MICHIGAN REGIONAL COUNCIL OF CARPENTERS' FRINGE BENEFIT FUNDS

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Dear Participant:

Although you may be familiar with deductibles and co-insurance, we have compiled this Q & A to answer some of the most commonly asked questions to our customer service staff. Please take a few minutes to review the following Questions and Answers and as always feel free to call the Benefits office with any questions or concerns.

1. ***What is a deductible?*** The amount of out-of-pocket cost that must be paid for health care expenses by you, the participant, before becoming payable by the Fund. You have an individual and a family deductible under the Plan.

2. ***My individual deductible is $250, can I just pay that to the hospital and have my deductible satisfied?*** No. The reason is that your deductible is taken off your claims in the order your claims are **received** at the benefits office. Your lab bill may come in before your hospital bill which may apply a smaller amount than what your deductible is.

   Example: your hospital fee is $300, but your lab fee is $50. If the lab bill is received first, $50 will be applied to your deductible, and the remaining $200 will get applied to your deductible from your hospital bill. If you prepay the full $250 to the hospital you will have overpaid the hospital by $50.

3. ***What is a "family" deductible?*** The total dollar amount of out-of-pocket expense that must be paid for health care expenses ***by your family*** before becoming payable by the Fund.

   

   Example: The individual deductible is $250, and the total family deductible is $500. This means that a total of $500 must be paid for health care expenses by any members of the entire family. Once $500 has been applied, the deductible is met for everyone in the family.

4. ***My son is very ill and will have a lot of claims. Can the family deductible be met by just one person in the family?*** No, one family member cannot have more than the individual deductible amount applied toward the family deductible.

5. ***What is the difference between in-network and out-of-network deductibles***? You may have a different deductible amount to satisfy for in-network benefits than what is required for out-of-network benefits. However, the deductibles DO satisfy each other. Meaning, if you met your $250 deductible for in-network, then you have $250 applied to your out-of-network deductible as well.

6. ***What is Deductible Carry Over?*** Any amount that was applied to your deductible in the third quarter of the prior year, will be applied toward your deductible in the current year.

   Example: In November 2014 you incurred a medical claim and $75 was applied to your deductible. Beginning the new year, January 1, 2015 you will already have $75 applied toward your 2015 deductible and now only have $175 left to meet.

7. ***What is co-insurance?*** The amount that the participant and the Fund share in the cost of medical expenses after the deductible is met.

   Example: If you are covered under the 80% co-insurance plan, the Fund will pay 80% of the covered expenses and you will pay 20% after your deductible is met for the remainder of the calendar year, or until you reach your co-insurance maximum.

   Important: do not pay your 20% co-insurance until you receive your Explanation of Benefits (EOB) statement since the original charge will most likely be reduced based on your HAP PPO network allowable or reasonable and customary allowable.

8. ***What is co-insurance maximum?*** The co-insurance limit or maximum amount that a participant will have to pay.

   Example: If your co-insurance maximum is $3,000, you will pay 20% out-of-pocket up to $3,000. The Plan will then pay covered expenses at 100% for the remainder of the calendar year.

9. ***What is a co-pay?*** A co-pay differs from co-insurance in that it is a set dollar amount that you must pay, typically for office visits and emergency room visits. **Co-pays do not apply to your deductible or co-insurance**.

   Example: All office visits require a $25 co-pay, and then the plan pays the remainder of the office visit expense. All emergency room visits require a $100 co-pay, and then the plan pays the remainder of the emergency room visit.

10. ***Who do I pay my deductible, co-insurance and/or co-pay to and when do I pay this?*** Your deductible, co-insurance or co-pay should be paid directly to the doctor or hospital from which it was applied. Be sure to first compare your Explanation of Benefits (EOB) statement(s) you receive from the Plan to any bills you receive from your providers to pay. Be sure you are paying the correct amount owed.

11. ***Who determines what benefits are offered to myself and to my family?*** The Michigan Regional Council of Carpenters' Employee Benefits Plan determines the level of benefits that are afforded to its members. HAP PPO does NOT design the benefit coverage you have. HAP PPO and its affiliate networks contract with your doctors and hospitals to obtain the lowest possible fees the plan and you will have to pay for each service you receive.

12. ***My doctor is not in the network and I don't really want to change doctors.*** You may not have to. Contact the Benefits office and talk with a Customer Service Representative. We will contact the network you are enrolled in and find out if your doctor may be eligible to become a part of the network.

13. ***I was just having some back pain, why do I have to complete an accident report?*** We may need to know more details of your claim to make sure your claim is processed accurately. Back pain or another type of injury may be a result of a work related claim or an auto related claim that would be covered by another carrier.

We hope the information above is helpful to you. In addition you can help your Plan keep medical costs down by following some of these simple suggestions:

- Carefully review every Explanation of Benefits (EOB) statement that you receive to make sure it is accurate; are the services indicated on the EOB actually the services you received?
- Is every test and procedure necessary, don't be afraid to ask your doctor.
- Always ask for generic medications whenever possible.
- If you are starting to use a new medication, start with a one month dosage to make sure your body responds before getting a 90-day supply.
- Do follow your doctor's directions. Do always take your medications as directed, but immediately report to your doctor any unusual side effects.
- Does your spouse have other insurance that may be primary? Make sure the Benefits Office has the most current information on file.
- Always try to use In-Network providers. This is a savings to both you and the Plan.
- Stay healthy, eat well, exercise and play as hard as you work. Finding that balance will help you maintain a positive outlook on life, and overall good health.