Ohio Carpenters' Fringe Benefit Funds
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October 31, 2019

To: All Shop Employees of the Ohio Carpenters Health Plan

From: Board of Trustees of the Ohio Carpenters Health Plan

The Board of Trustees of the Ohio Carpenters Health Plan (Plan) is pleased to announce that medical benefit options for Shop Employees are expanding effective January 1, 2020. Please read this Notice very carefully as it sets forth these options, how to make your election, and corresponding costs for each option. **In order to make an election, you must return the enclosed election Form to the Fund Office by December 15, 2019.**

Effective January 1, 2020, Shop Employees will be able to elect one of the following options:

- Coverage under the Shop Plan, at a cost of $450 per month single or $750 per month family.
- Coverage under the Full Plan, at a cost of $950.00 per month (same cost single or family)

Important Note: Out of pocket costs for participants are higher under the Shop Plan, and there is NO COVERAGE for prescription drugs, dental, hearing, or vision, and no Dollar Bank or Medical Reimbursement Account, which is why it costs less than the Full Plan.

Coverage Options: A summary of these coverage options for 2020 are as follows:

		Full Plan ($950 Single or Family)	**Shop Employees Plan ($450 Single/ $750 Family)**
Medical Deductible	Single		
	In-Network	$500	$1,750
	Out-of-Network	$1,000	$3,500
	Family		
	In-Network	$1,000	$3,500
	Out-of-Network	$2,000	$7,000
Medical Out-of-Pocket Maximum	Single		
	In-Network	$3,500	$7,350
	Out-of-Network	No out of pocket limit for out-of-network expenses.	$14,7000
	Family		
	In-Network	$7,000	$10,000
	Out-of-Network	No out of pocket limit for out-of-network expenses.	$20,000

		Full Plan ($950 Single or Family)	**Shop Employees Plan ($450 Single/ $750 Family)**
Medical Coinsurance (percentage paid by Plan, with remainder paid by Participant)	In-Network	75%	75%
	Out-of-Network	55%	55%
Prescription Drug Coverage		Yes	No
Dental, Vision, and Hearing Coverage		Yes	No
Cost of Coverage Per Month	Single	$950.00	$450.00
	Family	$950.00	$750.00
Dollar Bank		No	No
Medical Reimbursement Account		No	No

In order to establish eligibility effective January 1, 2020, contributions received on your behalf in the month of November 2019 (for the work month of October 2019) must equal or exceed the cost of coverage (set forth above). The monthly cost of coverage will be deducted from the contributions received on your behalf.

If the monthly contributions received are less than the cost of coverage, then the Shop Employee will be required to self-pay the difference in order to maintain coverage. A Shop Employee may only make full self-payments for 12 months. After 12 months coverage is terminated. Thus, for example, if contributions received in November 2019 do not cover the cost of coverage for January 2020, you will receive a self-pay notice in December 2019.

If you do not timely make an election, you will automatically be enrolled in the Full Plan ($950 Single or Family).

Switching Options

A Shop Employee may only switch coverage options during a calendar year if the Shop Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption and the request to change an election is made within 60 days of such. If the request to change an election is timely received, coverage will be retroactive to the date of such event. If the request to change an election is not timely received, coverage will be effective the first day of the first month following the requested change.

In addition, once per calendar year, a Shop Employee covered under the Full Plan may elect to switch to the Shop Employees Plan.

IN ORDER TO MAKE AN ELECTION, YOU MUST RETURN THE ENCLOSED ELECTION FORM TO THE FUND OFFICE BY DECEMBER 15, 2019.

If you have any questions, please contact the Fund office at (248) 641-4967.
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OHIO CARPENTERS' HEALTH PLAN

P.O BOX 1257
TROY, MI 48099-1257
(248) 641-4967
(855) 837-3528

ELECTION FORM – SHOP

Rates Effective 1/1/2020

MEDICAL BENEFITS (choose only one):

*Includes Medical/Prescription

	Single Coverage	Family Coverage
SHOP PLAN	**$450.00** _____	**$750.00** _____
FULL PLAN	**$950.00** _____	**$950.00** _____

By signing this form, I acknowledge that I have reviewed the enclosed information. I also understand that regardless of my election, the Plan encourages participants to use providers (doctors, hospitals, etc.) that participate in the Fund's network, and this will result in lower out of pocket costs to me and my family. I also understand that my election cannot be changed until the next calendar year unless I have a qualifying event, such as marriage or a new dependent.

Participant's Name: _____
(Print)

Participant's Signature: _____

Participant's Social Security #: _____

Date: _____

https://www.ourbenefitoffice.com/OhioCarpenters/Benefits/