are not vested and will be paid as long as the Fund can operate on a sound financial basis. No benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, any Employer, or the Trustees. The Trustees and the Union shall not be held liable for any benefits or contracts except as provided in the agreement between the Employers and the Union.

Only the Board of Trustees has the power to interpret and construe the Plan, determine all questions of eligibility and status under the Plan document, and determine all questions arising in the administration of the Plan, including the power to determine the rights or eligibility of employees, Participants, and their dependents and beneficiaries. This includes the authority and right to make findings of fact relating to these decisions.

No union representative, individual trustee, business agent, or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given the authority by the Board of Trustees and is acting on its behalf.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Privacy regulations govern the use and disclosure of protected health information ("PHI"). "Protected health information" means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form or medium. "Individually identifiable health information" is health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify an individual. The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (e.g. cost of a benefit, Plan maximums, and co-payments as determined for an individual's claim).
- Coordination of benefits.
- Adjudication of health benefit claims (including appeals and other payment disputes).
- Subrogation of health benefit claims.
- Establishing employee contributions.
- Risk adjusting amounts due based on enrollee health status and demographic characteristics.
- Billing, collection activities, and related health care data processing.
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to Participant (and their authorized representatives') inquiries about payments.
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance), if necessary in the future.
- Medical necessity reviews, or reviews of appropriateness of care or justification of charges.
- Utilization review, including precertification, preauthorization, concurrent review, and retrospective review.
- Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

- Quality Assessment.

- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives, and related functions.

- Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

- Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance).

- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development, or improvement of methods of payment or coverage policies.

- Business management and general administrative activities of the entity, including, but not limited to:
    - Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification.
    - Customer service, including the provision of data analyses for policyholders, Plan sponsors, or other customers.
    - Resolution of internal grievances.
    - Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code.

"Treatment" includes, but is not limited to, the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

For purposes of this section the Union is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

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

b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

c) Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

d) Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

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

f) Make PHI available to the individual in accordance with the access requirements of HIPAA;

g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

h) Make available the information required to provide an accounting of disclosures;

i) Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of HHS for the purposes of determining compliance by the group health plan with HIPAA;

j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- The Plan's Claims Processor
- Staff designated by the Plan's Administrative Manager or Claims Processor; and
- Board of Trustees of the Injured Workers Plan.

The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that are performed on behalf of the Fund. If the persons described in this section do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

STATEMENT OF ERISA RIGHTS

Statement of Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Administrative Manager's office or at other specified locations (such as worksites at which at least fifty (50) individuals are employed and union halls) all documents governing the Plan, including insurance contracts, collective bargaining agreements, and copies of all such documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan Documents and Plan information upon written request to the Administrative Manager. The Administrative Manager may make a reasonable charge for the copies.

Obtain a complete list of the employers sponsoring the Plan, upon written request to the Administrative Manager, which is available for examination by Participants and Beneficiaries at a reasonable copying charge. In addition, Participants and Beneficiaries may receive from the Administrative Manager, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address.

Receive a summary of the Plan's annual financial report (Form 5500). The Administrative Manager is required by law to furnish each Participant with a copy of this summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 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 $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a qualified domestic relations order or a medical child support order, you may file suit in Federal court. If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance form the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about this Statement or about your rights under ERISA, you should contact the nearest Employee Benefits Security Administration office, located as follows:

U.S. Department of Labor
Employee Benefits Security Administration
San Francisco Regional Office
71 Stevenson Street, Suite 915
San Francisco, CA 94105
(415) 625-2481

or

Division of Technical Assistance and Inquiries
U.S. Department of Labor
Employee Benefits Security Administration
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 publication hotline of the ERISA. For single copies of publications, contact the EBSA Brochure Request Line at 1-866-444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices online at www.dol.gov/ebsa/.

PLAN DEFINITIONS

Here are some definitions of terms used in this booklet, as they apply to your Plan:

Agreement and Declaration of Trust – The term "Agreement and Declaration of Trust" as used herein shall mean the IBEW Local 1245 Injured Workers Fund Agreement and Declaration of Trust including all amendments thereto.

Appeal Process – If you are unhappy with the handling of your claim, there is a multi-step claim and appeal process which is outlined on Pages 8-13 of the SPD. The appeal process allows you to have a separate review of your claim.

Beneficiary – A person who is designated by the Participant to receive a Death Benefit payable under this Plan, provided however, that no Death Benefit can be paid directly to a minor.

Child – The word "child" or “children**”** includes the following:

1. Your natural born child.
2. Your legally adopted child, including a child being placed for adoption, whether or not the adoption has become final.
3. Your Stepchild residing in your household, solely supported by you as evidenced by your federal income tax returns.
4. The word "child" also includes a relative of a Participant or Spouse who the Participant has legal custody of and has maintained legal custody of for two (2) years or more.

Proof that the child is an eligible Surviving Dependent may be established by one or more of the following documents:

1. Child's birth certificate.
2. Child's baptismal certificate.
3. Court order or record or other legally recognized proof of dependent status.
4. Participant Tax Returns to establish dependent status.

Employee or Participant – The term "Employee" or “Participant” shall mean all general foremen, foremen, journeymen linemen, cable splicer foremen, cable splicers, line equipment men, groundmen, powdermen, welding linemen, and apprentices employed by an Employer, represented by the Union or eligible for benefits as provided by the Injured Workers Plan. This term may be modified in the future to include other classifications or types of employees who are members of the Union.

Employee Contributions - The term "Employee Contributions" as used herein shall mean after-tax contributions made to the Trust Fund by an Employee.

Employer – The term “Employer” as used herein shall mean employers who are members of the Western Line Constructors Chapter, Inc. NECA, Inc and signatories to collective bargaining agreements with the Union. This term may be modified in the future to include additional employers who are signatories to collective bargaining agreements with the Union.

ERISA – The term “ERISA” shall mean the Employee Retirement Income Security Act of 1974, such amendments may from time to time be made, and any regulations promulgated pursuant to the provisions of the Act.

Fund or Trust Fund – The term “Fund” or “Trust Fund” shall mean the IBEW Local 1245 Injured Workers Fund and the entire assets thereof including all funds received in the form of employee or employer contributions, together with all contracts (including dividends, interest, refunds, and other sums payable to the Trustees on account of such contracts), all investments made and held by the Trustees, all income, increments, earnings and profits therefrom, and any and all other property or funds received and held by the Trustees by reason of their acceptance of the IBEW Local 1245 Injured Workers Fund Agreement and Declaration of Trust.

Plan – The term “IBEW Local 1245 "Injured Workers Plan" or “Injured Workers Plan” as used herein shall mean the plan, program, method, rules, and procedure for the payment of benefits from the Trust Fund and amendments thereto which have been established and adopted by the Trustees as herein provided. This booklet shall constitute both a Plan document and a Summary Plan Description.

Surviving Dependent – The term “Surviving Dependent” shall mean the Spouse or Child of a deceased eligible Participant, who shall become eligible for a death benefit pursuant to the Plan Document, Summary Plan Description, or rules and regulations provided for by the Injured Workers Plan.

Trustees – The term "Trustees" as used herein shall mean natural persons designated as Trustees pursuant to the Agreement and Declaration of Trust creating the IBEW Local 1245 Injured Workers Fund.

Union – The term "Union" as used herein shall mean the International Brotherhood of Electrical Workers (AFL-CIO), Local Union No. 1245.

Union Contributions – The term “Union Contributions” as used herein shall mean contributions made to the Trust Fund by the Union.

Work – The term “Work” as used herein, specifically in the phrase “performing work with an employer pursuant to the California Outside Line Construction Agreement,” shall mean the performance of all duties and functions for which the employer pays the employee under said agreement. Consistent with the California Outside Line Construction Agreement, this explicitly includes direct travel to and from the work site, subject to the general exclusions of the Plan.

IN WITNESS WHEREOF, THE TRUSTEES OF THE IBEW LOCAL NO. 1245 INJURED WORKERS PLAN HAVE ADOPTED AND APPROVED THIS SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT ON THIS 2 DAY OF March 2021, TO BE EFFECTIVE February 1, 2021.

TRUSTEES