



Laborers

Benefit Bulletin

Assisting you in understanding your benefits

Eligibility for Health and Welfare Coverage

Under the Laborers Active Plan, your employer must pay monthly contributions to the Health and Welfare Trust Fund for each hour you work in covered employment. Your paid hours are placed into an "Hour Bank" and your eligibility for Health and Welfare coverage begins the **FIRST** day of the **SECOND** month after you have 440 hours in your "Hour Bank."



Work Month	May	June	July	July Hour Bank Total (-110) H&W Deduction
Hours Employer Reported and Paid	210	185	200	595 - 110 = 485

For example if your "Hour Bank" totals 485 hours at the end of July, you have accumulated the sufficient number of hours for Health and Welfare eligibility beginning September 1.

Remember that 110 hours are taken from your Hour Bank for each month of Health and Welfare coverage.

Work Month	August	September	October	November Hour Bank Total
Bank Balance (+) Hours Employer Reported & Paid and (-) H&W Deduction	485 + 190 - 110	565 + 200 - 110	655 + 120 - 110	665

Note: To continue month-to-month coverage, you must maintain a minimum balance of 440 hours.

For your protection, retain all paycheck stubs. If you find you have more worked hours than hours reported, contact the Trust Fund Office.

REMINDER

When you write a check for:

Union Dues:

Mail the check to your Local Union Office, *not* the Trust Fund Office.

Provider Services:

Mail the check to the Provider of Service noted on the EOB Form, *not* to the Trust Fund Office.



Summary of Benefits Pamphlet

Active Plan

Enclosed with this issue of the Benefit Bulletin is the revised Summary of Benefits pamphlet.

This pamphlet summarizes benefits available to eligible participants and dependents.

Attention Former Kaiser Members and Newly Eligible Participants

Explanation of Benefits (EOB)

If you have recently visited a doctor, the Trust Fund Office will soon send you an EOB in the mail. The EOB summarizes services performed by your doctor.

Each procedure shows a "Billed Amount," and a "Negotiated Amount" or "Allowed Amount." If you use the services of an Anthem Blue Cross *Prudent Buyer Plan* (PPO) provider, the EOB indicates "Yes" under the Billing Summary and the amount the provider has contracted for the service appears under the column "Negotiated Amount." If you did not use the services of a PPO provider, a "No" appears next to "Participating" under the Billing Summary. There is no discount when you use the services of a non-PPO provider.

Columns A, B, and C show the Patient Responsibility (the amount you pay) for copayment, deductible and co-insurance. The PPO provider co-insurance is 10%; the non-PPO provider co-insurance is 30%.

The difference between the Negotiated /Allowed Amount, less patient responsibility under Columns A, B, or C equals the Fund Payment.

If you used the services of a non-PPO provider, the Patient Responsibility is the difference between the Billed Charges and the Fund Payment.

Always review the EOB. It is your record of how the Trust Fund Office processed your claim for benefits.

Laborers Health and Welfare Trust Fund for Northern California

220 Campus Lane Fairfield, CA 94534-1498 Telephone (707) 864-2800

Explanation of Benefits

This notice summarizes the benefits for the claim described below.

See reverse side for Important Information

BILLING SUMMARY

INSURED'S NAME: J LABORERS **DATE OF SERVICE:** 03/01/09-03/01/09
INSURED'S ID: LA0006789 **PROVIDER:** J PHYSICIAN, MD
PATIENT'S NAME: JOHN **PARTICIPATING:** YES
PATIENT'S ACCT: 9999999999 **TOTAL CHARGES:** \$475.00

PAYMENT SUMMARY

ISSUED TO: PROVIDER
CHECK DATE: 03/20/09
CHECK AMOUNT: \$157.50
CHECK NUMBER: 987654

BREAKDOWN OF BILLED CHARGES AND BENEFIT DETERMINATION

DATES OF SERVICE FROM THRU	DESCRIPTION OF SERVICES AND BENEFIT APPLICATION	BILLED AMOUNT	NEGOTIATED AMOUNT	ALLOWED AMOUNT	A LESS COPAY	B LESS DEDUCTIBLE	C LESS COINSURANCE	FUND PAYMENT	PATIENT RESPONSIBILITY	SEE NOTE BACK
03/01/09	99213 VISIT OFFICE/OTHER	\$100.00	\$75.00		\$15.00	\$60.00		\$0.00	\$75.00	1
03/01/09	41000 INTRAORAL INCISION	\$200.00	\$150.00			\$90.00	\$6.00	\$54.00	\$96.00	1
03/01/09	71020 CHEST X-RAY	\$175.00	\$115.00				\$11.50	\$103.50	\$11.50	1
TOTALS		\$475.00	\$340.00	\$0.00	\$15.00	\$150.00	\$17.50	\$157.50	\$182.50	
		LESS PPO DISCOUNT	\$135.00	The patient or the Trust Fund is not responsible for this amount per Prudent Buyer Plan agreement.						
		LESS PRIMARY INSURANCE PAYMENT	\$0.00							
		LESS PREVIOUS PAYMENT	\$0.00							
		LESS PROVIDER REFUND	\$0.00							
		LESS PROVIDER TAX	\$0.00							
		LESS FUND PAYMENT	\$157.50							
		PATIENT RESPONSIBILITY	\$182.50	Amount payable by participant less copayment paid at the time of doctor visit.						

BENEFIT CONTACT INFORMATION

Delta Dental 800-765-6003 www.deltadentalca.org	Bright Now! Dental 888-274-4486 www.brightnow.com	Rx Solutions 800-562-6223 www.rxsolutions.com	PacificCare / Secure Horizons 800-624-8822 www.pacificcare.com
DeltaCare USA 800-422-4234 www.deltadentalca.org	Pacific Union Dental 800-999-3367 www.pacificuniondental.com	Health Net / Seniority Plus 800-522-0088 www.healthnet.com	Vision Service Plan 800-877-7195 www.vsp.com
Claremont Behavioral Services 800-834-3773 www.claremonteap.com			