Central Illinois Carpenters Health & Welfare Trust Fund
200 S. Madigan Drive • Lincoln, IL 62656 • (866) 732-1919 • www.cichealth.org
Office Hours: 8:00 a.m. to 4:30 p.m., Monday-Friday

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

NOVEMBER 2024

Dear Plan Participant and Covered Dependent(s):

It is the intention of the Board of Trustees of the Central Illinois Carpenters Health & Welfare Trust Fund ("Plan") to change benefits from time to time when the financial soundness of the Plan requires, and at other times to comply with changes to the Federal law or provide notice of updates to the Summary Plan Description. This Summary of Material Modifications contains information regarding updates to your Summary Plan Description ("SPD"). Accordingly, please retain a copy of this Summary of Materials Modifications with your SPD.

Effective January 1, 2025, the following language in the "Vision Care Services" section of the SPD's Schedule of Benefits will be amended to read as follows:

Vision Care Services	Benefit
In-Network Benefits	Plan Pays After $10 Copay
Examination (every 12 months)	100% *
Lenses (every 12 months) (Single Vision, Bifocal, Trifocal)	$10 Copay $25.00 Copay for anti-reflective lens improvements Up to 40% Discount for Non-Covered Lense Enhancements
Retail Frames (every 24 months)	$200 maximum benefit
Brand Frames (every 24 months)	$220 maximum benefit
Contact Lenses (every 12 months) Elective Contact Lenses	$200 maximum benefit
Medically Necessary Contact Lenses	$10 Copay
* Up to the plan allowance as established by VSP.	
Out-of-Network Benefits	Maximum Plan Pays After $10 Copay
Examination (every 12 months)	$45
Lenses	
Single Vision	$30
Bifocal	$50
Trifocal	$65
Lenticular	$100
Frames	$70
Contact Lenses	
Elective	$105
Medically Necessary	$210
Prescription Safety Glasses	Plan will reimburse a Participant up to $100 for the cost of prescription safety glasses (lenses and frames only) every 12 months from the last date of service. This benefit will be administered by the Fund Office. The Participant must be eligible for benefits with the Plan on the date of service to qualify for this reimbursement benefit. See the "Vision Care Benefit" section of this Summary Plan Description for further information.

Effective May 30, 2024, the SPD's the "When Dependent Coverage Begins" section of the SPD was amended to read as follows:

When Dependent Coverage Begins

Generally, coverage for your Dependents becomes effective on the date you become eligible for coverage. You will be required to provide proof of your Dependent's eligible status under the Plan.

Adding Dependents

If you are eligible for benefits and you acquire a Dependent through a qualifying event such as marriage, the birth of a child, adoption, or placement for adoption of a child or obtaining legal guardianship of a child, eligibility for that Dependent begins on the date of the qualifying event as long as you notify the Fund Office within 90 days of one of these events **AND** return a completed enrollment form with supporting documentation within the required timeframe. Supporting documentation includes, but is not limited to, the following:

- Birth certificate and social security number (when you have a baby).
- Marriage certificate (when you get married and need to add a new dependent).
- Court paperwork (when you adopt a child, or a child is placed with you for adoption or guardianship).

In addition, coverage for your additional Dependents will be effective from the date of the event if you apply for a change within 90 days of any of the following events:

- Loss of eligibility for your Dependent when Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
- Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

You must request this special enrollment within 90 days of the loss of Medicaid or CHIP coverage, or within 90 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Coverage will be effective no later than the first of the month after the special enrollment request is received.

Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 90 days of the date the Fund Office mailed the form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office. <u>YOUR NEWLY ACQUIRED DEPENDENT(S) WILL NOT BE COVERED RETROACTIVELY TO THE DATE OF THE QUALIFYING EVENT BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME.</u> If you do properly enroll your dependents after the 90-day timeframe you will have the opportunity to secure prospective coverage for your dependents – see the "Late Enrollment of Dependents After Qualifying Event" section of this Plan Description for further information.

Late Enrollment of Dependents after Qualifying Event

If you are eligible for benefits and you acquire a Dependent through a qualifying event but fail to notify the Fund Office and return a completed enrollment form within the required timeframes discussed in the "Adding Dependents" section above, you may still seek to enroll the Dependent with the Fund Office. Under these circumstances, you would need to request an enrollment form and return the completed enrollment form and supporting documentation to the Fund Office. Thereafter, the Dependent will be provided coverage from the date the completed enrollment form and supporting documentation are post-marked or received by the Fund Office. Please note that coverage for the Dependent will not be provided retroactively to the date of the qualifying event, and you must be eligible for benefits with the Fund to enroll the Dependent.

Effective May 30, 2024, the SPD's the "Family Status Changes" section of the SPD was amended to read as follows:

Family Status Changes

At some point in your life, you may experience a change in family status that affects your health benefits. The information below is designed to explain what you need to do when you experience a change in family status.

Notifying the Fund Office – What you Need to Do

By notifying the Fund Office of Qualifying Events or Changes in Family Status, such as gaining new Dependents, you help avoid delays or denials in payment of benefits. It is also important to notify the Fund Office when a Dependent loses eligibility. This helps ensure your Dependent is offered COBRA continuation coverage if applicable.

You should notify the Fund Office within 60 days of the date you experience any of the following Qualifying Events:

- When your Dependent acquires other health and/or dental plan coverage (Certificate of Credible Coverage with effective date will be needed);
- When your Dependent loses his/her other health plan coverage (Certificate of Credible Coverage with effective date will be needed);
- When you get divorced (court paperwork will be needed); or
- When your child is no longer eligible for coverage.

Completing an Enrollment/Beneficiary Form

If you experience one of the qualifying events described above, you may also be asked to complete a new enrollment/beneficiary form. Your completed enrollment form and supporting documentation MUST be post-marked or received by the Fund Office within 60 days of the date the Fund Office mailed the form to you. Your completed form and supporting documentation may be returned via mail, scan/email, fax or hand-delivery (during office hours) to the Fund Office.

YOUR NEW DEPENDENT(S) WILL NOT BE COVERED RETROACTIVELY TO THE DATE OF THE QUALIFYING EVENT BY THE HEALTH PLAN IF YOU DO NOT RETURN THE COMPLETED ENROLLMENT FORM AND SUPPORTING DOCUMENTATION WITHIN THE REQUIRED TIMEFRAME.

This enables the Fund Office to maintain up-to-date Dependent data and information about whether you or your Dependents have other health coverage. All of this information allows the Fund Office to process your claims more quickly and more accurately.

Other Changes

When You Have A Change of Address

- Contact the Fund Office for a change of address form or download the form at www.cichealth.org; and
- Send a completed change of address form to the Fund Office as soon as possible after the address change.

In the Event of Your Death

- Your surviving spouse and/or dependents must contact the Fund Office.
- If your Dependents want to continue coverage under COBRA after your death, they must contact the Fund Office within 60 days of the date of your death and request COBRA coverage, unless your Dependents qualify for extended coverage after your death as described on page 53 of this Plan Description. For more information about COBRA, see the "Continuing Coverage Under Special Circumstances" section of this Plan Description.

IF YOU HAVE ANY QUESTIONS ABOUT QUALIFYING EVENTS OR CHANGES IN FAMILY STATUS, PLEASE CONTACT THE FUND OFFICE.

A Final Note

We are pleased to provide you and your family with comprehensive coverage and hope this information helps you get the most out of your benefits. If you have specific questions about your benefits or the SPD, please contact the Fund Office toll free at 866-732-1919.

Sincerely,

Board of Trustees

This announcement, which serves as a Summary of Material Modifications, contains only highlights of a recent change to the Central Illinois Carpenters Health & Welfare Plan. Full details are contained in the documents that establish the Plan provisions. If there is a discrepancy between the wording here and the documents that establish the Plan, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Plan at any time.