MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Important Information Regarding the Annual Open Enrollment Process

Marketplace (Hourly)

January 17 – February 28, 2022

The information provided in this document is of general nature only and does not replace or alter the official rules and policies contained in the official Plan Documents (including amendments) that legally govern the terms and operations of the Midwest Operating Engineers Welfare Fund. If this publication differs in any way from the official Plan Documents, the official Plan Documents will always govern. The Board of Trustees have the right to modify the Midwest Operating Engineers Welfare Fund at any time. [2022 OE Guide Edition]

Important Information Regarding the Annual Open Enrollment Process

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Open Enrollment Information

What is Annual Open Enrollment?

Annual open enrollment will be held from January 17 through February 28, 2022. During this time, you can review all the Marketplace health plan options, compare plans, review projected work hours to determine which health plan option will best fit your family's needs. The health plan option that you select will be for medical and pharmacy coverage for the new Plan Year effective April 1, 2022 through March 31, 2023.

During open enrollment, you can:

- Select a new health plan option or retain the same health plan option
- Select your coverage tier (Member Only, Member + 1, Family)
- You can dis-enroll dependents from your health plan – You may need to contact the Fund Office to complete a 2022 Dependent Disenrollment form, depending on your specific situation
- You can add dependents to your health plan for the upcoming plan year
- You can transfer credits from your Credit Bank to your Retiree Medical Saving Plan (RMSP) account, if eligible

Who is Eligible for Open Enrollment?

Depending on when you met the eligible requirements of the Marketplace, each year you may be given the opportunity to select a different health plan option and/or coverage tier. If you became eligible during the 2021/2022 Plan Year, it is critical for you to attend an open enrollment event. You and your spouse can meet with a Fund Office navigator and discuss the health plan options that you can afford based on your Credit Bank and anticipated work hours. You do not want to choose an option that you cannot afford; you will run the risk of losing eligibility. Upon regaining eligibility, you will once again be automatically enrolled in the Bronze PPO Plan.

If you were automatically enrolled in the Bronze PPO Plan, open enrollment is extremely important. This is your opportunity to select from seven health plan options with varying monthly credit cost deductions. Please take the time to use the **Health Plan Wizard** and **Affordability Calculator** to determine which health plan option best meets your family's needs based on your expected work hours and your Credit Bank reserve.

If you are first eligible January 1 or February 1, 2022, you will automatically be placed in the Bronze PPO Plan for the remainder of the 2021/2022 Plan Year. If you need to update your coverage tier, please submit the required documents so that the Fund Office can validate these dependents as soon as possible. During open enrollment, you will also be required to choose a health plan option/coverage tier for the upcoming Plan Year: April 1, 2022 through March 31, 2023. If you have any questions, call the Fund Office at 708-579-6675.

PLEASE NOTE: If you are first eligible March 1, 2022, you will automatically be placed in the Bronze PPO Plan and will remain in this health plan option through March 31, 2023. You will not be allowed to change your health plan option until the open enrollment period for the 2023/2024 Plan Year (mid-January 2023 through February 28, 2023), for coverage effective April 1, 2023 through March 31, 2024.

Open Enrollment Events

The Fund Office will be hosting open enrollment events in select District Union Halls. The purpose of these events is for you to meet one-on-one with a Fund Office navigator to discuss the health plan options, answer any questions you may have regarding the various health plans, assist you with the enrollment process and if eligible, assist you with determining how many credits you can transfer to your RMSP account. To register for one of the events, visit https://local150.org/moe/about/benefit-seminar-open-enrollment-information/. Appointments will start at 9:00 a.m. Please bring your spouse; however, you must make alternative childcare arrangements.

The event schedule is as follows:
District 1 Union Hall – 6200 Joliet Road, Countryside, IL 60525 – Saturday, January 22, 2022
District 7 Union Hall – 2193 W. 84th Place, Merrillville, IN 46410 - Saturday, January 29, 2022
District 5 Union Hall – 740 E. Route 5, Utica, IL 61373 - Saturday, February 19, 2022

PLEASE NOTE: The Fund Office navigator is not licensed to recommend which health plan option to select or how many credits you should transfer.

For first year Apprentices, if you are unable to attend one of the above events, there will be a mandatory open enrollment event scheduled for Friday, February 11, 2022, from 9 a.m. – Noon and will be held at the training site.

Additional Resources Available During Open Enrollment

MOE Health Plan Marketplace Call Center: Get assistance from an experienced Blue Cross Blue Shield of Illinois licensed health navigator with enrolling and transferring credits to your RMSP account, if applicable. Translators are available upon request. To get started, call **844-693-1467** toll-free during open enrollment:
— Monday–Friday: 8 a.m. to 7 p.m. CST
— Saturday: 8 a.m. to 12 p.m. CST

Fund Office Marketplace Call Center: Call 708-579-6675 with a question or to schedule an appointment at the Fund Office. During the open enrollment period, staff will be available during the following hours to assist members with the open enrollment process:
— Monday, Tuesday, Wednesday, Friday: 8 a.m. to 7 p.m. CST
— Thursday: 9 a.m. to 7 p.m. CST
— Saturday: 8 a.m. to 12 p.m. CST

OHC Plan Member Services Representative: If you are interested in the OHC Plan, speak to a specialized representative at 708-579-6668.

Computer Kiosks: Available at each District Office and the Fund Office to help you register for My150 and/or enroll in the Marketplace and transfer credits, if eligible.

Important Reminders

Are you registered on My150 (www.My150.com)? If not, please do so as soon as possible. The open enrollment process is handled through your My150 account.

If you already have a My150 account, please be sure that you can access your account. If you have not used your My150 account in a while, you may need to reset your password, or worst case, your account may be locked due to inactivity. If you need assistance with either of these situations, please contact Technical Support at 888-220-3599.

Once you are in your My150 account, you should:

- review your profile information and ensure your address is correct
- review your Credit Bank and determine how many credits you used during the 2021/2022 Plan Year. Did you have a surplus in credits or was there a deficit? Are you planning on retiring in the upcoming 2022/2023 Plan Year? If you are eligible to transfer credits, start considering how many credits you may want to transfer to your RMSP account.
- review your dashboard and your My Claims to determine if you optimized the coverage under the health plan option that you selected for the 2021/2022 Plan Year?

Features of the Midwest Operating Engineers Health Plan Marketplace (i.e., Marketplace)

What health plan options and coverage tiers are available to eligible member of the Marketplace during the open enrollment period?

There are seven different health plan options available under the Marketplace:

- The Operators' Health Center (OHC) Plan
- Plan A PPO
- Platinum PPO
- EPO (modified HMO)
- Gold PPO
- Silver PPO
- Bronze PPO

There are three different coverage tiers available under the Marketplace:

- Member Only
- Member + 1
- Family

To review and compare health plan options, visit www.local150.org/moe/, click **READ MORE** and then click on the Marketplace tile.

Updated Monthly Credit Cost Deductions Effective April 1, 2022 through March 31, 2023

The updated monthly credit cost deductions are shown below. The updated rates are based on a 3.00% increase.

Updated Monthly Credit Cost Deductions for the MOE Health Plan Marketplace							
Health Plan Option	**OHC Plan**	**Plan A**	**Platinum**	**EPO (modified HMO)**	**Gold**	**Silver**	**Bronze**
Updated Rates from April 1, 2022 – March 31, 2023							
Family	1,584	1,864	1,779	1,754	1,633	1,536	1,269
Member + 1	1,394	1,638	1,564	1,540	1,434	1,349	1,115
Member Only	1,201	1,412	1,346	1,328	1,238	1,164	680
Current Rates through March 31, 2022							
Family	1,538	1,810	1,727	1,703	1,585	1,491	1,232
Member + 1	1,353	1,590	1,518	1,495	1,392	1,310	1,083
Member Only	1,166	1,371	1,307	1,289	1,202	1,130	660

Retiree Subsidy Effective April 1, 2022 through March 31, 2023

We are pleased to announce that the retiree subsidy will decrease from 20% to 17.3% for the upcoming Plan Year.

How Are Credits Allocated to the Credit Bank?

Monthly credits are determined based on your hourly Employer Contribution Rate less the Retiree Subsidy multiplied by the number of hours you work each month. As the Retiree Subsidy decreases, the Credit Cost per hour worked will increase.

Example:
If you fall under the Heavy Highway contract, your current hourly Employer contribution rate is $16.75. Therefore, to determine the cost of a credit, you will need to remove the retiree subsidy.

Employer Contribution Rate:	$16.75
Less Retiree Subsidy (16.75 x .173):	(2.90)
Credit Cost Per Hour Worked:	13.85/hour

If you work 145 hours in June 2022, those hours are received in July 2022, and credits will be added to your bank to use for August 2022 of 2,008 credits (145 hours x 13.85).

If you would like to remain under the Family Plan A health plan option for the 2022/2023 Plan Year, to maintain this coverage you would need to work approximately 1,615 hours [(1,864 plan cost/13.85 credit cost) x 12] per Plan Year. Any hours worked above 1,615 will add a surplus of credits to your Credit Bank.

If you are required to be in the Bronze PPO plan with Member Only coverage, to maintain this coverage you would need to work approximately 589 hours [(680/13.85) x 12] per Plan Year. Any hours worked above 589 will add a surplus of credits to your Credit Bank.

If you are a seasonal member and you only work nine months out of the year, you need to be mindful of how many credits you earn during those nine months to maintain your coverage. Suppose the member works 160 hours/month and he earns 13.85 credits/hour. What health plan option should he select to maintain his eligibility for Family coverage?

On a monthly basis, he will bank:

160 (hour/month) x 13.85 (credits/hour) x 9/12 (months/year) = 1,662 credits

He will be able to afford Family coverage under the following health plan options:

- ✓ **OHC Plan** monthly credit cost is 1,584. He will have a surplus of 78 credits each month (1,662 – 1,584).
- ✓ **Gold PPO Plan** monthly credit cost is 1,633. He will have a surplus of 29 credits each month (1,662 – 1,633).
- ✓ **Silver PPO Plan** monthly credit cost is 1,536. He will have a surplus of 126 credits each month (1,662 – 1,536).
- ✓ **Bronze PPO Plan** monthly credit cost is 1,269. He will have a surplus of 393 credits each month (1,662 – 1,536).

PLEASE NOTE: If he selects Plan A PPO Plan, Platinum PPO Plan, or the EPO Plan, he will need to use credits in his Credit Bank which may cause him to lose coverage under the Marketplace. If he loses coverage, he will need to re-establish his eligibility and will be auto enrolled into the Bronze PPO Plan for Family coverage.

Overview of Health Plan Options

Here's a brief overview of the differences among your health plan options. Keep in mind, the Welfare Fund provides additional resources, including online decision tools and personalized assistance, to help you compare your options and choose the one that's best for you.

- **The OHC Plan uses a customized network, which includes the Operators' Health Center and HST Care Connect providers and facilities.** It gives you the flexibility to go In- or Out-of-Network, but you and your eligible dependents will receive all medical services covered by the plan for free when you use In-Network providers. This means there is no deductible and no coinsurance if you use an In-Network provider! **Note:** If you choose to see an Out-of-Network provider, you may pay more for services, except for a life-threatening emergency. **It is extremely important that you take an active role when selecting this health plan option.** If you are thinking about choosing the OHC Plan or have any questions, or to make sure your current health care providers are In-Network, contact a specialized OHC Plan Member Services Representative at **708-579-6668.** Also, you must take into consideration the geographic location of any covered eligible dependents (i.e., a child that resides with an ex-spouse or a child attending an out-of-state university).

  Members enrolled in the OHC Plan will have access to In-Network providers at:
  - **Operators' Health Centers.** Both the Countryside and Merrillville locations perform primary/acute care, lab work, condition management and DOT physicals. Both centers also provide on-site physical therapy services.
  - **Activate (the Union Division of Everside Health).** Facilities are in Rockford, IL and Davenport, IA.
  - **HST Care Connect network** for providers/facilities at:
    Advocate Health Care system, including Advocate Clinics at Walgreens
    Community Hospital system
    Methodist Hospital system

  For additional details on this health plan option, see section Operators' Health Center (OHC) Plan Details.

- **Plan A, Platinum, Gold, Silver and Bronze plans are Preferred Provider Organization (PPO) Plans.** These plans use the same Blue Cross Blue Shield network of providers. The main difference between these options is the amount of the deductibles and coinsurance. With these plans, once you meet the deductible, you pay your share of covered medical expenses through coinsurance. You can see any provider you want, but you save money if you use In-Network providers.

- **The Bronze Plan does not include dental, life insurance, accidental death and dismemberment, or disability benefits.** Under this health plan option, you need to optimize the available FREE services.

- **The EPO is an Exclusive Provider Organization.** It uses the same Blue Cross Blue Shield network as the PPO plans, but it works like a Health Maintenance Organization (HMO). You **must use** In-Network providers; otherwise, the plan will not pay benefits, except for life-threatening emergencies. There is no deductible, but you pay for medical services through copays. However, unlike an HMO, you do not have to choose a primary care physician (PCP) or get referrals to see specialists. **If you are thinking about choosing the EPO, refer to Finding In-Network Providers to make sure your current health care providers are in the network.**

PLEASE NOTE: You can also review the Comparison Chart by visiting www.local150.org/moe/, click READ MORE and then click on the Marketplace tile.

Does a member have to enroll into a health plan option if he can be covered under his parents' plan or a spouse's plan?

If you are earning credits in your Credit Bank, you must enroll into the Marketplace. You could select the lowest costing health plan option, member only coverage and continue to bank credits.

Do all family members have to select the same health plan option and coverage tier?

Yes!

Free Services Under ALL Health Plan Options

Regardless of the health plan option that you select during open enrollment, for coverage starting April 1, 2022 through March 31, 2023, be sure to use the following free services for you and your family.

- Under the Affordable Care Act, preventive services are covered at 100% if you see an In-Network provider. Talk to your provider about these services.
- Services covered by your plan are free if performed at one of the Operators' Health Center locations. Both health centers
  - offer free DOT physicals
  - offer free physical therapy services
  - can provide limited prepack medications at your appointment, when necessary
- Services covered by your plan are free if performed at one of the Activate facilities (the Union Division of Everside Health).
  - Both facilities offer free DOT physicals
  - Through our partnership with Activate, you can also utilize the 24/7 nurse line to seek triage after hour services.
  - Providers can prescribe and distribute generic medication, if necessary
- Absolute Solutions will provide FREE MRI, CT, and PET scans, if medically necessary, when you use one of their facilities.
- MinuteClinics, located in CVS and Target retail stores, cover several services for free. There are some cash-pay services.
- ATI Physical Therapy covers physical therapy services for free, if medically necessary.
- If you use an EyeMed Advantage Network provider, you and your covered dependents will receive a FREE eye exam. In addition, the EyeMed Advantage Network offers numerous discounts on vision services.
- The Member Assistance Program through Employee Resource Systems, Inc. (ERS) offers up to five free counseling sessions (per episode) with master's-level clinicians for you and any family member, regardless of eligibility.

PLEASE NOTE: Newly eligible members on or after March 1, 2022 and members that re-establish eligibility, will remain in the Bronze PPO Plan until March 31, 2023. Please take advantage of the above FREE services.

Operators' Health Center (OHC) Plan Details

Recap of the OHC Plan

When the Trustees first considered providing a Plan of this nature, the goal was to ensure great services which were accessible and cost effective. Therefore, the Plan details were outlined as follows:

- The OHC Plan is a customized network and **not affiliated with the BCBS PPO network**.
- **By using the customized network, members pay nothing!** No deductibles, no co-insurance/co-payments. In other words, you receive all covered services for free, as long as you use the customized network.
- The monthly credit cost deductions are significantly less than Plan A PPO. The OHC Plan cost is approximately 15% less than Plan A PPO.
- To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Community, or Methodist Hospital; otherwise, this health plan option will not appear as one of the health plan options in My150.

Members and covered dependents under the OHC Plan must take an active role in determining if providers/facilities are in the network. Refer to the OHC Plan - Finding In-Network Providers.

Expanded OHC Plan Network

Effective April 1, 2021, the OHC Plan network expanded to include Northwest Indiana by adding both Community Hospital system and Methodist Hospital system. Members who are eligible to enroll into the OHC Plan, have access to in-network providers at:

- Both OHC locations; Countryside, IL and Merrillville, IN.
- Both Activate locations, Rockford, IL and Davenport, IA.
- HST Care Connect Network for providers/facilities at:
    - Advocate Healthcare System, including Advocate Clinics at Walgreens
    - Community Hospital system
    - Methodist Hospital system
- Take advantage of the FREE Services
- Use EyeMed to receive a free eye exam per Plan Year and discounts on vision wear; receive reimbursement under your Family Supplemental Benefit
- Use Delta Dental of IL to receive dental services that will be considered in-network
- The certification program through Valenz, the Fund's Case Manager remains the same

PLEASE NOTE:

- The monthly credit cost deduction from your Credit Bank will be the same for both Illinois and Indiana residents.
- To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Community, or Methodist Hospital. If you live outside this established mile radius, the OHC Plan will not appear as one of the health plan options available to select in My150.

OHC Plan Design

The objective of the OHC Plan is that if you use in-network providers, all covered services are FREE!

For those eligible active members that can select the Operators' Health Center (OHC) Plan as a health plan option, the **plan design is as follows:**

Deductible and Out-of-Pocket Limits	New OHC Plan Design Effective April 1, 2021	
	In-Network	**Out-of-Network**
Individual Deductible	$0	$300
Family Deductible	$0	$700
Individual Out-of-Pocket Limit	$2,500	$2,500
Family Out-of-Pocket Limit	$6,000	$6,000
Services Considered At	100%	70% of VBP[(1)]

[(1)] VBP is a transparent way of determining how much a provider or facility will be paid for certain services received outside of the network. It works by reimbursing the provider or facility based on a reference price. Because it is fully transparent and based on costs, the end result is a price that is fair to both the provider or facility and the patient.

How the OHC Plan Works

The Operators' Health Center (OHC) Plan allows you and your covered family members to receive routine health care and urgent care at the Operators' Health Center—located at the Countryside, IL campus or in Merrillville, IN—at no cost to you. You and your covered family members can also receive FREE routine health care and urgent care at Activate (the Union Division of Everside Health)-located in Rockford, IL or in Davenport, IA.

For after-hours urgent care, you can visit a MinuteClinic in CVS or Target retail stores, or an Advocate Clinic located in Walgreens stores. For medical services not provided at the Operators' Health Center, such as specialist visits or hospitalization, the OHC will refer you to an HST Care Connect provider. HST Care Connect providers include those from Advocate Health Care, the Community Hospital system, or the Methodist Hospital system. **PLEASE NOTE:** Always verify with your provider or a specialized OHC Plan Member Services representative of the provider/facility's network status to ensure that they remain in-network.

If you choose to see an out-of-network provider or facility, you will pay more for services, except for a life-threatening emergency. However, certain out-of-network services with limited or no in-network access will be covered at 100%. For example, the OHC can refer you to any chiropractor or acupuncturist, and the services will be covered at 100%. HST Care Connect currently does not have a network of chiropractors or acupuncturists.

For more specific information regarding this health plan option, contact a specialized OHC Plan Member Services representative at **708-579-6668.**

What services have limited or no In-Network access?

There are some provider gaps that have been identified. These service gaps will be considered at the In-Network benefit level, regardless of the provider that the member uses. These services include:

- Acupuncture
- Ambulance
- Ancillary Charges related to an In-Network Admit (anesthesiologist, surgeon, etc.)
- Behavior Health/Substance Abuse (all levels of care. Inpatient and Outpatient)
- Chiropractic Care
- Durable Medical Equipment
- Life Threatening Emergency Room Visit
- Skilled Nursing Facilities
- TMJ

What happens if I use an out-of-network provider or facility?

If you use an out-of-network provider or facility, you will pay more. The out-of-network provider or facility may balance bill you. If you are balance billed, contact the Patient Advocacy Center (PAC) at **888-837-2237** or **pac@hstechnology.com**. They will handle all communications with the provider or facility and negotiate the best price for any out-of-network services that you receive. **PLEASE NOTE:** Balance billing is not subject to your out-of-pocket maximum.

The following are examples for illustrative purposes only. If you use an out-of-network provider, the provider may balance bill you for the service rendered. In situations like this, you will need to contact the Patient Advocacy Center (PAC) at 888-837-2237. The PAC will be responsible for negotiating the VBP with the provider.

Example 1 - Routine Doctor's Visit: The VBP is based on the cost Medicare would pay for a service plus a negotiated percentage. In this example, the VBP would be the Medicare allowable expense plus 160%. If you have an out-of-network doctor's visit and Medicare pays $50 for that visit, the VBP would be $80 ($50 x 1.60).

Suppose you already met the $300 out-of-network deductible. Under the current OHC Plan design, you would be responsible for paying only 30% of the out-of-network VBP or $24 (30% x $80).

Example 2 – Knee Replacement: The VBP is based on the cost Medicare would pay for a service plus a negotiated percentage. In this example, the VBP would be Medicare allowable expense plus 180%. If you have a knee replacement and you opted to use an out-of-network surgeon and Medicare pays $5,000 for the knee replacement, the VBP would be $9,000 ($5,000 x 1.80).

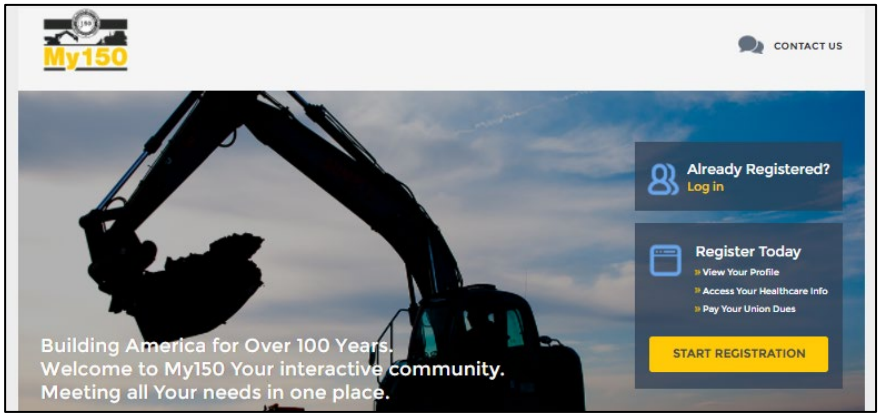
Under the current OHC Plan design, you must first pay $300 towards the out-of-network deductible. Your remaining coinsurance amount would be 30% of the VBP less the deductible or $2,610 determined as follow: ($9,000 - $300) x .30 = $8,700 x .30 = $2,610. However, this amount exceeds the total out-of-pocket expenses which is limited to $2,500 ($300 deductible + $2,200 coinsurance). Your coinsurance will be limited to $2,200.

Selecting a Health Plan Option/Coverage Tier

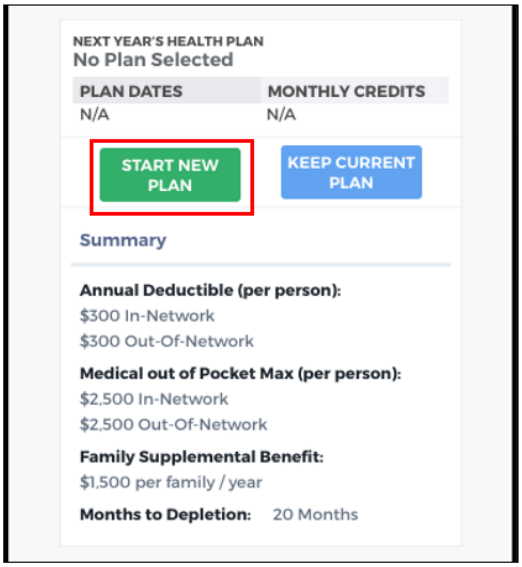
You can enroll for coverage through the My150 community website at: www.My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime, from anywhere.

Follow these steps to enroll:

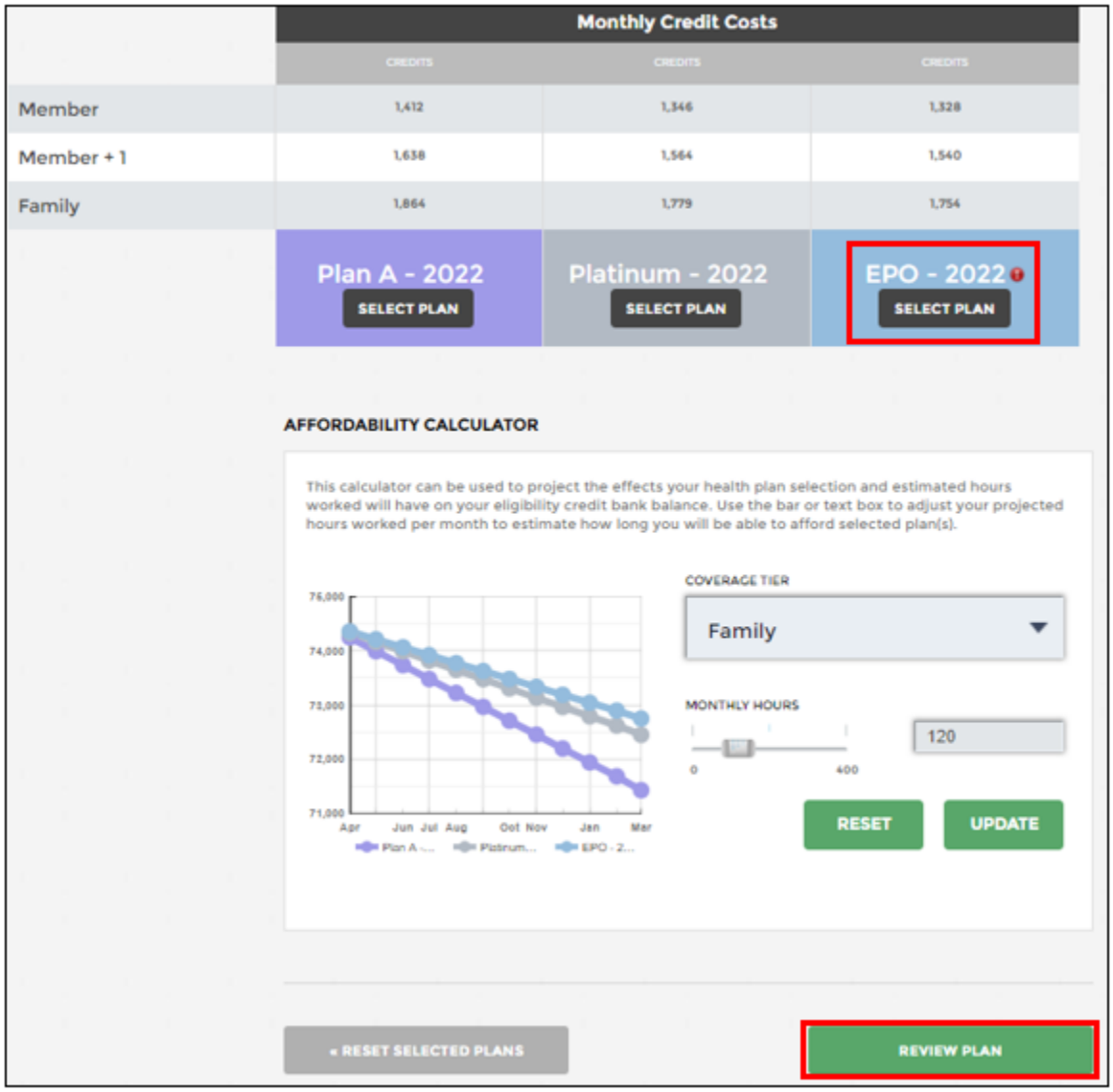
1. Log in to your My150 account and review the My Health Plan tile on the homepage. If you're not registered, click **Start Registration,** and follow the prompts to create your My150 account.



2. Click **START NEW PLAN** and follow the steps to compare up to three health plan options. Explore your health plan options with the Health Plan Wizard.



3. Compare up to three health plan options and review credit costs with the Affordability Calculator.

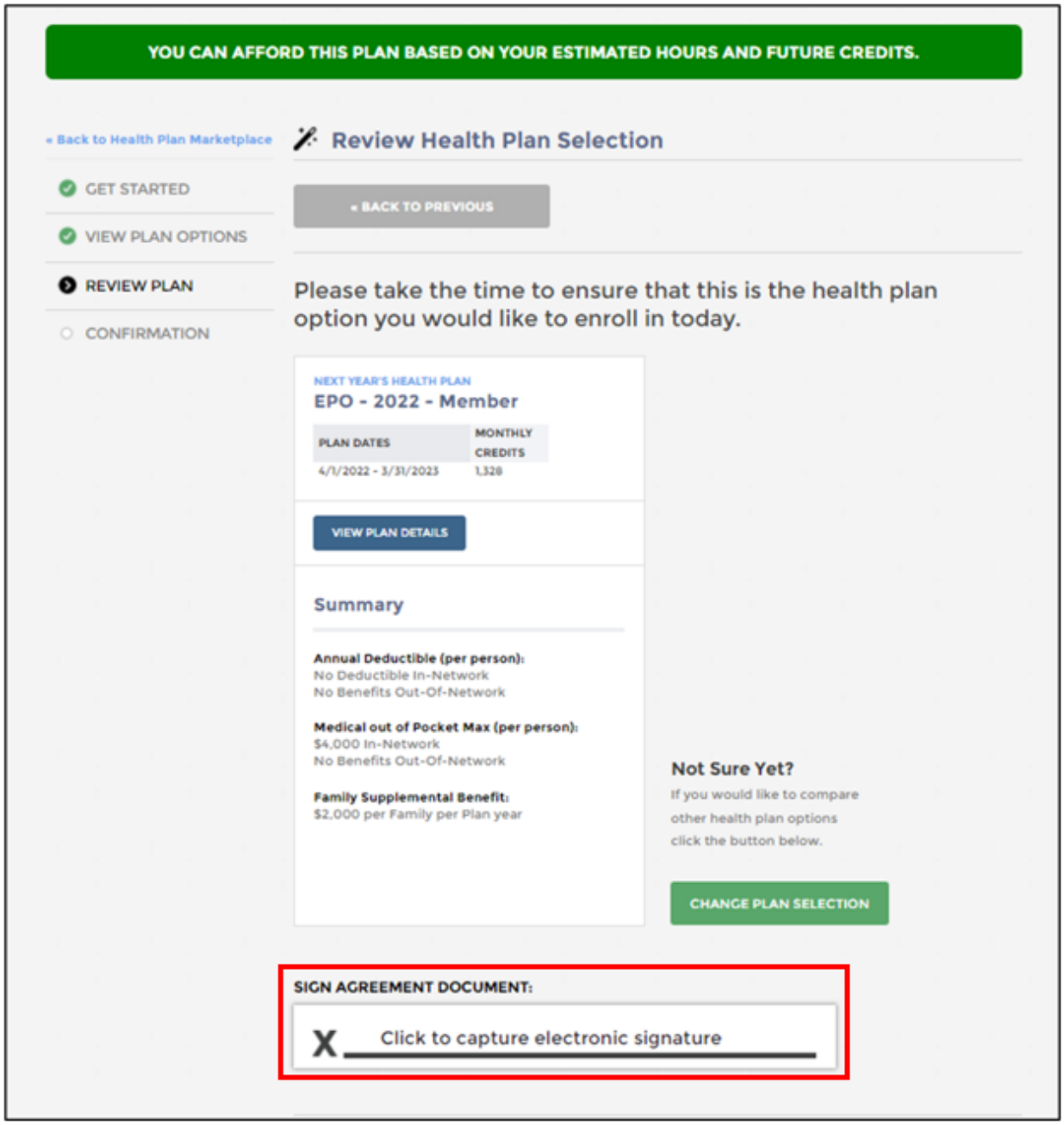


PLEASE NOTE:

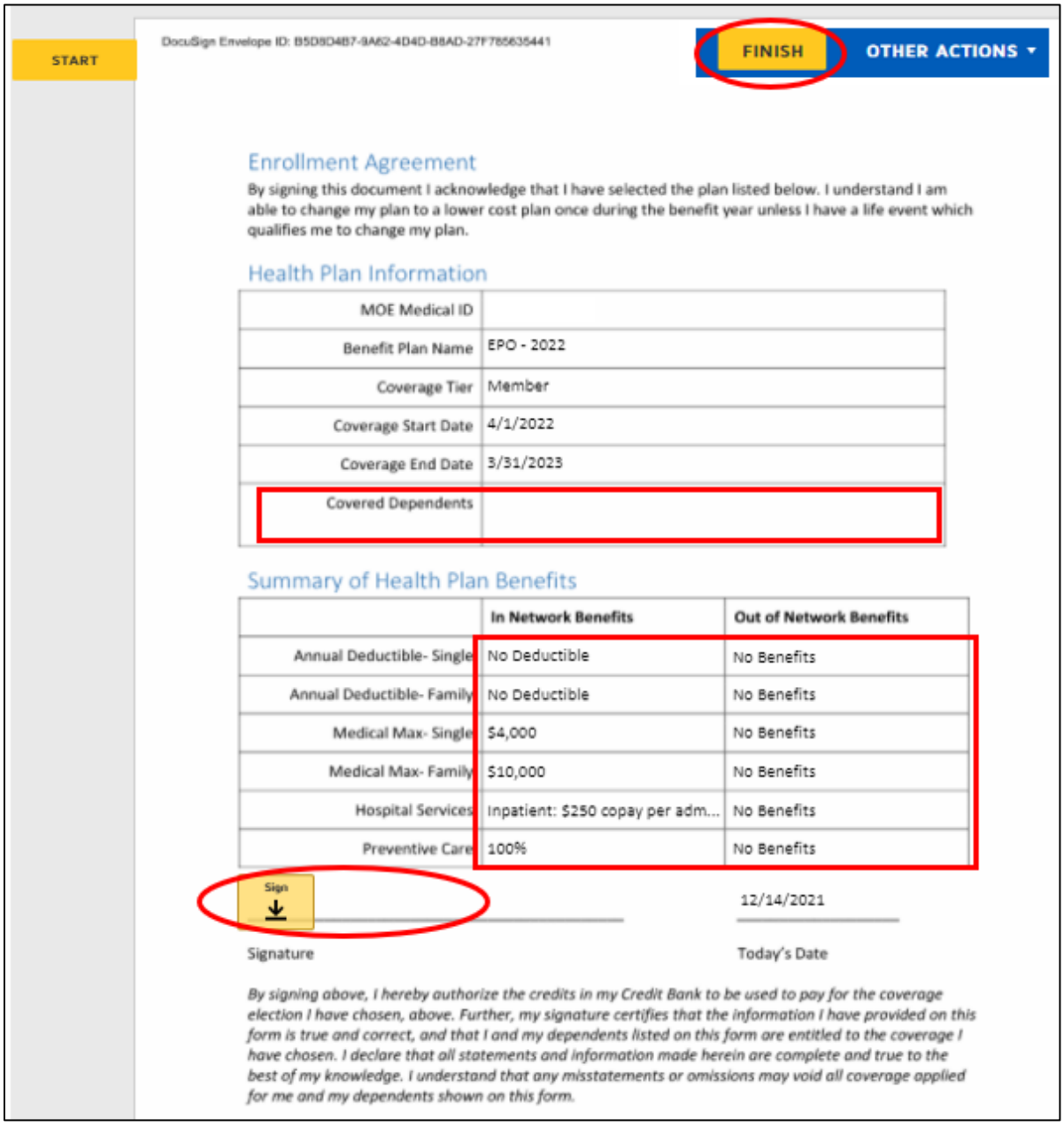
- If you are married and after you **SELECT PLAN** AND **REVIEW PLAN,** you will then need to complete the Coordination of Benefits information.

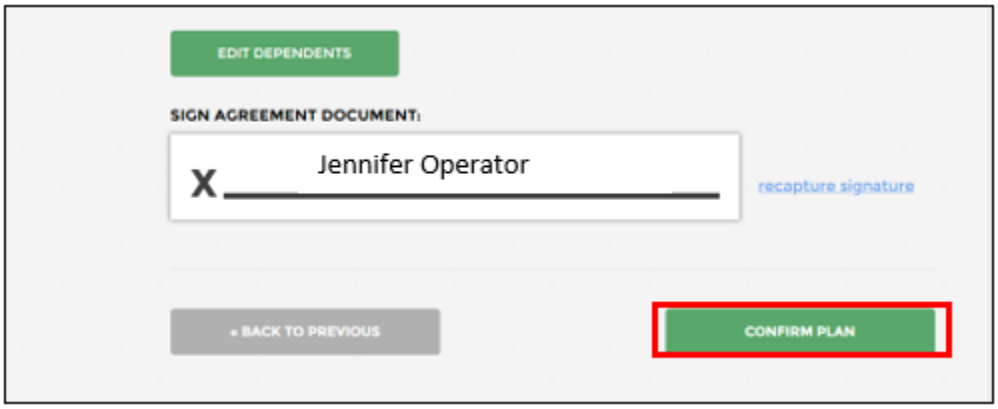
4. After you select a health plan option, click on the **SIGN AGREEMENT** section. This will transition over to the DocuSign Agreement. Be sure to review the selected plan details and review your covered dependents.

   Each year, you can change your coverage tier (Member Only, Member + 1, Family). If you are adding a new dependent, you will need to ensure that you upload the required documents as noted in the Adding a Dependent During Open Enrollment section.

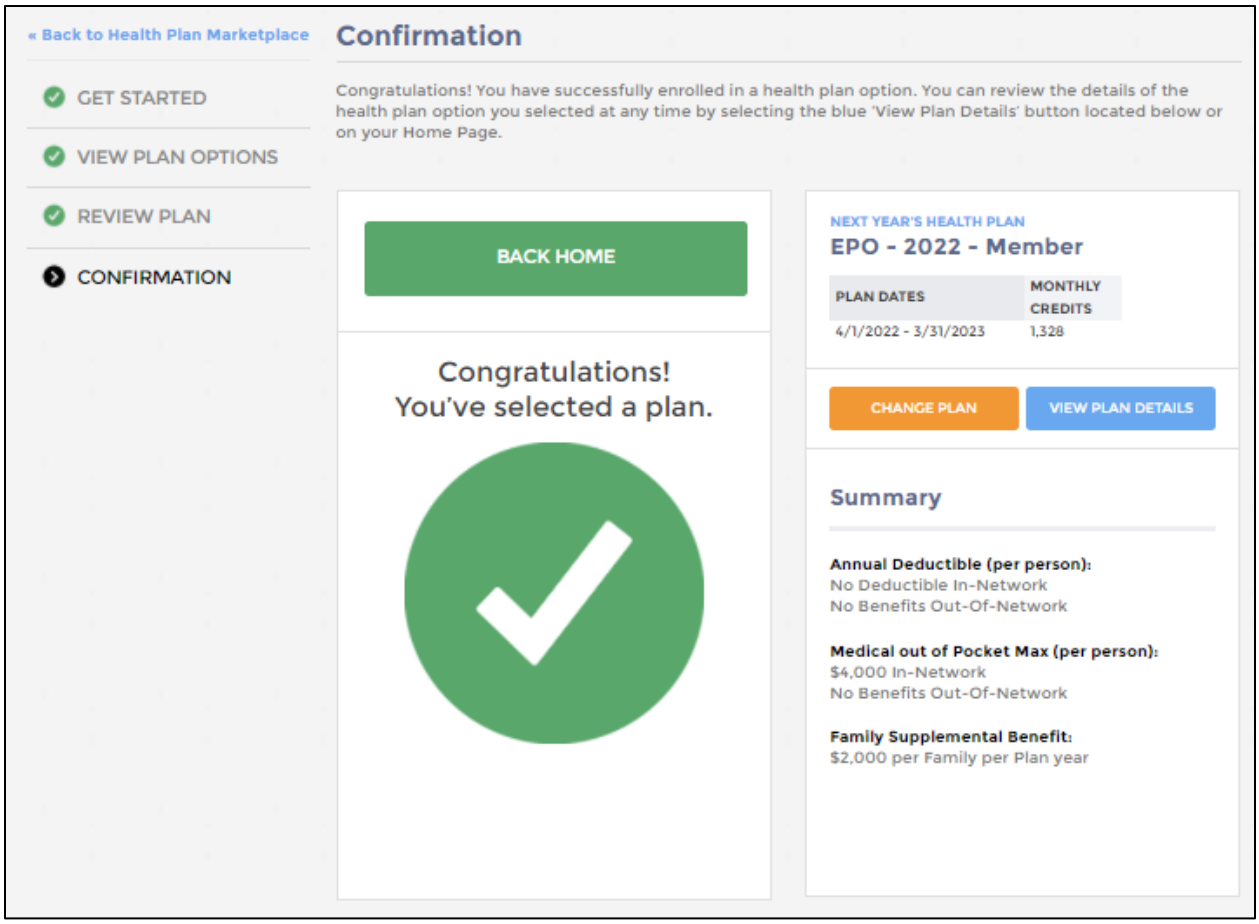


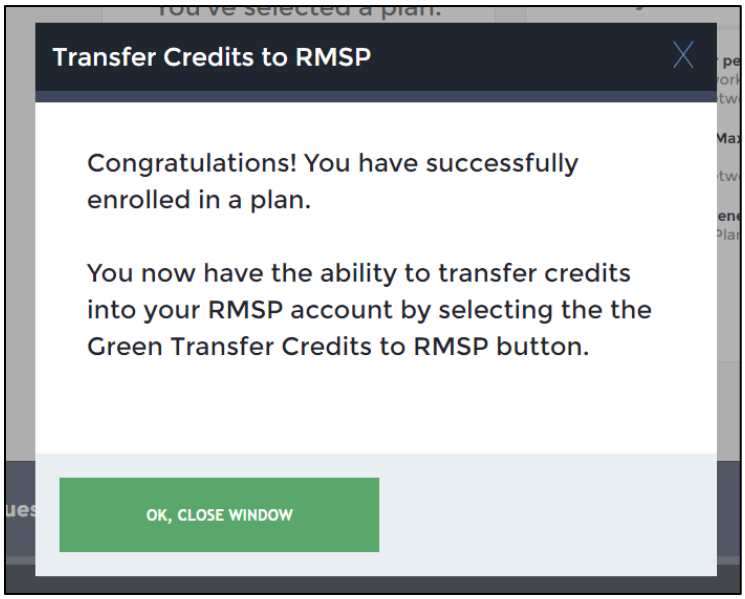
If your selection looks good, be sure to complete the DocuSign agreement and click FINISH.





5. Once you decide, click **Adopt** and **Sign**. You will receive a confirmation pop-up that you have successfully selected a health plan option. You will also receive an email confirmation. The document you sign will be added to the **My LIBRARY** page.

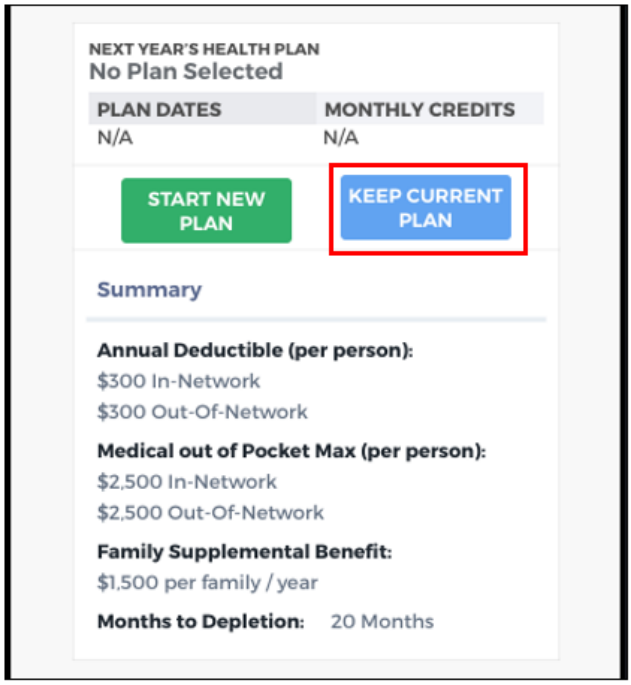




If you can transfer credits, you will be prompted to do so after you select your health plan option or you have until February 28th to make your transfer. For more information, refer to the Transfer Credit section.

Keep Current Plan

If you are satisfied with the health plan option that you had for the 2021/2022 Plan Year, we request that you actively log in to your My150 account and click the **KEEP CURRENT PLAN** to start the re-enrollment process. You'll review your plan coverage details, your coverage tier and covered dependents, then confirm your choice for the upcoming Plan Year. You can refer to Steps 4 and 5 above to complete your selection.

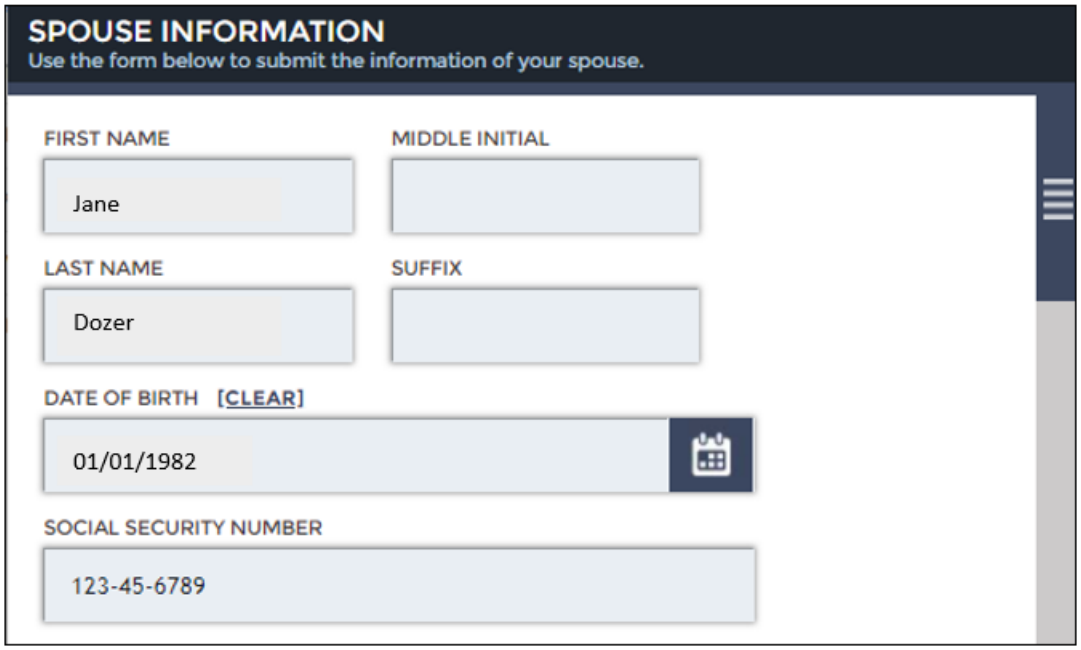


NEW! Coordination of Benefits (COB)

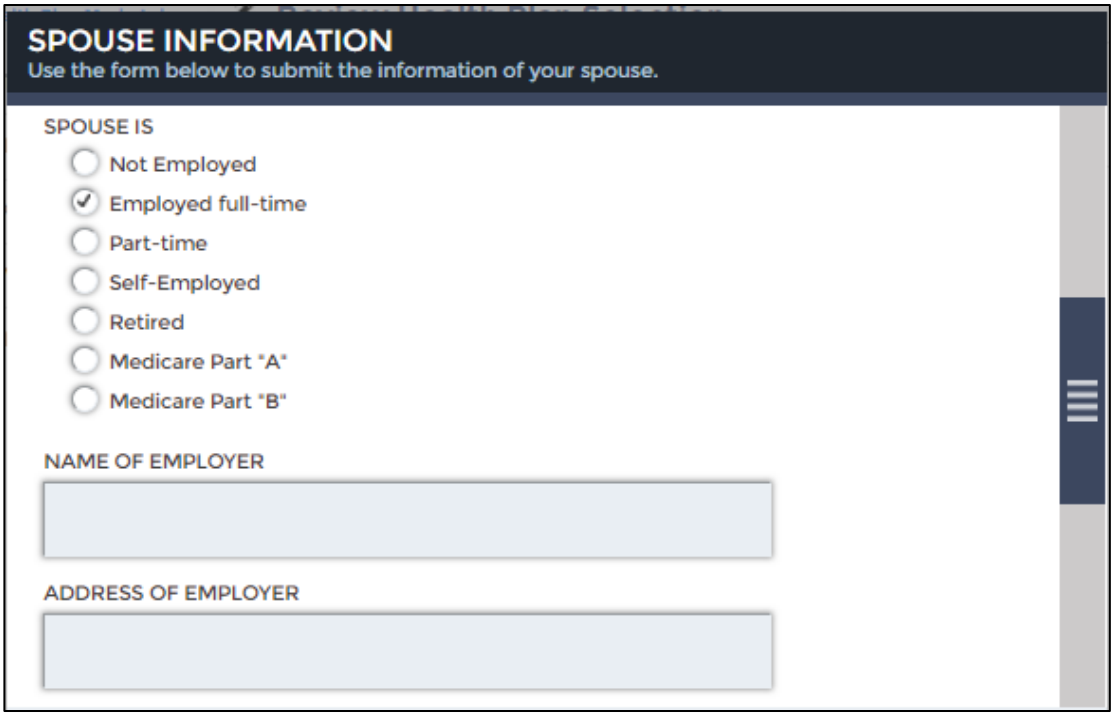
During Open Enrollment, we will be gathering Coordination of Benefits information to process your claims more efficiently.

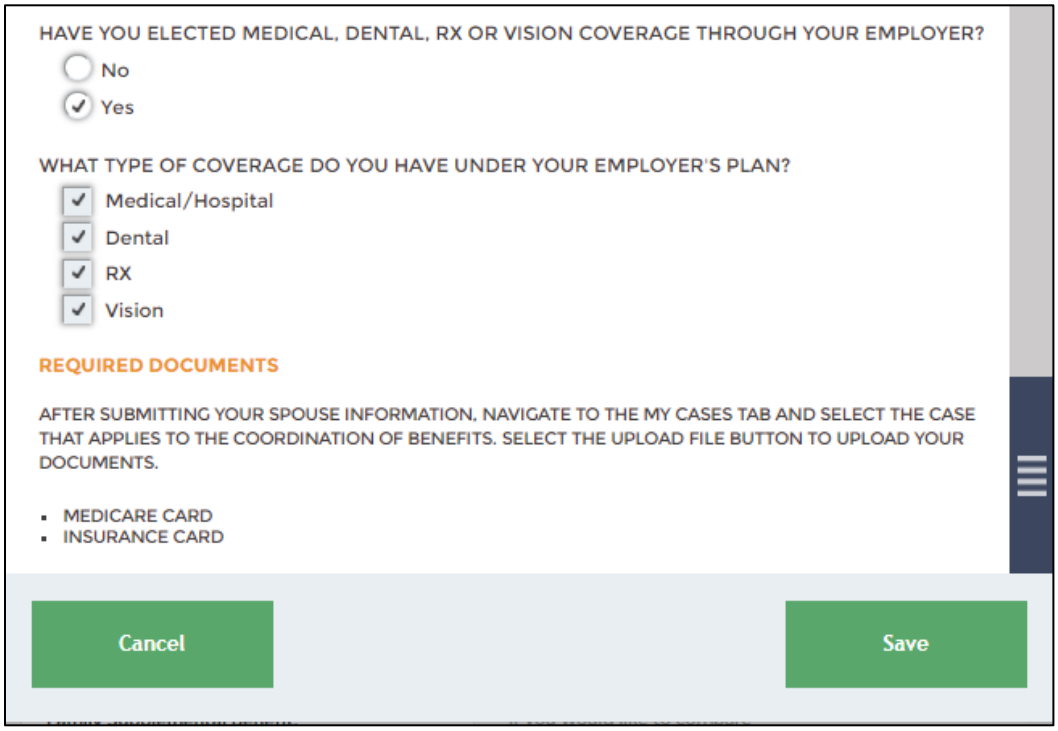
If you are married, and once you complete the open enrollment process (i.e., select a health plan option/coverage tier), you will be prompted to complete the Coordination of Benefits (COB) process.

The following screens will appear for you to complete.



You will be required to complete the Spouse Information section, if you are married.





As noted in the **Required Documents** section (shown in the image above), a case will be created on your behalf under the **My CASES** tab in your My150 account.

You will be notified via email of the case so that you can upload the Required Documents.

From: **noreply@my150.com** <noreply@my150.com>
Date: Mon, Jan 17, 2022, at 1:50 PM
Subject: Thank you for Submitting your Spousal Coordination of Benefits Information
To: jdozer@gmail.com

My150

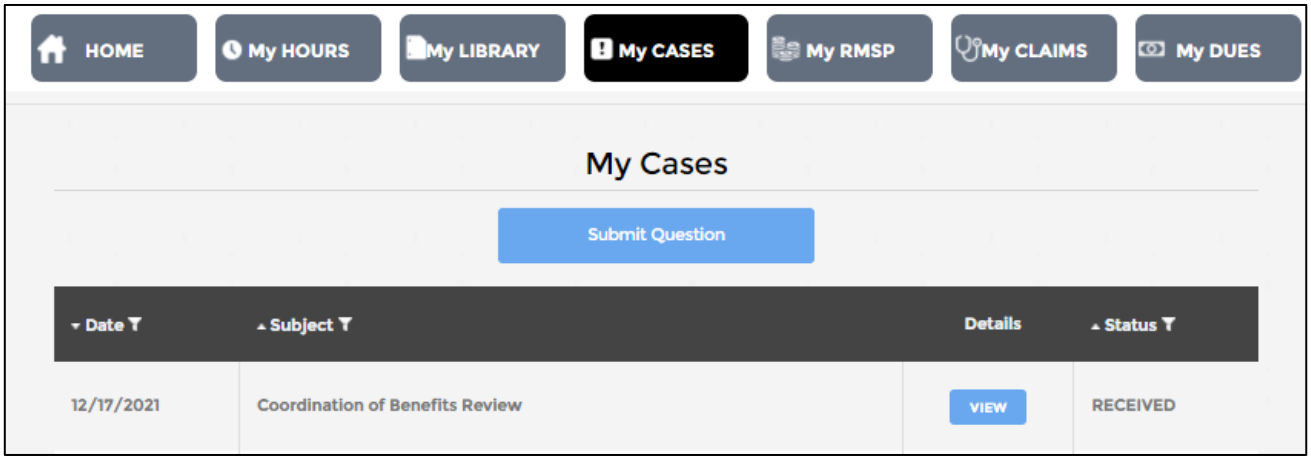
Dear JOHN,

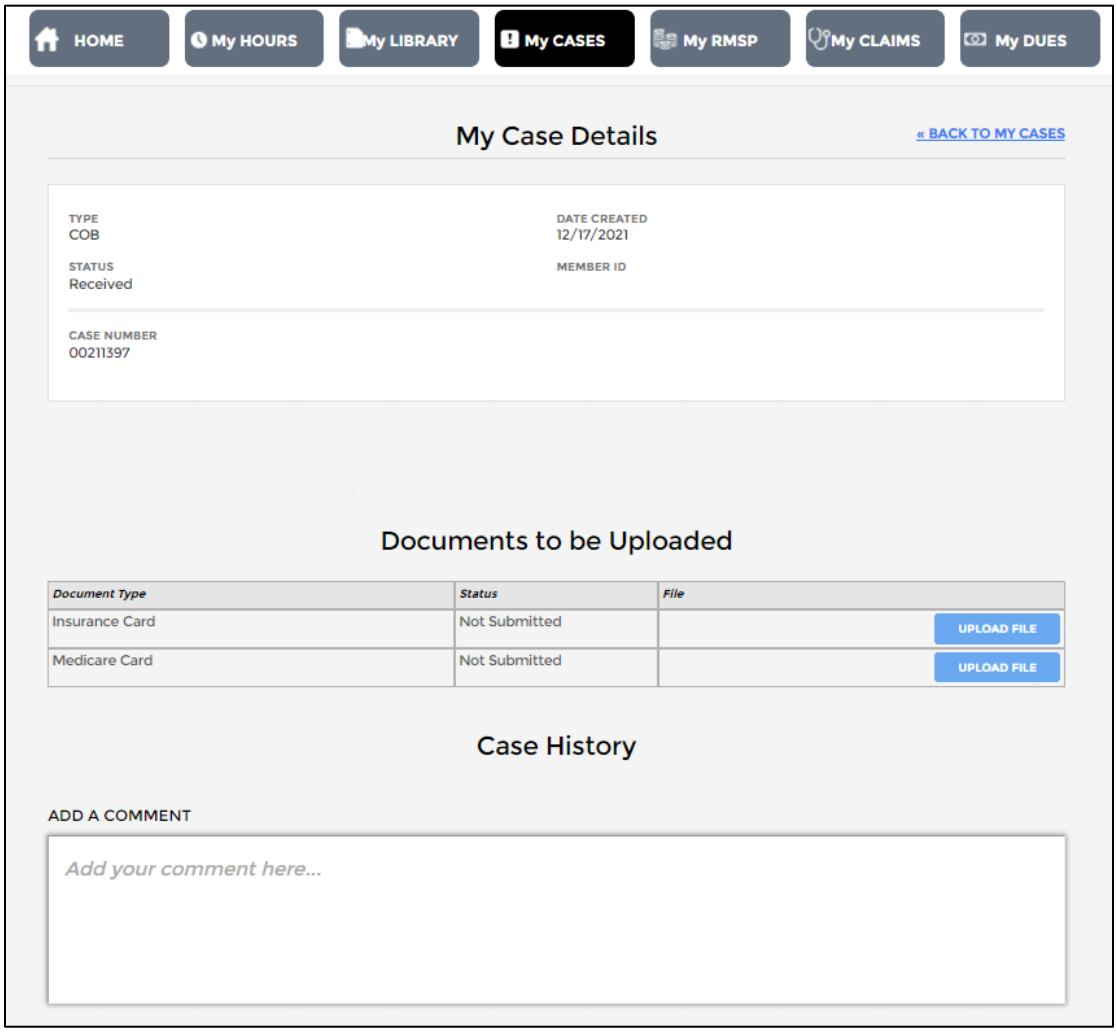
Thank you for submitting your Spousal Coordination of Benefits information. Please upload the required documents at Case link.

If you should have any questions regarding whom is covered by your health plan, please call the Member Services Department at (708)579-6675.

Sincerely,
MOE Welfare Fund Staff

You will be able to VIEW the created case and upload a copy of your spouse's insurance card or Medicare card to complete the case.





With the new COB process, your claims will be processed more quickly and efficiently. If you have any questions or concerns with the COB process, please refer to the Additional Resources Available During Open Enrollment.

Adding a Dependent During Open Enrollment

If you are adding a new dependent to your coverage, you can do so by:

1. Clicking on the **QUICK LINKS** tile, and then click on **Need to add or remove a dependent?**
2. Next, click on the green **SUBMIT LIFE CHANGING EVENT** button
3. You will then be required to complete details of the life changing event and then click **NEXT**
4. You will be redirected to your My Case Details page for you to upload the required documents to "ADD" a new dependent

Removing a Dependent During Open Enrollment

If you disenrolled a dependent during last year's open enrollment period (and not due to a life changing event) and you want to continue to exclude the dependent from coverage for the upcoming Plan Year, you must contact Member Services at 708-579-6675 to request a Disenrollment Form. This form must be completed each Plan Year to ensure you understand your decision and the Fund Office has confirmation of this decision. This form would only need to be completed if disenrolling the dependent **does not** cause a tier change.

Transferring Credits to Your Retiree Medical Savings Plan (RMSP) Account

For those members that are already age 55 or will turn age 55 by March 31, 2023, you should have received a detailed letter in December regarding the transfer of credits from your Credit Bank to your RMSP account. If you did not receive this letter, please visit www.local150.org/moe, click **READ MORE** and then click on the Marketplace tile to access a copy of this letter. Included in this letter are pros/cons of transferring credits and a useful Decision Checklist. Please take the time to read this letter and understand your options. The biggest decision that you need to make is whether you are going to retire during the upcoming 2022/2023 Plan Year. If so, this open enrollment period is the time for you to transfer credits to your RMSP account to optimize the use of these credits. If you do not transfer these credits, you will NOT lose them; instead, you will continue to use them for coverage under the Active Welfare Fund until they are depleted and then you will transfer over to the Midwest Operating Engineers Retiree Welfare Plan (RWP) if you elect coverage under the RWP.

REMINDER: You can only transfer credits during an open enrollment period. It's important that you take the time to consider how many credits to transfer as you only have one opportunity during open enrollment. Once you complete the DocuSign agreement, the credits cannot be transferred back to your Credit Bank.

NEW! RMSP Wizard Tool

For members eligible to transfer credits, the process has been made easier through the creation of the RMSP Wizard Tool. After you make your health plan option/coverage tier selection, you will be given the opportunity to transfer credits. You have up until February 28, 2022, to make your transfer credit election.

The RMSP Wizard prompts you with questions and based on the answer to your questions, you can determine the number of credits to transfer. Recall, that depending on when you make your transfer election, the Fund Office will withhold a safety net of credits to provide Active Welfare Fund coverage through March 31, 2022:

- If you make your credit transfer in January, we will withhold the credit cost deductions associated with your current health plan to provide you continued Welfare Fund coverage for February and March 2022.
- If you make your credit transfer in February, we will withhold the credit cost deduction associated with your current health plan to provide you continued Welfare Fund coverage for March 2022.

Transferring credits is an important decision because you DO NOT want to lose active eligibility coverage. Once you complete the Docusign document, the transfer of credits is final, and you will not be able to transfer them back to your active Credit Bank. If you do transfer too many credits and you lose eligibility, you will need to re-establish eligibility under the Bronze PPO Plan and if you are near retirement, losing active eligibility could jeopardize you from meeting the RWP eligibility requirements causing you to NOT receive RWP coverage. Therefore, we strongly encourage you to attend an Open Enrollment Event or utilize any of the Additional Resources Available During Open Enrollment.

Finding In-Network Providers

Plan A, Platinum, Gold, Silver, Bronze, and EPO health plan options:

- These health plan options ALL use the BCBS PPO network of providers and facilities.
- Go to www.bcbs.com
- Hover over **Find a Doctor** tab as shown on the top ribbon and a pop-up will appear
- After selecting United States, you are prompted click on **Choose a location and plan**
  - Enter an address, city or zip code
  - Enter the three-letter prefix on your BCBS medical ID card
    - **Example: MOE123456789 ➔ Enter M O E**
  - You will be able to search for doctors, specialty, facilities by name or type
  - A list of doctors/facilities will be created based on the above criteria
- **REMINDER:** Be sure to call your provider/facility to receive verbal confirmation that they are in the BCBS network, or call BCBS directly at 800-810-2583 (as shown on the back of your BCBS medical ID card)

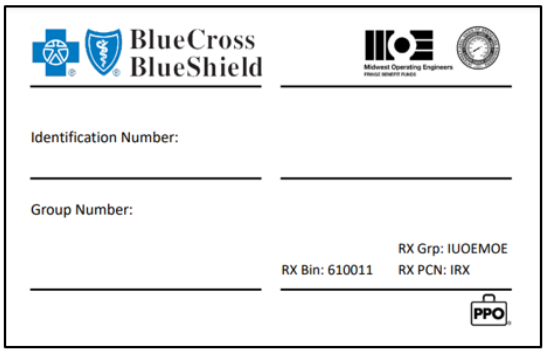
OHC Plan:

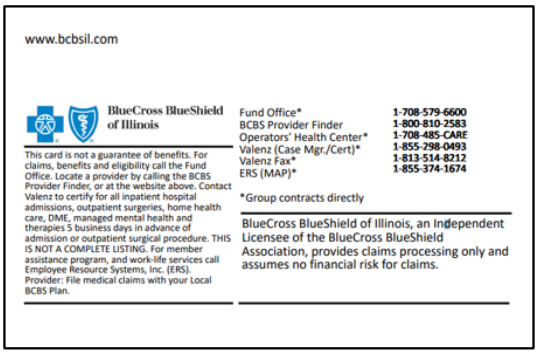
- This health plan option uses the Operators' Health Centers and providers and facilities in the HST Care Connect network.
- Visit www.operatorshealthcenter.com to view Operators' Health Center locations and providers
- Go to www.moefunds.hstechnology.com
- Click either Doctor or Facility/Location
  - Enter your search criteria
- **REMINDER:** Be sure to call your provider to receive verbal confirmation that they are in the HST Care Connect network or call a specialized OHC Plan Member Services representative at 708-579-6668 for assistance locating an in-network provider/facility

Medical ID Cards

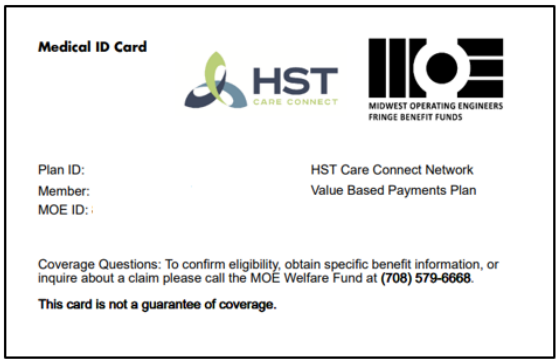
Regardless of whether you are changing your health plan option for the upcoming Plan Year, all eligible members of the Welfare Fund will be receiving new medical ID cards to use effective April 1, 2022[(1)]. It is imperative that you use this new medical ID card on or after April 1, 2022 and keep it on your person at all times. You will also be able to download a copy of your card through your My150 account.

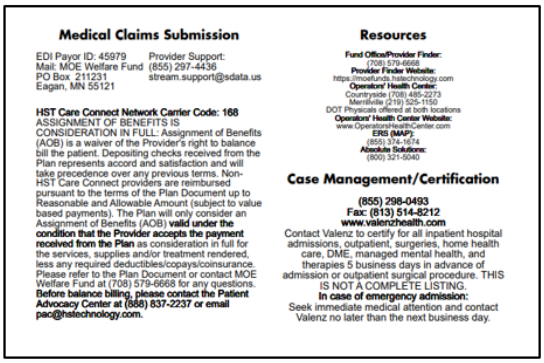
If you select one of the PPO Plans (Plan A, Platinum, Gold, Silver, Bronze, or EPO), you will receive a BCBS of Illinois medical ID card.





If you select the OHC Plan, you will receive the following HST Care Connect medical ID card.





(1) PLEASE NOTE: New medical ID cards will be issued due to the No Surprise Act, effective April 1, 2022.

Family Supplemental Benefit (FSB)

Each of the Marketplace health plan options provide $2,000 in an FSB benefit. This amount is renewed at the start of each Plan Year. Unused balances at the end of the Plan Year will be forfeited; the amounts do not rollover to the next Plan Year. You can use the FSB benefit to pay for medically necessary services that are not covered under your health plan option, or for services that have a benefit maximum. For example:

- ❖ You can use your FSB benefit to receive reimbursement for vision and hearing services: none of the health plan options of the Midwest Operating Engineers Welfare Fund cover these types of services.
- ❖ If you select the Bronze PPO Plan, this plan does not cover any dental services. Therefore, you can use your FSB benefit to receive reimbursement for dental services.

To review your FSB utilization, log in to your My150 account and view the information on your dashboard. For more information, visit local150.org/moe/.

Review Your Beneficiaries

The annual open enrollment period is a great time to review and/or update your designated beneficiaries. Through your My150 account **HOME** page, scroll to the **QUICK LINKS** tile and click **My Beneficiaries**. Most importantly, if you experience a Life Changing Event (marriage, divorce, birth, death, etc.), you should always review your beneficiaries to ensure this information is up to date.

Welfare Fund Death Benefit – If you die as an active eligible member of the Welfare Fund, your named beneficiary will receive a $40,000 tax-free death benefit. You can name anyone as your primary beneficiary(ies) and anyone as your contingent beneficiary(ies).

Pre-Retirement Pension Death Benefit – If you are married, this benefit is automatically paid to your spouse as the primary beneficiary. However, you can also name contingent beneficiary(ies) should your spouse die. If you are single, you can name anyone as your primary beneficiary(ies) and anyone as your contingent beneficiary(ies).

IUOE Vacation Savings – You can name anyone as your primary beneficiary(ies) and anyone as your contingent beneficiary(ies).

Retiree Medical Savings Plan (RMSP) Account – Only your spouse and children can be named as either your primary or contingent beneficiary(ies).

Retirement Enhancement Fund – Fidelity Investments is responsible for maintaining beneficiary information for this fringe benefit. To access your plan's benefits and update your beneficiary, visit www.NetBenefits.com/atwork to setup a username and password. From here, click on "Profile" and then scroll down to select "Beneficiaries".

If you require any assistance with updating your beneficiaries, you can call Member Services at 708-579-6600.

PLEASE NOTE: If you are an active dues paying member, you also have $10,000 of Life Insurance through the Midwest Coalition of Labor (MCL). The Fund Office does not administer this benefit but for more information, visit coalitionoflabor.org. You can also access the beneficiary designation form to download, print, complete and mail to VOYA Financial by visiting: http://local150.org/wp-content/uploads/2021/10/voya-beneficiary-form-final.pdf.

A word about the No Surprises Act Transparency Notice

Effective April 1, 2022, all benefits are subject to eligibility, maximum Plan benefit, reasonable and customary determination (or negotiated fee amounts for PPO provider services), and any special limits noted in the Plan. Charges that exceed the reasonable and customary amount or other Plan limitations will not be considered eligible in determing Plan benefits.

Special rules apply to any benefits subject to the No Surprises Act (NSA). The No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from an Out-of-Network provider at an In-Network facility. In certain circumstances, non-emergency items or services that are otherwise covered by the Plan from an Out-of-Network provider who is working at an In-Network facility are also subject to the No Surprises Act.

For benefits subject to the No Surprises Act, any cost-sharing payments count toward your In-Network deductible and In-Network Out-of-Pocket Expense Maximum. An explanation of your rights under the No Surprises Act is available at:
http://local150.org/wp-content/uploads/2021/11/FINAL-Welfare-Fund-NSA-Transparency-Notice.pdf

Eligible expenses must be medically necessary and are subject to the Plan Year deductible unless otherwise noted. Age limitations, as specified in this Comparison Chart, are applied as of the last day of the month in which the eligible dependent's birthday occurs.

The Fund Office is working closely with both BCBS of IL, HST Care Connect, and the Welfare Fund's professionals to ensure we comply with these new regulations that will become effective with the upcoming Plan Year, April 1, 2022. Therefore, some of the information contained in this document may be subject to change based on the rules and guidance received.