I.B.E.W. Local 688 Health & Welfare Plan

33 FITCH BOULEVARD
AUSTINTOWN, OHIO 44515

PHONE: 800-435-2388
FAX: 330-270-0912

SUMMARY OF MATERIAL MODIFICATIONS FOR THE SUMMARY PLAN DESCRIPTION (SPD) OF THE I.B.E.W. LOCAL 688 HEALTH & WELFARE PLAN

The Trustees have made ***changes*** to the Plan that will affect various provisions of your SPD. These changes are effective for services rendered on or after **August 1, 2013.** This "Summary of Material Modifications" explains these changes and should be kept with your SPD.

Effective **August 1, 2013,** the section entitled "Dental and Vision Care Benefits" on page 40 will be modified as follows. The changes are underlined for your reference.

Non-Pediatric Dental and Vision Care Benefits		100% of combined total up to a maximum of $800 per year for non-pediatric services. This benefit is not subject to the deductible
Pediatric Dental Benefits		Subject to Annual Maximum Limit (as defined in this SPD and Plan Document), if any. Maximum of one exam every 180 days per child. Fillings, extractions, crowns and root canals as needed are covered. Braces and other orthodontia are NOT covered under Pediatric Dental Benefits, but are subject to the limit under Non-Pediatric Dental Benefits.
Pediatric Vision Benefits		Subject to Annual Maximum Limit (as defined in this SPD and Plan Document), if any. Maximum of one eye exam per year per child. Maximum of one pair of eyeglasses per year per child. Contact lenses are covered in lieu of eyeglasses. Eyeglass frames and contact lenses limited to maximum of $150.00 per year per child. Tinted lenses and low-vision aids are NOT covered unless medically necessary.

Note: Claims are payable through the Plan Office. Payments will be made directly to the Participants. Proof of payment to the provider is required. The Plan has up to thirty days from the date when the Participant presents the expense claim(s) to pay the applicable benefit. For payment to be received for claims paid in a Calendar Year, the claim and proof

must be submitted to the Plan Office not later than January 31st of the following Calendar Year.

Also, effective **August 1, 2013**, Paragraph (X) on pages 77-78 of the SPD will be modified to read as follows. The change has been underlined for your reference.

> Dental/Vision Care Benefits – The Plan will pay 100% of the total incurred for dental and vision care combined up to a maximum of $800 per year per Participant/Participant's family of the combined total amount (excluding pediatric oral and vision care, which have no lifetime maximum limits <u>but are subject to the limits described on page 40 of this SPD</u>). This benefit also is not subject to the Calendar Year deductible. Payment of the benefit is made by reimbursement directly to the Participant upon the Participant's presentation to the Plan of proof of payment to the provider. The Plan has up to thirty (30) days from the date when the Participant presents the expense claim(s) to pay the applicable benefit amount. For payment to be received for claims in a Calendar Year, the claim and proof must be submitted to the Plan Office not later than January 31st of the following Calendar Year.

As always, if you should have any additional questions, please contact the Fund Office.

BOARD OF TRUSTEES
I.B.E.W. LOCAL 688 H&W PLAN

May 30, 2013