MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Important Information Regarding Annual Open Enrollment

January 15 – February 29, 2024

Owner Operator/Relative Shareholder (Monthly Members)

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. [2024 version]

Important Information Regarding the Annual Open Enrollment

Table of Contents

Open Enrollment Information

What is Annual Open Enrollment?

Annual open enrollment will be held from January 15 through February 29, 2024. During this time, you can review all the Owner Operator/Relative Shareholder health plan options and compare plans, 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, 2024 through March 31, 2025.

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 –
- Please contact the Fund Office to receive a 2024 Dependent Disenrollment form. **PLEASE NOTE**: If you disenrolled a dependent from your plan, you will need to disenroll them annually to ensure they are not added back onto your plan. Refer to Removing a Dependent During Open Enrollment.
- You can add dependents to your health plan for the upcoming Plan Year
- If you are married or have adult dependents, you are strongly encouraged to update Coordination of Benefits information
- Review/update your My150 account details and Communication Preferences under your My Profile

Who is Eligible for Open Enrollment?

As an Owner Operator/Relative Shareholder member, your Employer makes a required monthly contribution to the Fund on your behalf for you to maintain eligible for coverage. As an eligible member, you may be given the opportunity during annual Open Enrollment to select a different health plan option and/or coverage tier. We strongly encourage you to attend an open enrollment event. You and your spouse can meet with a Fund Office navigator and discuss the various health plan options.

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 option(s), answer any questions you may have regarding the available health plans, and assist you with the enrollment process. 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 noon. Please bring your spouse; however, please make alternative childcare arrangements.

Open Enrollment events will take place on the following dates:

- District 5 Union Hall (Utica, IL) – Saturday, January 20, 2024
- District 7 Union Hall (Merrillville, IN) – Saturday, February 10, 2024
- Midwest Operating Engineers Fringe Benefit Funds Office – 6150 Joliet Road, Countryside, IL 60525 – Saturday, February 17, 2024

PLEASE NOTE: The Fund Office navigator is not licensed to recommend which health plan option to select.

Additional Resources Available During Open Enrollment

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: 8:00 a.m. to 5:00 p.m. CST
— Thursday: 9:00 a.m. to 5:00 p.m. CST
— Saturday: 8:00 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.

Have you migrated to the new My150 platform? Thanks to all the feedback from members, My150 has undergone a complete remodel featuring a clean, modern design and improved usability. If you did not receive an email to migrate, visit My150.com, click to reset your password, enter your email address, and click the link that was sent to your email inbox to set your new password and login.

If you run into any issues, 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**.** Your Communication Preferences allow you to be in control of what you would and would not like sent to you via a text message or email when new information is available in your My Library.
- Review and/or update your beneficiary information.
- Review your dashboard and your My Claims to determine if you optimized the coverage under the health plan option that you selected for the 2023/2024 Plan Year.

PLEASE NOTE: You must notify your Employer of the health plan & tier that you select during Open Enrollment to ensure that your Employer is making contributions for the correct plan and tier.

Features of Your MOE Health Plan Options

What health plan options are available to an eligible Owner Operator/Relative Shareholder during Open Enrollment?

There are seven different health plan options available for you to choose from:

- 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 for each health plan option:

- Member Only
- Member + 1
- Family

To review and compare health plan options, visit https://local150.org/moe/about/benefit-seminar-open-enrollment-information/, and click on the Owner Operator/Relative Shareholder tile to access the Comparison Chart.

Updated Monthly Costs Effective April 1, 2024 through March 31, 2025

The updated monthly costs are shown below.

Updated Monthly Costs							
Health Plan Option	**OHC Plan**	**Plan A**	**Platinum**	**EPO**	**Gold**	**Silver**	**Bronze**
Updated Rates from April 1, 2024 – March 31, 2025							
Member Only	$1,660	$1,996	$1,897	$1,908	$,1731	$1,620	$1,019
Member + 1	$1,925	$2,315	$2,200	$2,213	$2,007	$1,879	$1,671
Family	$2,190	$2,634	$2,503	$2,518	$2,284	$2,138	$1,900
Current Rates through March 31, 2024							
Member Only	$1,630	$1,966	$1,867	$1,878	$1,701	$1,591	$966
Member + 1	$1,891	$2,280	$2,166	$2,179	$1,973	$1,845	$1,634
Family	$2,152	$2,595	$2,465	$2,479	$2,245	$2,100	$1,859

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:

- **Local 150 Primary Medical Homes:**
  We are proudly partnered with Premise Health, Everside Health, and the Midwest Coalition of Labor (MCL) to open access to quality healthcare for all eligible active members, retirees, and their eligible covered dependents. **All services covered under your health plan option are free if received at a Local 150 Primary Medical Home.** Visit https://local150.org/moe/local-150-primary-medical-homes-2/ for a list of covered services, Medical Home locations, and other additional information.
    - **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.
    - **MCL Health Centers:** Northbrook, Grayslake, Elgin, and Joliet locations are open and seeing patients. Utica (located inside the District 5 Union Hall) is scheduled to open in 2024.
- **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, refer to 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 https://local150.org/moe/about/benefit-seminar-open-enrollment-information/, and click on the Owner Operator/Relative Shareholder tile.

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, 2024 through March 31, 2025, 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.
- **Local 150 Primary Medical Homes:**
  We are proudly partnered with Premise Health, Everside Health, and the Midwest Coalition of Labor (MCL) to open access to quality healthcare for all eligible active members, retirees, and their eligible covered dependents. **All services covered under your health plan option are free if received at a Local 150 Primary Medical Home.** Visit https://local150.org/moe/local-150-primary-medical-homes-2/ for a list of covered services, Medical Home locations, and other additional information.
    - **Operators' Health Centers:** Both the Countryside and Merrillville locations perform primary/acute care, lab work, condition management, DOT physicals, on-site physical therapy services, and can provide limited prepack medications at your appointment, when necessary. Behavioral health services are available at the Countyside location. Visit operatorshealthcenter.com for more information.
    - **Everside Health Centers:** Facilities are in Rockford, Illinois, Davenport, Iowa, and six locations in northern Indiana. Each location offers many of the same services as offered at the OHC. Everside also has a nurse line available 24/7 if you need to seek triage after hours. Visit eversidehealth.com/local150.com for more information.
    - **MCL Health Centers:** Northbrook, Grayslake, Elgin, and Joliet locations are open and seeing patients. Utica (located inside the District 5 Union Hall) is scheduled to open in 2024.
- 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. Primary plan rules must be followed.
- 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
- Virta offers a free type 2 diabetes management program, if you qualify
- Gateway Foundation or Recovery Centers of America (RCA) offer free substance abuse treatment co-occurring mental health treatment, if necessary

If you have any questions about any of the free services, please contact Member Services at 708-579-6600.

Exclusive 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/.

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.
- MCL Health Centers in Northbrook, Grayslake, Elgin, Joliet, and Utica (coming in 2024)
- 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
- 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.

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 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 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 at the Everside Health Centers or MCL Health Center locations.

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?

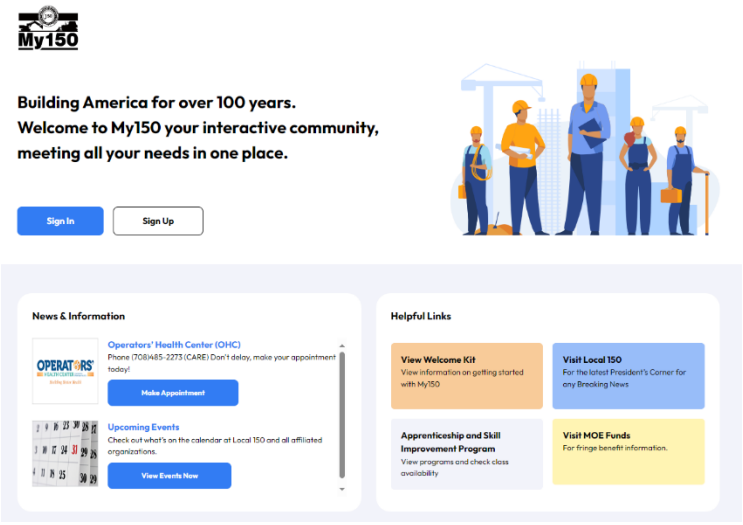
If you use an out-of-network provider or facility, you will pay more. The out-of-network provider or facility may balance bill you. If you are balance billed, contact the Patient Advocacy Center (PAC) at **888-837-2237** or **pac@hstechnology.com**. The PAC will be responsible for negotiating the VBP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

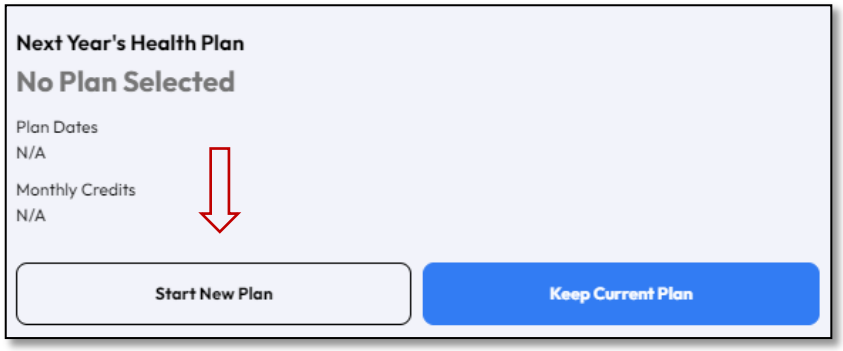
You can select a health plan option and coverage tier through your My150 account at My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime, from anywhere.

Follow these steps to select a health plan option and coverage tier:

1. Log in to your My150. If you're not registered, click Sign Up, and follow the prompts to create your My150 account.

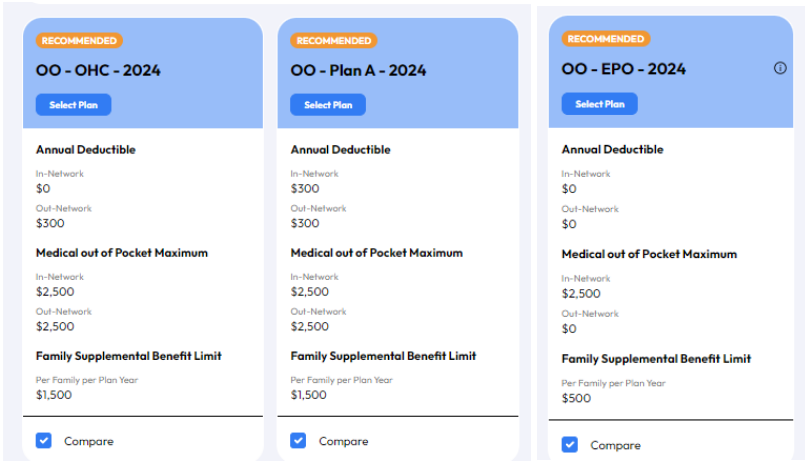


2. Click Under Next Year's Health Plan, select Start New Plan and follow the steps to compare up to three health plan options with the Health Plan Wizard.

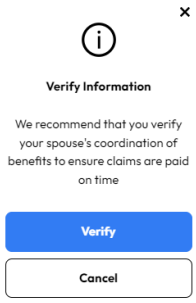


3. If you know which health plan option you would like to select, you can skip the wizard and continue with your plan selection. If you are unsure about the health plan option that you would like to select, you can utilize the Health Plan Wizard. You will be asked some questions about you and your family's specific situation. By answering these questions, the Health Plan Wizard will assist you in assessing which health plan options best meets you and your family's needs. Each year, you can change your coverage tier (Member Only, Member + 1, Family). If you are adding a new dependent, it's important to upload the required documents. **PLEASE NOTE: Required documents must be submitted to the Fund Office by 5:00 pm on February 29, 2024 to add your dependents for coverage beginning April 1, 2024. If documents are received after this date, you will not be able to add your dependents until next year's open enrollment period, unless you have a life changing event.**

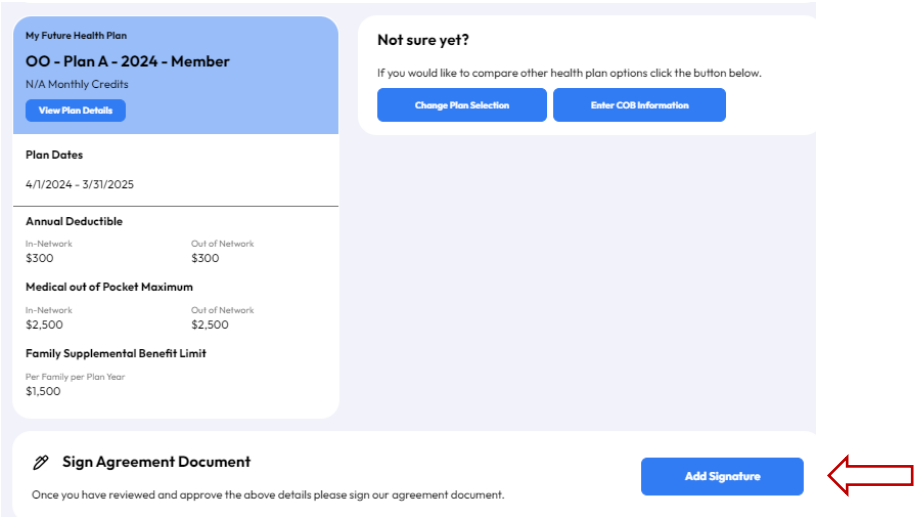
4. Based on your responses, three health plan options will be recommended for you to compare and review.



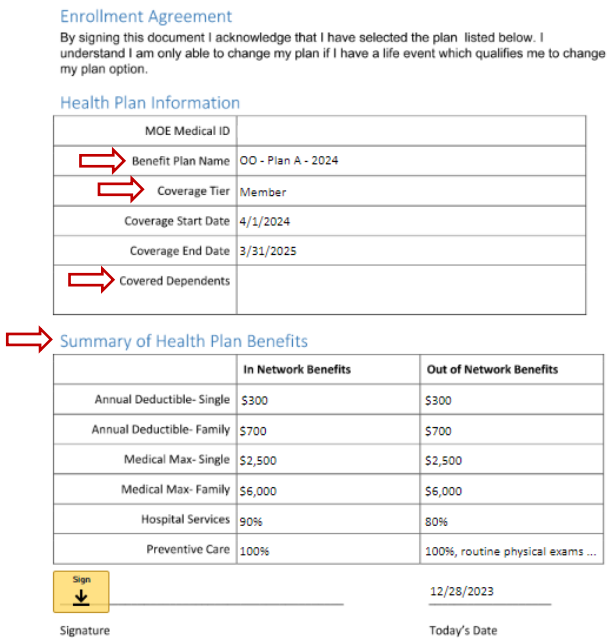
5. Once you have selected a health plan option and coverage tier, a prompt will appear recommending that you verify your spouse's coordination of benefits information, if you have a spouse that is eligible for coverage. Please be sure to verify/update that information to ensure that there is not a delay in claims processing or denied claims.



6. Review your health plan option details and if everything looks good, click Add Signature.



7. You will be given one last opportunity to review the details of the health plan option that you selected, the coverage tier, and covered dependents. If your selection looks good, click to sign, and then FINISH.



Enrollment Agreement

By signing this document I acknowledge that I have selected the plan listed below. I understand I am only able to change my plan if I have a life event which qualifies me to change my plan option.

Health Plan Information

MOE Medical ID	
Benefit Plan Name	OO - Plan A - 2024
Coverage Tier	Member
Coverage Start Date	4/1/2024
Coverage End Date	3/31/2025
Covered Dependents	

Summary of Health Plan Benefits

	In Network Benefits	Out of Network Benefits
Annual Deductible- Single	$300	$300
Annual Deductible- Family	$700	$700
Medical Max- Single	$2,500	$2,500
Medical Max- Family	$6,000	$6,000
Hospital Services	90%	80%
Preventive Care	100%	100%, routine physical exams ...

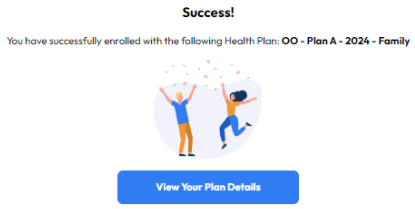
Sign

Signature

12/28/2023

Today's Date

8. The last and final step is click Confirm in the lower righthand side of the screen below Recapture Signature. You will see Success, confirming that you have successfully selected your health plan option for the upcoming Plan Year. You will also receive an email confirmation. The document you sign will be added to the My LIBRARY page.



Keep Current Plan

If you are satisfied with the health plan option and coverage tier that you had for the 2023/2024 Plan Year, we request that you actively log in to your My150 account and click 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.

Coordination of Benefits (COB)

During Open Enrollment, you will be prompted to complete the Coordination of Benefits (COB) process once you selected a health plan option if you are married. You must verify basic spouse information along with the Medicare and employment status. Also, if medical, dental, RX or vision coverage was elected through their employer, if applicable.

Once you have updated/confirmed your spouse's COB information, a case will be created and can be found on your My Cases page with the subject Coordination of Benefits Review 2024. You will receive an email containing with a link to upload their important documents such as an insurance or Medicare card. You can also select to view the case from your My Cases page and upload their important documents.

To update the Coordination of Benefits information for your adult dependents you can log in to your My150 account, click on My LIBRARY, then My COB Docs and then Enter Updated COB Information.

Failure to update your spouses or adult dependents COB information may result in delayed claims processing or denied claims.

Adding a Dependent During Open Enrollment

To add a new dependent to your coverage, you need to submit a Life Changing Event. Log in to your My 150 account, click MY FAMILY, and click Submit Life Changing Event. You will be required to complete details of the life changing event and then select Add Dependent. After you enter and save your dependents details, you will see a pop up indicating that your dependent has been created successfully. It is very important that you then click Submit. You will see another pop up indicating that your Life Changing Event has been successfully submitted.

A case has been created and can be found on your My Cases page with the subject Life Changing Event. You will receive an email containing a link to upload their important documents such as a birth certificate or adoption letter, Social Security Card, marriage certificate etc. You can also select to view the case from your My Cases page and upload their important documents.

PLEASE NOTE: During Open Enrollment, required documents must be submitted by 5pm Feb 29th, 2024. Failure to upload the required documents will result in that dependent not being added to the plan, and they will not have the opportunity to be added again until Open Enrollment in 2025. The only other time a dependent can be added onto the plan is during a Life Changing Event i.e. marriage, birth, adoption, loss/gain of other insurance coverage or divorce. You have 90 days from the actual date of your Life Changing Event to submit the required documents, not the date you submit your Life Changing Event. Failure to upload the required documents will result in that dependent not being added to the plan.

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.

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)

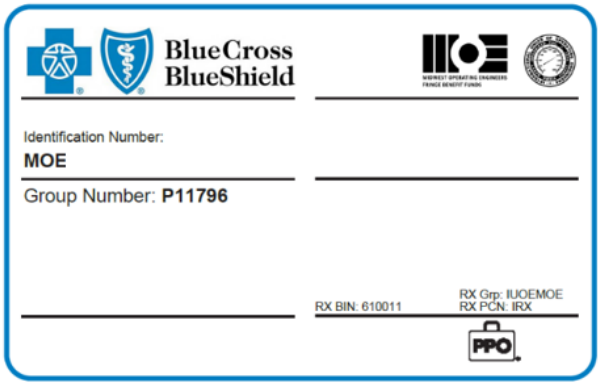
OHC Plan:

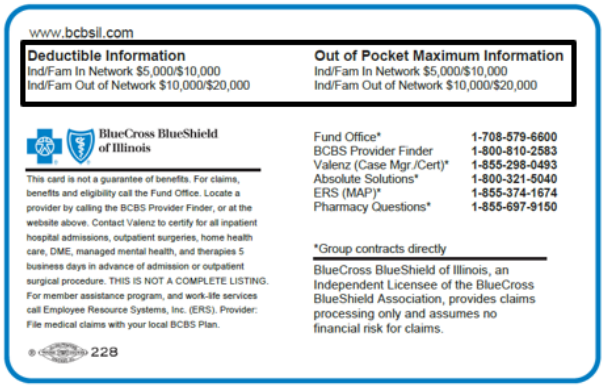
- This health plan option uses the Operators' Health Centers and providers and facilities in the HST Care Connect network. **PLEASE NOTE:** Be sure to reference the free services too!
- Visit www.operatorshealthcenter.com to view Operators' Health Center locations and providers
- Go to www.moefunds.hstechnology.com
- 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

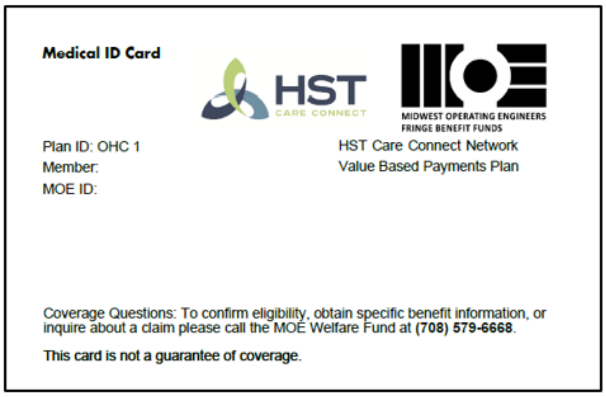
If you are changing your health plan option for the upcoming Plan Year, you will receive new medical ID cards to use effective April 1, 2024. It is imperative that you use this new medical ID card on or after April 1, 2024 and always keep it on your person. You will also be able to download a copy of your card through your My150 account. If you need additional cards, please contact Member Services at 708-579-6600.

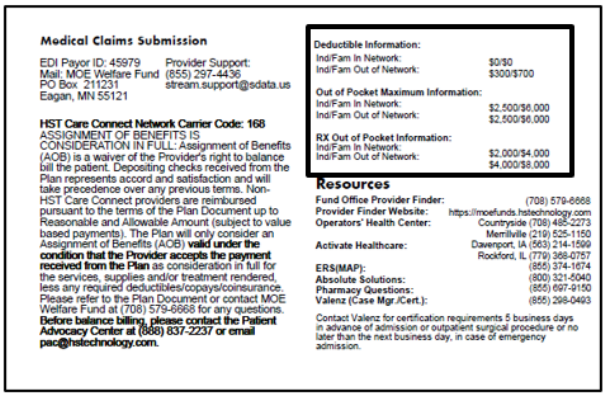
If you select one of the PPO Plans (Plan A, Platinum, Gold, Silver, Bronze, or EPO), you will receive a BCBS of Illinois medical ID card. The information on the back of the card is specific to the health plan option you selected.





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





As a reminder, if you keep your current health plan option for the upcoming Plan Year, you will not receive a new medical ID card.

Family Supplemental Benefit (FSB)

Each of the health plan options provide a different 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 https://local150.org/moe/family-supplemental-benefit/.

Review Your Beneficiaries

The annual open enrollment period is a great time to review and/or update your designated beneficiaries. To review your current beneficiaries, 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. Once a divorce has been finalized, it is imperative to contact the Benefits & Eligibility Services Group at 708-937-0327 and submit a copy of your divorce decree as quickly as possible to avoid potential medical, dental, and pharmacy overpayments that the member will be responsible for paying!

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 – This benefit is not available to Owner Operator/Relative Shareholders.

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

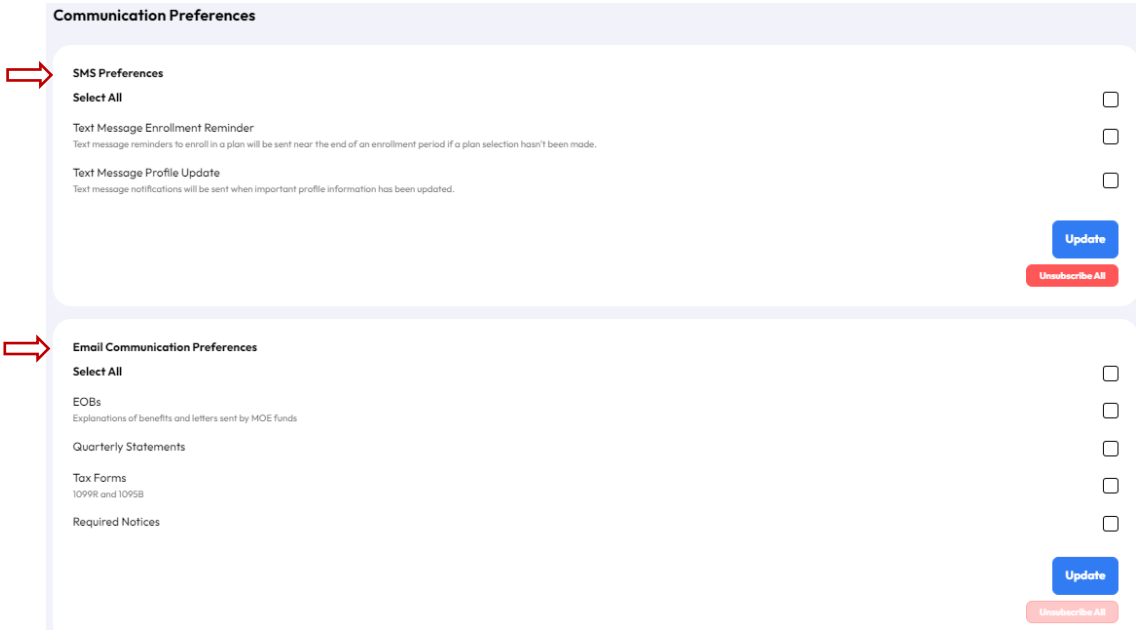
Retirement Enhancement Fund – Fidelity Investments is responsible for maintaining beneficiary information for this fringe benefit. To access your plan's benefits and update your beneficiary, visit www.NetBenefits.com/atwork to setup a username and password. From here, click on "Profile" and then scroll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

Communication Preferences

Communication Preferences allows you to select if you would like to receive electronic notifications when your EOB's, Quarterly Statements, and Required Notices are available and ready to be viewed in your My150 account in lieu of receiving them in the mail. Your Communication Preferences can be updated by logging in to your My150 account, clicking the My Profile Icon and selecting Communication Preferences under settings. You can 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.



Where is everything located?

- Explanation of Benefits (EOBs) can be found under MY CLAIMS
- Your Quarterly Statements can be found under MY HOURS
- Under MY LIBRARY, you can find your annual required notices, form documents, your DocuSigned documents, Summary Plan Descriptions, Coordination of Benefits forms, and tax documents.

Your preferences can be updated or changed at any time.

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 balanced 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 800-985-3059.

For ERISA Plans: For technical assistance and complaints, you should call EBSA's toll free number at 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.