

Important Information Regarding the Annual Open Enrollment Process

Marketplace (Hourly)

January 16 – February 28, 2023

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. [2023 OE Guide Edition]

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Open Enrollment Information

What is Annual Open Enrollment?

Annual open enrollment will be held from January 16 through February 28, 2023. 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, 2023 through March 31, 2024.

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 2023 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
- If you are married, you will need to complete the [Coordination of Benefits](#) information
- **NEW!** You will have the opportunity to complete the [Communication Preferences](#) under your My Profile

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 2022/2023 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, 2023, you will automatically be placed in the Bronze PPO Plan for the remainder of the 2022/2023 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, 2023 through March 31, 2024. If you have any questions, call the Fund Office at 708-579-6675.

PLEASE NOTE: If you are first eligible March 1, 2023, you will automatically be placed in the Bronze PPO Plan and will remain in this health plan option through March 31, 2024. You will not be allowed to change your health plan option until the open enrollment period for the 2024/2025 Plan Year (mid-January 2024 through February 29, 2024), for coverage effective April 1, 2024 through March 31, 2025.

Open Enrollment Events

The Fund Office will be hosting open enrollment events. 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 8:00 a.m. with the last appointment at 2:00 p.m. Please bring your spouse; however, you must make alternative childcare arrangements.

The event schedule is as follows:

Midwest Operating Engineers Fringe Benefit Funds Office – 6150 Joliet Road, Countryside, IL 60525 – Saturday, January 21, 2023

District 7 Union Hall – 2193 W. 84th Place, Merrillville, IN 46410 - Saturday, February 4, 2023

District 5 Union Hall – 740 E. Route 5, Utica, IL 61373 - Saturday, February 18, 2023

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 10, 2023 and will be held at the training site. Be on the lookout for more information.

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 eligible. 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 5 p.m. CST
— Thursday: 9 a.m. to 5 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.

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 all the information is correct. Set your [COMMUNICATION PREFERENCES](#). This is a **NEW** feature to your My150 account.
- Review and/or update your [beneficiary information](#).
- Review your Credit Bank and determine how many credits you used during the 2022/2023 Plan Year. Did you have a surplus in credits or was there a deficit? Are you planning on retiring in the upcoming 2023/2024 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 2022/2023 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 Plan
- 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 to access the Comparison Chart.

Updated Monthly Credit Cost Deductions Effective April 1, 2023 through March 31, 2024

The updated monthly credit cost deductions are shown below. The updated rates are based on a 5.00% increase.

Updated Monthly Credit Cost Deductions for the MOE Health Plan Marketplace							
Health Plan Option	OHC Plan	Plan A	Platinum	EPO	Gold	Silver	Bronze
Updated Rates from April 1, 2023 – March 31, 2024							
Family	1,663	1,957	1,868	1,842	1,715	1,613	1,332
Member + 1	1,464	1,720	1,642	1,617	1,506	1,416	1,171
Member Only	1,261	1,483	1,413	1,394	1,300	1,222	714
Current Rates through 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

Retiree Subsidy Effective April 1, 2023 through March 31, 2024

The Welfare Fund Board of Trustees are pleased to announce that the retiree subsidy will **remain** at 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 \$17.25. Therefore, to determine the cost of a credit, you will need to remove the retiree subsidy.

Employer Contribution Rate:	\$17.25
Less Retiree Subsidy (17.25 x .173):	(2.98)
Credit Cost Per Hour Worked:	14.27

If you work 145 hours in June 2023, those hours are received in July 2023, and credits will be added to your bank to use for August 2023 of 2,069 credits (145 hours x 14.27).

If you would like to remain under the Family Plan A health plan option for the 2023/2024 Plan Year, to maintain this coverage you would need to work approximately 1,646 hours [(1,957 plan cost/14.27 credit cost) x 12] per Plan Year. Any hours worked above 1,646 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 600 hours [(714/14.27) x 12] per Plan Year. Any hours worked above 600 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 175 hours/month and he earns 14.27 credits/hour. What health plan option should he select to maintain his eligibility for Family coverage?

On a monthly basis, he will bank:

$$175 \text{ (hour/month)} \times 14.27 \text{ (credits/hour)} \times 9/12 \text{ (months/year)} = 1,873 \text{ credits}$$

He will be able to afford Family coverage under all the health plan options, except Plan A PPO and he will have a surplus of credits going into his Credit Bank.

PLEASE NOTE: If he selects Plan A PPO 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 option 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. Visit operatorshealthcenter.com for more information.
- **Everside Health Centers.** Facilities are in Rockford, Illinois, Davenport, Iowa, and six locations in northern Indiana. Visit eversidehealth.com/local150.com for more information.
- **HST Care Connect network** for providers/facilities at:
Advocate Health Care system, including Advocate Clinics at Walgreens
Community Hospital system
Methodist Hospital system

PLEASE NOTE: The OHC Plan **does not** use the Blue Cross Blue Shield network. 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 Plan is an Exclusive Provider Organization.** It uses the same Blue Cross Blue Shield network as the PPO plans, but it does not use coinsurance; instead, it uses copayments. 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 copayments. The copayment is a flat fee for service and the flat fee will vary depending on what type of service you receive. You also **do not** have to choose a primary care physician (PCP) and you **do not** need to receive referrals to see specialists.

If you are thinking about choosing one of the PPO Plans or the EPO Plan, 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, 2023 through March 31, 2024, 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. Also, effective November 1, 2022, the Welfare Fund Board of Trustees approved to remove limitations from Plans for routine services; will be paid at 100% when using in-network providers for all ages. Vaccinations will also be paid at 100% if you stay in-network.
- ❖ 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
 - behavioral health services at the Countryside, IL OHC
- ❖ Services covered by your plan are free if performed at one of the Everside Health Centers
 - All facilities offer free DOT physicals
 - Through our partnership with Everside, you can also utilize the 24/7 nurse line to seek triage after hour services.
 - Providers can prescribe and distribute generic medication, if necessary
 - The Rockford, IL and the Davenport, IA facilities offer free chiropractic services
- ❖ [Absolute Solutions Imaging Network](#) 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.
- ❖ **NEW!** [Gateway Foundation or Recovery Centers of America \(RCA\)](#) offer free substance abuse treatment co-occurring mental health treatment, if necessary

PLEASE NOTE: Newly eligible members on or after March 1, 2023 and members that re-establish eligibility, will remain in the Bronze PPO Plan until March 31, 2024. Please take advantage of the above FREE services.

Exclusive Vendor Partnerships

The fringe benefit funds partner with several vendors to provide benefits to our eligible members and covered dependents. For more information regarding these partnerships, please visit <https://local150.org/moe/h-w/exclusive-partnerships/>.

UPDATED! Absolute Solutions Imaging Network

The Welfare Fund originally partnered with Absolute Solutions Imaging Network effective January 1, 2021. However, in an effort to further reduce costs for imaging services, the following changes are effective January 1, 2023. These changes are only for active eligible members and their covered dependents.

Absolute Solutions Imaging Network – Effective January 1, 2023					
Eligible Active Members and Covered Dependents	Lives within a 30-mile radius of an Absolute Solutions Facility			Does NOT live within a 30-mile of an Absolute Solutions Facility	
	Decides to use an Absolute Solutions Facility	Decides NOT to use an Absolute Solutions Facility but stays within the Health Plan Option's Network	Decides NOT to use an Absolute Solutions Facility and goes Out-of-Network	Utilizes the Health Plan Option Network	Does NOT utilize the Health Plan Option's Network
CT/MRI Scan	100% Paid by the Welfare Fund: NO deductible, NO coinsurance, NO copayment	Deductible applies, must pay coinsurance or copayment, subject to the out-of-pocket maximum		100% Paid by the Welfare Fund: NO deductible, NO coinsurance, NO copayment	Deductible applies, must pay coinsurance or copayment, subject to out-of-pocket maximum
PET Scan		Deductible applies and then covered at 100%	Deductible applies, must pay coinsurance or copayment, subject to the out-of-pocket maximum		

Bottom line, if you need imaging services (MRI/CT/PET scans) and live within a 30-mile radius of an Absolute Solutions facility, to save money, use the nearest Absolute Solutions facility. If you do not live within a 30-mile radius of an Absolute Solutions facility, be sure you are using your health plan option's network (i.e., either the BCBS PPO Network or the HST Care Connect Network) to save money. If you have any questions, please contact Member Services at (708) 579-6600.

NEW! Substance Abuse Partnerships

The Welfare Fund Board of Trustees is proud to announce the partnership with Gateway Foundation and the Recovery Centers of America. This partnership will be effective January 1, 2023 for all eligible active members, eligible pre-Medicare retirees, and covered dependents (ages 18 years and older).

With these partnerships, there will be no cost sharing by the member, pre-Medicare retiree, or covered dependent; **ALL medically necessary covered services will be FREE – no deductible, no co-payment, and no co-insurance.**

The Gateway Foundation and/or Recovery Centers of America (RCA) will provide the full continuum of care including:

- Residential/Inpatient treatment
- Virtual outpatient treatment (including adolescents)
- Withdrawal management
- Transitional housing/recovery home
- Family involvement & support
- Treatment for co-occurring mental health & substance abuse disorders; including gambling program
- Medication-assisted treatment
- Transportation provided to residential treatment
- 24/7 admissions
- Alumni programs for continued support & social events; including an alumni app for virtual 12-step facilitation meeting and support

Their physicians, psychologists, and licensed clinical staff work directly with patients to develop an individualized treatment program to treat the whole person, not just their addiction to drugs or alcohol. In addition, the Welfare Fund's partnered Members Assistance Program through ERS currently works with both organizations, which will ease the intake process for our Local 150 families.

The Gateway Foundation has locations in Aurora, Carbondale, Caseyville, three Chicago locations (Independence, Kedzie, River North), Downers Grove, Gurnee, Jacksonville, Joliet, Lake Villa, Pekin, Skokie, Springfield, and Swansea.

Recovery Centers of America has a location in St. Charles and Indianapolis. **PLEASE NOTE:** Depending on the individual's needs will dictate which location would be most beneficial as the services between the facilities vary.

Recovery is a lifelong process that requires continued focus and commitment. We firmly believe Gateway Foundation and RCA will allow our members and families, affected by substance abuse, a road to recovery.

Gateway Foundation

Contact Sandra Beecher at (309) 296-3053 or call (877) 379-9225

Visit [Gatewayfoundation.org](https://www.gatewayfoundation.org) for more information.

Recovery Centers of America (RCA)

Contact Ross Bacon at (773) 490-6488

Visit [Recoverycentersofamerica.com](https://www.recoverycentersofamerica.com) for more information.

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, if 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

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.
- Everside Health Centers in Rockford, IL, Davenport, IA and six locations in northern IN.
- 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	OHC Plan Design	
	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 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 the Everside Health Center locations too.

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 inpatient/outpatient care)
- 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?

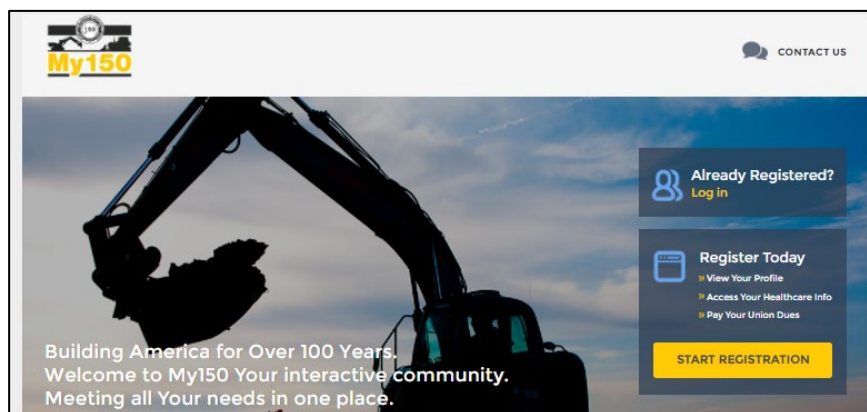
If you use an out-of-network provider or facility, you will pay more. The out-of-network provider or facility may balance bill you. If you are balance billed, contact the Patient Advocacy Center (PAC) at **888-837-2237** or **pac@hstechnology.com**. The PAC will be responsible for negotiating the VBP with the provider and/or facility and will 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.

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.

NEXT YEAR'S HEALTH PLAN	
No Plan Selected	
PLAN DATES	MONTHLY CREDITS
N/A	N/A
START NEW PLAN	KEEP CURRENT PLAN
Summary	
Annual Deductible (per person):	
\$300 In-Network	
\$300 Out-Of-Network	
Medical out of Pocket Max (per person):	
\$2,500 In-Network	
\$2,500 Out-Of-Network	
Family Supplemental Benefit:	
\$1,500 per family / year	
Months to Depletion:	20 Months



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

	Monthly Credit Costs		
	CREDITS	CREDITS	CREDITS
Member	1,261	1,483	1,394
Member + 1	1,464	1,720	1,617
Family	1,663	1,957	1,842

OHC - 2023
 SELECT PLAN

Plan A - 2023
 SELECT PLAN

EPO - 2023
 SELECT PLAN

AFFORDABILITY CALCULATOR

This calculator can be used to project the effects your health plan selection and estimated hours worked will have on your eligibility credit bank balance. Use the bar or text box to adjust your projected hours worked per month to estimate how long you will be able to afford selected plan(s).

COVERAGE TIER

Family

MONTHLY HOURS

0 400 140

RESET UPDATE

« RESET SELECTED PLANS

REVIEW PLAN


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.

- 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.

YOU CAN AFFORD THIS PLAN BASED ON YOUR ESTIMATED HOURS AND FUTURE CREDITS.

[Back to Health Plan Marketplace](#)  **Review Health Plan Selection**

✓ GET STARTED

✓ VIEW PLAN OPTIONS

✓ COMPARE PLANS

➔ REVIEW PLAN

○ CONFIRMATION

BACK TO PREVIOUS

Please take the time to ensure that this is the health plan option you would like to enroll in today.

NEXT YEAR'S HEALTH PLAN

EPO - 2023 - Family

PLAN DATES	MONTHLY CREDITS
4/1/2023 - 3/31/2024	1,842

VIEW PLAN DETAILS

Summary

Annual Deductible (per family):
No Deductible In-Network
No Benefits Out-Of-Network

Medical out of Pocket Max (per family):
\$10,000 In-Network
No Benefits Out-Of-Network

Family Supplemental Benefit:
\$2,000 per Family per Plan year

Not Sure Yet?

If you would like to compare other health plan options click the button below.

CHANGE PLAN SELECTION

YOUR DEPENDENTS:

Please review the below list of dependents that will be covered under your selected Health Plan option. If you would like to disenroll any of these dependents for the upcoming plan year, please contact Member Services at (708)579-6600 to request a disenrollment form.

Dependent 1

AGE: 21

Dependent 2

AGE: 23

SIGN AGREEMENT DOCUMENT:

X

Click to capture electronic signature

Your MOE Health Plan Marketplace

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

Enrollment Agreement

By signing this document I acknowledge that I have selected the plan listed below. I understand I am able to change my plan to a lower cost plan once during the benefit year unless I have a life event which qualifies me to change my plan.

Health Plan Information

MOE Medical ID	
Benefit Plan Name	EPO - 2023
Coverage Tier	Family
Coverage Start Date	4/1/2023
Coverage End Date	3/31/2024
Covered Dependents	Dependent 1, Dependent 2

Summary of Health Plan Benefits

	In Network Benefits	Out of Network Benefits
Annual Deductible- Single	No Deductible	No Benefits
Annual Deductible- Family	No Deductible	No Benefits
Medical Max- Single	\$4,000	No Benefits
Medical Max- Family	\$10,000	No Benefits
Hospital Services	Inpatient: \$250 copay per adm...	No Benefits
Preventive Care	100%	No Benefits

Sign
↓

12/29/2022

Signature

Today's Date

By signing above, I hereby authorize the credits in my Credit Bank to be used to pay for the coverage election I have chosen, above. Further, my signature certifies that the information I have provided on this form is true and correct, and that I and my dependents listed on this form are entitled to the coverage I have chosen. I declare that all statements and information made herein are complete and true to the best of my knowledge. I understand that any misstatements or omissions may void all coverage applied for me and my dependents shown on this form.

Enrollment Agreement.pdf1 of 1

FINISH

SIGN AGREEMENT DOCUMENT:

X

DocuSigned by:
455 X0307D9F455...

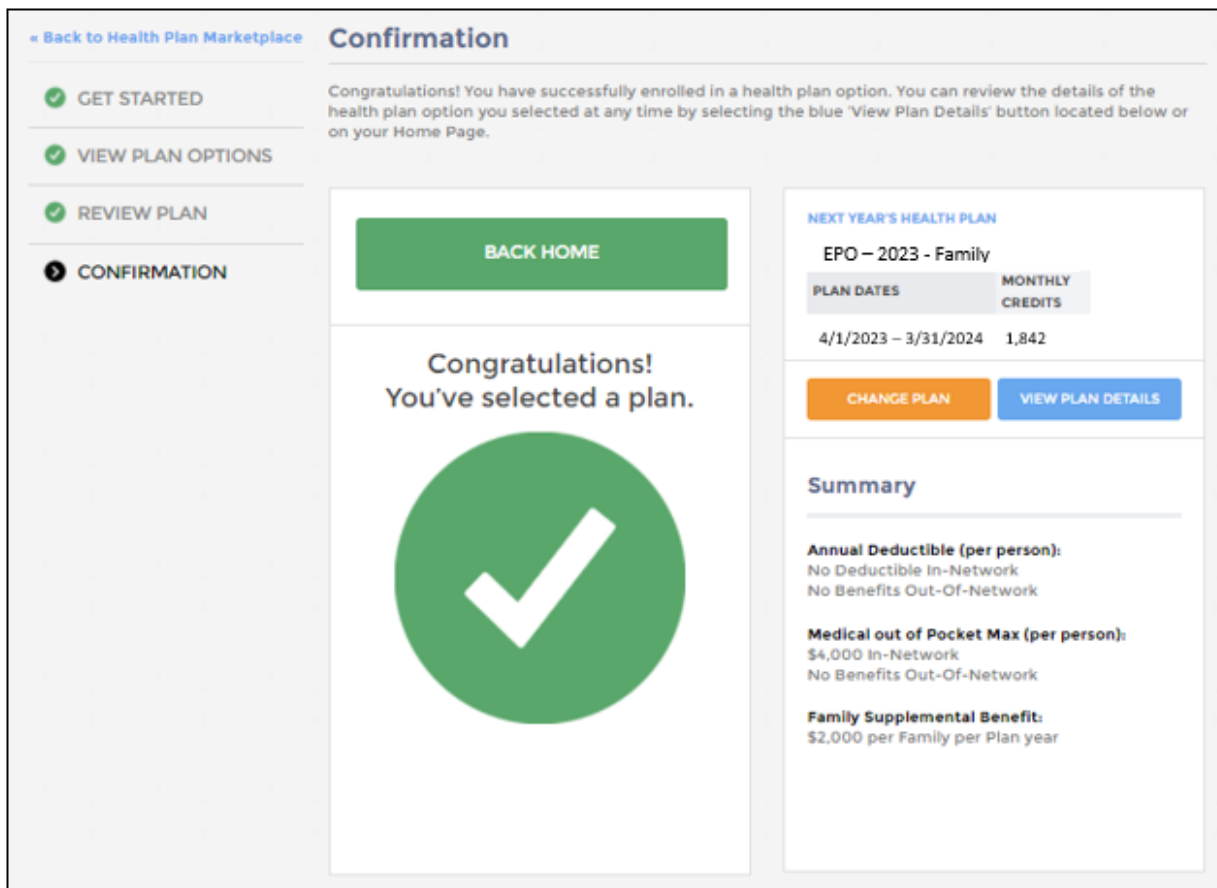
[recapture signature](#)

« BACK TO PREVIOUS

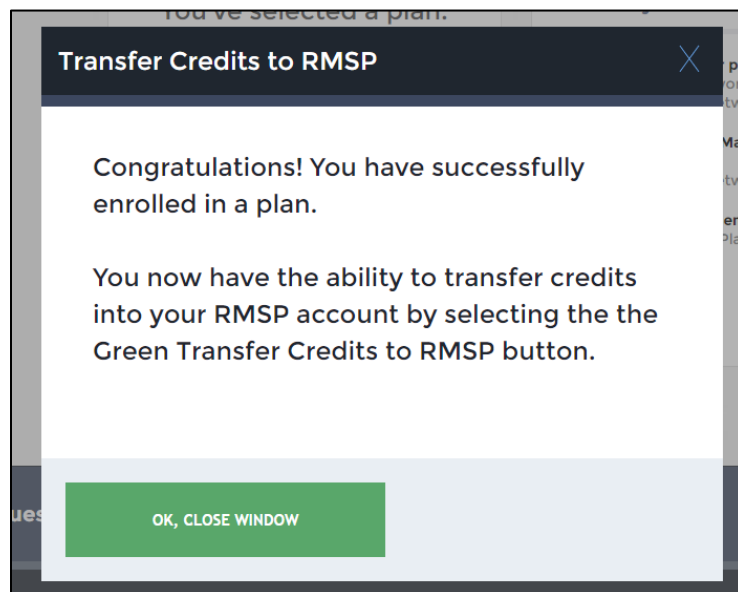
CONFIRM PLAN

Your DocuSign signature will be imported into your My150 and then you can click CONFIRM PLAN.

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.



The screenshot shows a web page titled "Confirmation" with a navigation sidebar on the left. The sidebar includes links: "Back to Health Plan Marketplace", "GET STARTED", "VIEW PLAN OPTIONS", "REVIEW PLAN", and "CONFIRMATION" (which is highlighted with a right-pointing arrow). The main content area has a green "BACK HOME" button at the top. Below it, a large green circle with a white checkmark is centered, with the text "Congratulations! You've selected a plan." above it. To the right of the checkmark, there is a section titled "NEXT YEAR'S HEALTH PLAN" for "EPO – 2023 - Family". It shows "PLAN DATES" as "4/1/2023 – 3/31/2024" and "MONTHLY CREDITS" as "1,842". Below this are two buttons: "CHANGE PLAN" (orange) and "VIEW PLAN DETAILS" (blue). Further down is a "Summary" section with the following details: "Annual Deductible (per person): No Deductible In-Network, No Benefits Out-Of-Network"; "Medical out of Pocket Max (per person): \$4,000 In-Network, No Benefits Out-Of-Network"; and "Family Supplemental Benefit: \$2,000 per Family per Plan year".



The screenshot shows a pop-up window titled "Transfer Credits to RMSP" with a close button (X) in the top right corner. The text inside the pop-up reads: "Congratulations! You have successfully enrolled in a plan." followed by "You now have the ability to transfer credits into your RMSP account by selecting the the Green Transfer Credits to RMSP button." At the bottom of the pop-up is a green button labeled "OK, CLOSE WINDOW".

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 2022/2023 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.

Next Year's Health Plan
No Plan Selected

PLAN DATES	MONTHLY CREDITS
N/A	N/A

START NEW PLAN **KEEP CURRENT PLAN**

Summary

Annual Deductible (per person):
\$300 In-Network
\$300 Out-Of-Network

Medical out of Pocket Max (per person):
\$2,500 In-Network
\$2,500 Out-Of-Network

Family Supplemental Benefit:
\$1,500 per family / year

Months to Depletion: 20 Months

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.

SPOUSE INFORMATION
Use the form below to submit the information of your spouse.

FIRST NAME: Jane
MIDDLE INITIAL:
LAST NAME: Dozer
SUFFIX:
DATE OF BIRTH: 01/01/1982 [CLEAR]
SOCIAL SECURITY NUMBER: 123-45-6789

You will be required to complete the Spouse Information section if you are married. Please take the time to complete this information accurately.

SPOUSE INFORMATION

Use the form below to submit the information of your spouse.

SPOUSE IS

☐ Not Employed

☒ Employed full-time

☐ Part-time

☐ Self-Employed

☐ Retired

☐ Medicare Part "A"

☐ Medicare Part "B"

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

HAVE YOU ELECTED MEDICAL, DENTAL, RX OR VISION COVERAGE THROUGH YOUR EMPLOYER?

☐ No

☒ Yes

WHAT TYPE OF COVERAGE DO YOU HAVE UNDER YOUR EMPLOYER'S PLAN?

☒ Medical/Hospital

☒ Dental

☒ RX

☒ Vision

REQUIRED DOCUMENTS

AFTER SUBMITTING YOUR SPOUSE INFORMATION, NAVIGATE TO THE MY CASES TAB AND SELECT THE CASE THAT APPLIES TO THE COORDINATION OF BENEFITS. SELECT THE UPLOAD FILE BUTTON TO UPLOAD YOUR DOCUMENTS.

- MEDICARE CARD
- INSURANCE CARD

Cancel

Save

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



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.

[HOME](#) [My HOURS](#) [My LIBRARY](#) [My CASES](#) [My RMSP](#) [My CLAIMS](#) [My DUES](#)

My Cases

Submit Question

Date ▼	Subject ▼	Details	Status ▼
12/17/2021	Coordination of Benefits Review	VIEW	RECEIVED

HOME

My HOURS

My LIBRARY

My CASES

My RMSP

My CLAIMS

My DUES

My Case Details

[« BACK TO MY CASES](#)

TYPE

COB

DATE CREATED

12/17/2021

STATUS

Received

MEMBER ID

CASE NUMBER

00211397

Documents to be Uploaded

Document Type	Status	File
Insurance Card	Not Submitted	<div>UPLOAD FILE</div>
Medicare Card	Not Submitted	<div>UPLOAD FILE</div>

Case History

ADD A COMMENT

Add your comment here...

With the 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 as in the case with Family coverage.

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, 2024, you will have the opportunity to transfer credits from your Credit Bank to your RMSP account during the upcoming open enrollment period. For details on how to transfer credits, please visit www.local150.org/moe, click **READ MORE** and then click on the Marketplace tile to access the Credit Transfer Information. Included in these instructions 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 2023/2024 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.

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, 2023, 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, 2023:

- 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 2023.
- 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 2023.

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. **PLEASE NOTE:** Be sure to reference the [FREE services](#) too!
- Visit 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

If you are changing your health plan option for the upcoming Plan Year, you will receive new medical ID cards to use effective April 1, 2023. It is imperative that you use this new medical ID card on or after April 1, 2023 and always keep it on your person. You will also be able to download a copy of your card through your My150 account. If you need additional cards, please contact Member Services at (708) 579-6600.



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. The information on the back of the card is specific to the health plan option you selected.

Example: Bronze PPO Plan

 	
Identification Number: MOE	
Group Number: P11796	
RX BIN: 610011 RX Grp: IJOEMOE RX PCN: IRX	
	

www.bcbsil.com	
Deductible Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000	Out of Pocket Maximum Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000
 <p>This card is not a guarantee of benefits. For claims, benefits and eligibility call the Fund Office. Locate a provider by calling the BCBS Provider Finder, or at the website above. Contact Valenz to certify for all inpatient hospital admissions, outpatient surgeries, home health care, DME, managed mental health, and therapies 5 business days in advance of admission or outpatient surgical procedure. THIS IS NOT A COMPLETE LISTING.</p> <p>For member assistance program, and work-life services call Employee Resource Systems, Inc. (ERS). Provider: File medical claims with your local BCBS Plan.</p>	Fund Office* 1-708-579-6600 BCBS Provider Finder 1-800-810-2583 Valenz (Case Mgr./Cert)* 1-855-298-6493 Absolute Solutions* 1-800-321-5040 ERS (MAP)* 1-855-374-1674 Pharmacy Questions* 1-855-697-9150
*Group contracts directly BlueCross BlueShield of Illinois, an Independent Licensee of the BlueCross BlueShield Association, provides claims processing only and assumes no financial risk for claims.	

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

Medical ID Card	
	
Plan ID: OHC 1 Member: MOE ID:	HST Care Connect Network Value Based Payments Plan
Coverage Questions: To confirm eligibility, obtain specific benefit information, or inquire about a claim please call the MOE Welfare Fund at (708) 579-6668. This card is not a guarantee of coverage.	

Medical Claims Submission	
EDI Payor ID: 45979 Provider Support: Mail: MOE Welfare Fund (855) 297-4436 PO Box 211231 stream.support@sdia.us Eagan, MN 55121	HST Care Connect Network Carrier Code: 168 ASSIGNMENT OF BENEFITS IS CONSIDERATION IN FULL: Assignment of Benefits (AOB) is a waiver of the Provider's right to balance bill the patient. Depositing checks received from the Plan represents accord and satisfaction and will take precedence over any previous terms. Non-HST Care Connect providers are reimbursed pursuant to the terms of the Plan Document up to Reasonable and Allowable Amount (subject to value based payments). The Plan will only consider an Assignment of Benefits (AOB) valid under the condition that the Provider accepts the payment received from the Plan as consideration in full for the services, supplies and/or treatment rendered, less any required deductibles/copayments/coinsurance. Please refer to the Plan Document or contact MOE Welfare Fund at (708) 579-6668 for any questions. Before balance billing, please contact the Patient Advocacy Center at (888) 837-2237 or email pac@hsttechnology.com.

Deductible Information: Ind/Fam In Network: \$0/\$0 Ind/Fam Out of Network: \$300/\$700	Out of Pocket Maximum Information: Ind/Fam In Network: \$2,500/\$6,000 Ind/Fam Out of Network: \$2,500/\$6,000
RX Out of Pocket Information: Ind/Fam In Network: \$2,000/\$4,000 Ind/Fam Out of Network: \$4,000/\$8,000	Resources Fund Office Provider Finder: (708) 579-6668 Provider Finder Website: https://medfunds.hsttechnology.com Operators' Health Center: Countryside (708) 485-2273 Memphis (219) 525-1150 Davenport, IA (865) 214-1559 Rockford, IL (779) 368-0757 Activate Healthcare: (855) 374-1674 ERS(MAP): (800) 321-5040 Absolute Solutions: (855) 697-9150 Valenz (Case Mgr./Cert.): (855) 298-0493 Contact Valenz for certification requirements 5 business days in advance of admission or outpatient surgical procedure or no later than the next business day, in case of emergency admission.

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).

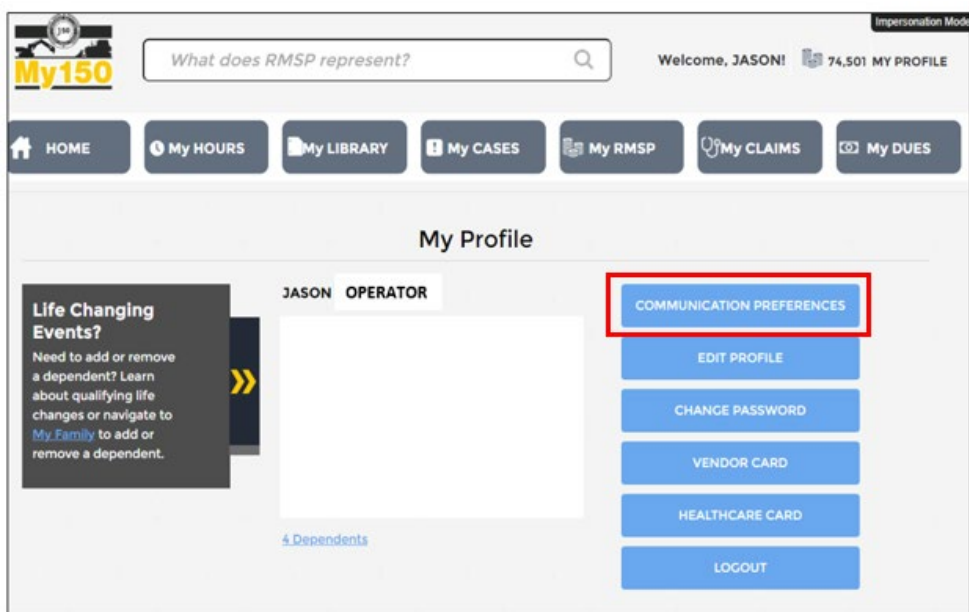
Retirement Enhancement Fund – Fidelity Investments is responsible for maintaining beneficiary information for this fringe benefit. To access your plan's benefits and update your beneficiary, visit www.NetBenefits.com/atwork to setup a username and password. From here, click on "Profile" and then scroll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

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

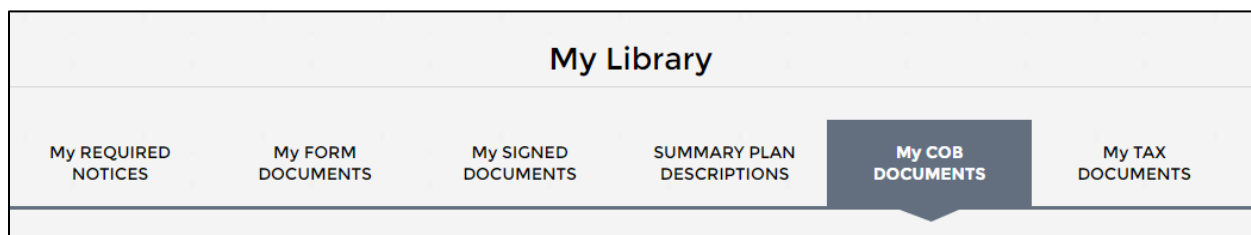
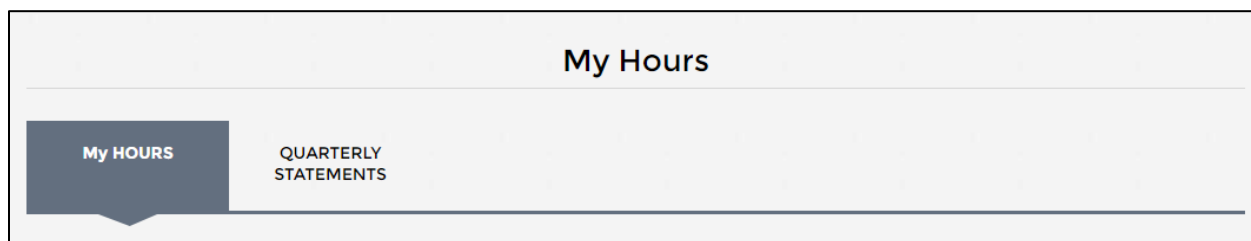
PLEASE NOTE: If you are an active dues paying member, you also have \$10,000 of Life Insurance through the Midwest Coalition of Labor (MCL). The Fund Office does not administer this benefit but for more information, visit coalitionoflabor.org. You can also access the beneficiary designation form to download,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

NEW! Communication Preferences

The Communication Preferences is a new feature in your My150 account under your MY PROFILE. When clicking on the blue tile, COMMUNICATION PREFERENCES, you will be able to select how you wish to be notified of when new information is dropped to your My CLAIMS, your My HOURS tab, or your My LIBRARY tab. It will be extremely important for you to ensure that all the information in your MY PROFILE is accurate and up to date.



Information that will be dropped to your My CLAIMS will be your Explanation of Benefits (EOBs) which is currently being executed. The Quarterly Statements will be dropped to your My HOURS tab. Items that will be dropped to your My LIBRARY tab will include annual required notices, form documents, your DocuSigned documents, Summary Plan Descriptions, Coordination of Benefits forms, and tax documents.



You will be able to select whether you would like to be notified via a text message or email notification for when these items are added to your My150 account. This information can be updated or changed at any time.

Update Communication Preferences

Toggle the options and click Update.

ALL PREFERENCES

Receive Notifications

Receive all notifications available through text message.

ALL

Receive Communications

Receive all communications available through Email.

ALL

TEXT MESSAGE NOTIFICATION PREFERENCES

SMS Enrollment Reminder

SMS reminders to enroll in a plan will be sent near the end of an enrollment period if a plan selection hasn't been made.

YESNO

SMS Profile Update

SMS notifications will be sent when important profile information has been updated.

YESNO

EMAIL COMMUNICATION PREFERENCES

EOBs

Explanations of benefits and letters sent by MOE funds

YESNO

Quarterly Statements

YESNO

Tax Forms

1099R and 1095B

YESNO

Required Notices

YESNO

Unsubscribe to All Text Notifications

Unsubscribe to All Email Communications

Close

Update

Your MOE Health Plan Marketplace

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A word about the No Surprises Act

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. Please review the explanation of [Your Rights and Protections Against Surprise Medical Bills](#).

Detailed information regarding the requirements of the NSA can be found at <https://local150.org/moe/no-surprises-act-nsa/>.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is “balance billing” (sometimes called “surprise billing”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network.

“**Out-of-network**” describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

“**Surprise billing**” is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the federal agencies at 1-800-985-3059.

For ERISA Plans: For technical assistance and complaints, you should call EBSA's toll free number at 1-866-444-3272. You may contact us electronically at www.askebsa.dol.gov.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.