

OPEN ENROLLMENT GUIDE

MARKETPLACE



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. [2025 version]

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What is Annual Open Enrollment?

Annual open enrollment will be held from January 13 through February 28, 2025. During this time, you can review all the Marketplace health plan options, compare plans, and 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 upcoming Plan Year effective April 1, 2025 through March 31, 2026.

During open enrollment, you can:

- Select a new health plan option or keep the same health plan option
- Select your coverage tier (Member Only, Member + 1, Family)
- You can remove dependents from your health plan. If you removed a dependent from your plan, you would need to remove 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
- You can transfer credits from your Credit Bank to your Retiree Medical Saving Plan (RMSP) account, if eligible
- If you are married or have adult dependents, you are strongly encouraged to update their [Coordination of Benefits](#) information
- Review/update your My150 account details and Communication Preferences under your My Profile

Scan to view a short video about Open Enrollment



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 2024/2025 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 be automatically enrolled in the Bronze PPO Plan.

Date that you are newly eligible or re-establishing eligibility	Important Information	Can you participate in 2025 Open Enrollment?	You Should Know
January 1, 2025 or February 1, 2025	You will be automatically enrolled in the Bronze PPO Plan through March 31, 2025	Yes!	You can select from any of the Marketplace health plan options for the upcoming Plan Year beginning April 1, 2025. If you do not select a plan, you will default back into the Bronze plan for the Plan Year.
March 1, 2025	You will remain in the Bronze PPO Plan for 13 months; through March 31, 2026	No!	You will be able to participate in the next Open Enrollment taking place in 2026

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. Appointments will start at 8:00am. Spouses welcome!

Scan to register for an event



or visit local150.org/moe/

Open Enrollment events will take place on the following dates:

- January 14: District 3 Union Hall, Lakemoor, IL
- January 25: District 1 Fund Office, Countryside, IL
- January 31: District 4 Union Hall, Rockford, IL
- February 8: District 5 Union Hall, Utica, IL
- February 11: District 6 Union Hall, Lakeville, IN
- February 18: District 8 Union Hall, Rock Island, IL
- February 22: District 7 Union Hall, Merrillville, IN

PLEASE NOTE: The Fund Office navigator is not licensed to recommend which health plan option to select or how many credits you should transfer. The Fund Office navigator is available to answer questions on the plan benefits and help explain how many credits you need to maintain coverage.

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: 8:00am to 5:00pm CST
- Thursday: 9:00am to 5:00pm CST
- Saturday: 8:00am to 12pm CST

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

Retirement Services Group: Call (708) 579-6630 for any questions about retirement, transferring credits, or the Worker Retention Program (WRP).

Benefits & Eligibility: If you have questions regarding RWP eligibility rules, RWP self-payment premiums, and transferring credits, call (708) 937-0327.

New for 2025 Open Enrollment!



Scan to view our Open Enrollment hot topics video library!

My150

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.

Once you are logged in to your My150 account, you should review your profile information and ensure all the information is correct. Be sure to 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. You can also update your [beneficiary information](#).

Navigating My150

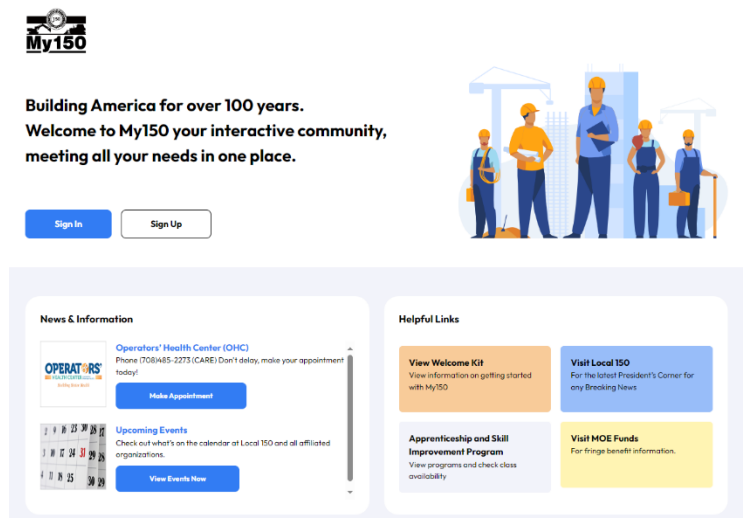
- Explanation of Benefits (EOBs) can be found under MY CLAIMS
- Your Quarterly Statements can be found under MY HOURS
- Under MY LIBRARY, you can find your annual required notices, form documents, your DocuSigned documents, Summary Plan Descriptions, Coordination of Benefits forms, and tax documents.

Selecting a Health Plan Option/Coverage Tier

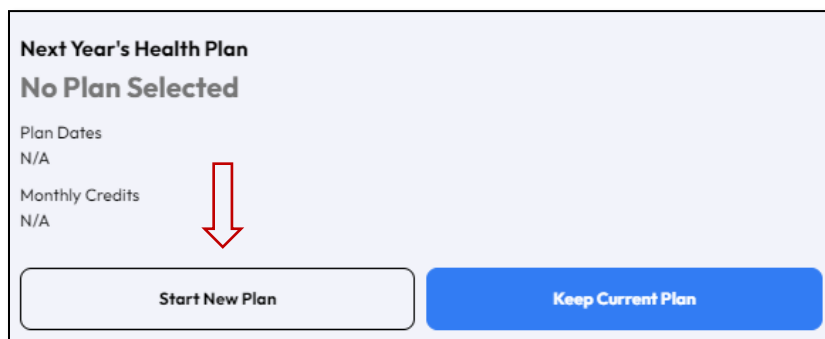
You can select a health plan option and coverage tier through your My150 app or at [My150.com](https://my150.com). Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime during Open Enrollment, from anywhere.

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.



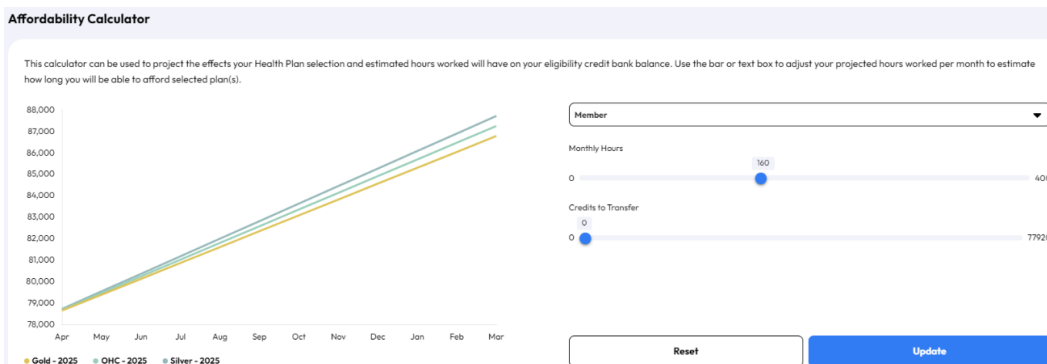
3. If you know which health plan option you would like to select, you can skip the wizard and continue with your plan selection. If you are unsure about the health plan option that you would like to select, you can utilize the Health Plan Wizard. You will be asked some questions about you and your family's 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 5:00pm CST on February 28, 2025, to add your dependents for coverage**

beginning April 1, 2025. 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.

- Based on your responses, three health plan options will be recommended for you to compare and review. If you know the health plan option you would like to select, click Select Plan to bypass the Affordability Calculator.

Plan Name	Monthly Credits	Annual Deductible (In-Network)	Annual Deductible (Out-Network)	Medical out of Pocket Maximum (In-Network)	Medical out of Pocket Maximum (Out-Network)	Family Supplemental Benefit Limit (Per Family per Plan Year)	Months Until Bank Depleted
Gold - 2025	1,300	\$1,000	\$2,000	\$4,000	\$8,000	\$2,000	59
OHC - 2025	1,261	\$0	\$300	\$2,500	\$2,500	\$2,000	61
Silver - 2025	1,222	\$2,000	\$4,000	\$4,000	\$8,000	\$2,000	63

- The Affordability Calculator Estimator can be used to project the effects your health plan selection and estimated hours worked will have on your Credit Bank balance which can impact your eligibility. With this tool, you can easily select your coverage tier (Member, Member + 1, or Family), your estimated monthly hours, and the number of credits you intend on transferring to your RMSP account during Open Enrollment, if applicable. Please note that this is not a guarantee of coverage. This is an estimate based on your current Health and Welfare Contribution Rate which is subject to change 4/1/2025. [Refer to Accumulating Credits and Monthly Credit Cost Deductions.](#)



- 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.

Verify Information

We recommend that you verify your spouse's coordination of benefits to ensure claims are paid on time

Verify Cancel

- New for 2025 Open Enrollment!** You can review your dependents and select the dependents that will be covered under your health plan option for the Plan Year. If you would like to de-select one of your listed dependents or add a new dependent, select Edit Dependent. If you would like to cover all your listed dependents and you reviewed your health plan option details, select Add Signature.

Review Plan

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

My Future Health Plan
Gold - 2025 - Family
 1,715 Monthly Credits
[View Plan Details](#)

Plan Dates
 4/1/2025 - 3/31/2026

Annual Deductible

In-Network	Out of Network
\$2,500	\$5,000

Medical out of Pocket Maximum

In-Network	Out of Network
\$8,000	\$16,000

Family Supplemental Benefit Limit
 Per Family per Plan Year
 \$2,000

Your Dependents

Please review the below Dependent that will be covered under your selected Health Plan option. If you would like to choose another Dependent, please click the "Change Dependent" button below.

ERIN WHEELER
 Age: 34
 EMMA WHEELER
 Age: 8
 VIOLET WHEELER
 Age: 7
 COLTON WHEELER
 Age: 12
 BREEZE WHEELER
 Age: 4

[Edit Dependent](#)

Sign Agreement Document

Once you have reviewed and approve the above details please sign our agreement document.

[Add Signature](#)

[Cancel](#) [Previous](#) [Confirm](#)

- 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 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	
Coverage Tier	Family
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	\$1,000	\$2,000
Annual Deductible- Family	\$2,500	\$5,000
Medical Max- Single	\$4,000	\$8,000
Medical Max- Family	\$8,000	\$16,000
Hospital Services	80%	60%
Preventive Care	100%	No Benefits

Signature: _____ Today's Date: 12/19/2023

- 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.

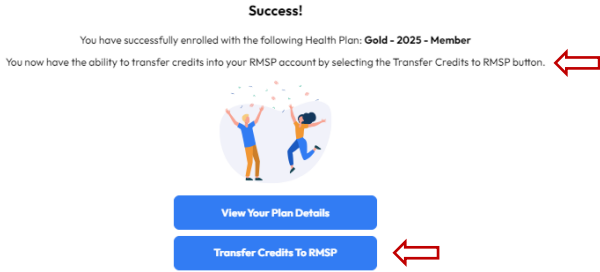
Sign Agreement Document

Once you have reviewed and approve the above details please sign our agreement document.

[Recapture Signature](#)

[Cancel](#) [Previous](#) [Confirm](#)

10. If you meet the requirements to transfer credits from your Active Credit Bank to your RMSP account, you will see an additional option to select as shown below. You will also see a Transfer Credits To My RMSP button on the My RMSP page in your My150 account. You have until the end of Open Enrollment, February 28, 2025 to make a credit transfer. [Refer to RMSP Wizard Tool.](#)



→ Only **one** credit transfer can be made from your Active Credit Bank to your RMSP account during Open Enrollment.

→ Once you confirm your credit transfer, it cannot be undone for any reason.

Keep Current Plan

If you are satisfied with your current plan and would like to keep it for 2025/2026, please log in to your My150 account and click Keep Current Plan. You'll review your plan coverage details, your coverage tier and covered dependents, then confirm your choice for the upcoming Plan Year. Please refer to Steps 6 through 9 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 or have adult dependents. You must verify basic information for your spouse or adult dependents including Medicare entitlement 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 or adult dependents COB information, a case will be created and can be found on your My Cases page with the subject Coordination of Benefits Review 2025. You will receive an email 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 required 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.

RMSP Wizard Tool

For members eligible to transfer credits, we welcome you to utilize 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, 2025, to make your transfer credit election. Be sure to review your My HOURS tab, before transferring credits.

The RMSP Wizard prompts you with questions and based on the answer to your questions, you can determine the number of credits to transfer. 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, 2025:

- 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 2025
- 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 2025

Transferring credits is an important decision because you DO NOT want to lose active eligibility coverage. Once you confirm your credit transfer, it is final, and you will not be able to transfer them back to your active Credit Bank. If you 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](#).

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 Open Enrollment Add.. 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.

Scan to view a short video about uploading required documents through your My150 account



PLEASE NOTE: During Open Enrollment, required documents must be submitted to the Fund Office by **5:00 pm on February 28, 2025**. 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 2026. 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.

You must also make an active plan selection for your dependents to be added to your plan. If you default, your dependents will not be added to your 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 actively enroll in a plan and select only the dependents you wish to cover.

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 along the left side of the page of your My150 MY DASHBOARD 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, covered under a plan that includes death benefits, 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, children, adopted children, and step-children can be named as either your primary or contingent beneficiary(ies).

Retirement Enhancement Fund (REF) – 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>.

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

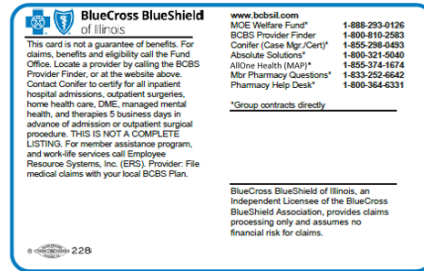
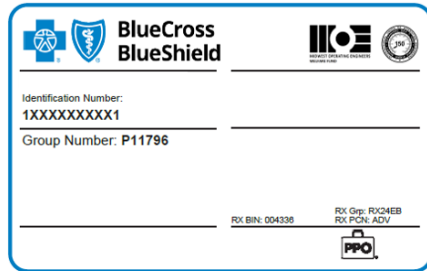
For those members that are already age 55 or will turn age 55 by March 31, 2025, you have the opportunity to transfer credits from your active Credit Bank to your RMSP account during Open Enrollment. For details on how to transfer credits, please visit <https://local150.org/moe/about/benefit-seminar-open-enrollment-information/>, and click on the Marketplace tile. 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 2025/2026 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.

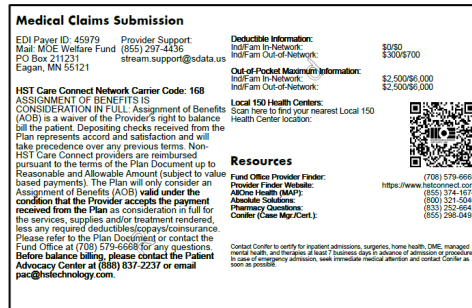
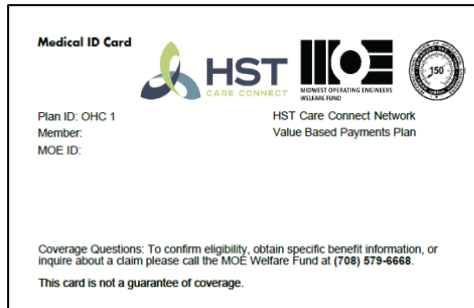
Medical ID Cards

If you are changing your health plan option for the upcoming Plan Year, you will receive new BCBS Medical ID cards to use beginning April 1, 2025. 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 BCBS PPO Plans, you will receive a BCBS Medical ID card.



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. If you are currently enrolled in the EPO Plan and keep the EPO Plan for the upcoming Plan Year, you will receive a new Medical ID card.

Midwest Operating Engineers Health Plan Marketplace

The MOE health plan marketplace enables you to choose a plan that best fits your needs. There are seven different health plan options available under the Marketplace:

- Plan A PPO
- Platinum PPO
- EPO Plan
- Gold PPO
- Operators' Health Center (OHC) Plan
- 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 <https://local150.org/moe/about/benefit-seminar-open-enrollment-information/>, and click on the Marketplace tile to access the Comparison Chart. Keep in mind, during Open Enrollment, you can access the Health Plan Wizard when selecting a plan. The Wizard will ask you a series of questions about you and your covered dependents and recommend three health plan options for you to review and compare, based on your responses. Whichever health plan option that the member selects is the health plan that all their covered dependents will have as well. Families covered under the same plan cannot select different health plans options.

Plan A, Platinum, Gold, Silver, and Bronze Plan

These plans are Preferred Provider Organization (PPO) Plans and 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.

Deductible and Out-of-Pocket Limits	Plan A		Platinum		Gold		Silver		Bronze	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible	\$300	\$300	\$500	\$1,000	\$1,000	\$2,000	\$2,000	\$4,000	\$5,000	\$10,000
Family Deductible	\$700	\$700	\$1,250	\$2,500	\$2,500	\$5,000	\$5,000	\$10,000	\$10,000	\$20,000
Individual Out-of-Pocket Maximum	\$2,500	\$2,500	\$3,500	\$7,000	\$4,000	\$8,000	\$4,000	\$8,000	\$5,000	\$10,000
Family Out-of-Pocket Maximum	\$6,000	\$6,000	\$7,000	\$14,000	\$8,000	\$16,000	\$8,000	\$16,000	\$10,000	\$20,000

To locate an In-Network provider/facility:

- Visit 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

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.

The biggest call out of these plan options is that the Bronze Plan does not include dental, life insurance, accidental death and dismemberment, or disability benefits. If you select this health plan option, it's recommended to utilize the [free services](#) available to you and your covered dependents.

OHC Plan

The OHC Plan's network of providers and facilities is provided by the HST Care Connect network. This is a customized network of providers and facilities – this is **NOT** a BlueCross BlueShield of Illinois PPO network. To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Powers Health (formerly Community Health), or Methodist Hospital.

The HST Care Connect network, consists of the following providers and facilities:

- Local 150 Health Centers – Operators' Health Centers located in Countryside, IL and Merrillville, IN, Marathon Health Centers, and Midwest Coalition of Labor (MCL) Health Centers. (Refer here for more information about Local 150 Health Centers)
- Advocate Healthcare System, including Advocate clinics in Walgreens
- Powers Health (formerly Community Health)
- Methodist Hospital System

The objective of the OHC Plan is that if you use In-Network providers, all medically necessary covered services are free. The plan design is as follows:

Deductible and Out-of-Pocket Limits	OHC Plan	
	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 any of the Local 150 Health Centers (Operators' Health Centers (OHC), Marathon Health Centers & Midwest Coalition of Labor Health Centers (MCL Health Centers)) at no cost to you.

For after-hours urgent care, you can visit a MinuteClinic in CVS or Target, or an Advocate Clinic located in Walgreens stores. For medical services not provided at the Local 150 Health Centers, such as specialist visits or hospitalization, the Local 150 Health Center provider will refer you to an HST Care Connect provider. HST Care Connect providers include those from Advocate Health Care, Powers Health (formerly Community Health), 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.

To locate providers and facilities in the HST Care Connect network, visit <https://www.hstconnect.com/> to access the provider finder.

- You will need to create an account by entering your MOE ID located on your HST ID card and some other basic information
- Select Find a Provider
- Enter your search criteria (name, NPI, specialty (family practice, therapist) etc.
- Providers and facilities in the search results are in-network if it indicated "HST Anchor", as shown below:

Advocate Lutheran General Hospital

General

1775 Dempster Street, Park Ridge, IL, 60068

(847) 723-2210

Details

VDHP Acceptance
HST Anchor

Distance
26.40 mile(s)

Get Directions

Quality Rating
★★★★★

**If there is no HST Anchor,
please contact Member Services
at (708) 579-6668 to confirm
network status!**

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.

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

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, even for the services identified as service gaps. 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.

If you are thinking about choosing the OHC Plan or have any questions, contact a specialized OHC Plan Member Services Representative at (708) 579-6668.

EPO Plan

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.

EPO Provisions – In-Network ONLY	
Deductible	\$0
Copayment for Primary Provider visits	\$20
Copayment for Specialists	\$40
Inpatient Hospital Services	\$250/admission
Emergency Services in a Hospital or Independent Freestanding	\$100/visit

To locate an In-Network provider/facility:

- Visit 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

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.

To compare health plan options side by side, you can review the Marketplace Comparison Chart by visiting <https://local150.org/moe/about/benefit-seminar-open-enrollment/>, and click on the Marketplace tile.

Accumulating Credits and Monthly Credit Cost Deductions

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. The retiree subsidy is going to increase from 17.3% to 20.1% beginning April 1, 2025.

Example #1 (Current Retiree Subsidy):

If you fall under the Heavy Highway contract, your current hourly Employer contribution rate is \$18.30. Therefore, to determine the cost of a credit, you will need to remove the retiree subsidy.

Employer Health and Welfare Contribution Rate:	\$18.30
Less the 17.3% Retiree Subsidy	(18.30 x .173): <u>(3.17)</u>
Credits Per Hour Worked:	15.13

Based on this example, 15.13 credits will be added to the member's Credit Bank for each hour they work. So, if this member works 160 hours in one month, 2,420 credits (15.13 X 160) will be added to their credit bank.

Example #2 (Retiree Subsidy beginning April 1, 2025):

Employer Health and Welfare Contribution Rate:	\$18.30
Less the 20.1% Retiree Subsidy	(18.30 x .201): <u>(3.67)</u>
Credits Per Hour Worked:	14.63

Based on the second example with the updated retiree subsidy beginning April 1, 2025, a member working under the Heavy Highway contract with an hourly Employer contribution rate of \$18.30 will have 14.63 credits added to their Credit Bank for each hour they work. So, if this member works the same number of hours (160) as they did in Example 1, 2,340 credits (14.63 X 160) will be added to their credit bank for the month. Please keep in mind that based on the contract, the Employer Contribution rate will increase in June 2025.

Credits are used to pay for your health plan each month. The health plan options will remain the same for the next Plan Year EXCEPT for Marketplace Plan A. Credit costs for Marketplace Plan A will increase by 5% for the 2025/2026 Plan Year.

Below is a chart outlining each Marketplace health plan option/tier credit costs for the current plan year and the upcoming plan year:

Updated Monthly Credit Cost Deductions for the MOE Health Plan Marketplace							
Health Plan Option	Plan A	Platinum	EPO	Gold	OHC Plan	Silver	Bronze
New Rates for April 1, 2025 through March 31, 2026							
Member Only	1,666	1,413	1,394	1,300	1,261	1,222	714
Member + 1	1,932	1,642	1,617	1,506	1,464	1,416	1,171
Family	2,199	1,868	1,842	1,715	1,663	1,613	1,332
Current Rates through March 31, 2025							
Member Only	1,587	1,413	1,394	1,300	1,261	1,222	714
Member + 1	1,840	1,642	1,617	1,506	1,464	1,416	1,171
Family	2,094	1,868	1,842	1,715	1,663	1,613	1,332

Parent Members and Active Hourly Dependent Members

New for 2025 Open Enrollment! Active hourly dependent members who are covered/or can be covered by their parent members' health plan can freeze their eligibility under their own health plan while continuing to accumulate credits in their active credit bank. This option will be available this upcoming Open Enrollment (January 13, 2025 – February 28, 2025). **Both the parent and the dependent member must participate in Open Enrollment for this to go into effect.** Eligibility requirements apply, and there are important things to consider if contemplating this option.

Scan the QR code to view a short video about this new option



Free Services Available Under the Marketplace Health Plan Options

Regardless of the health plan option that you select, for coverage starting April 1, 2025 through March 31, 2026, you and your family can use each of the following free services to maximize your benefits and minimize your out-of-pocket expenses:

- **Free best in class primary health care at Local 150 Health Centers:**
We are proudly partnered with Premise Health, Marathon 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 Health Center location.** Visit <https://local150.org/moe/local-150-health-centers/> for a list of covered services, Health Center 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 Countryside location. Coming in 2025, the Merrillville location will also offer behavioral health services. Visit <https://members.premisehealth.com/moe/> for more information.
 - **Marathon 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. Marathon Health also has a nurse line available 24/7 if you need to seek triage after hours. Visit clients.marathon.health/local150 for more information.
 - **MCL Health Centers:** Locations in Northbrook, Grayslake, Elgin, Joliet, and Utica. Visit <https://members.premisehealth.com/moe/> for more information.
 - **Free preventive health services** at in-network providers. Talk to your provider about these services. 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. For a complete list of services for adults, women, and children, visit healthcare.gov/coverage/preventive-care-benefits/.
 - **Free MRI, CT, and PET scans**, if medically necessary, through Absolute Solutions Imaging Network
 - **Free plan covered immediate care services** at MinuteClinics, located within select CVS and Target locations. There are also some cash-pay services.
 - **Free physical therapy services** through ATI Physical Therapy, if medically necessary. Primary plan rules must be followed.
 - **Free eye exam** if you use an EyeMed Advantage Network provider. The EyeMed Advantage Network also offers numerous discounts on vision services.
 - **Five free counseling sessions with a licensed** clinician, per episode, through AllOne Health (formerly ERS) our Member Assistance Program offers up to five free counseling sessions (per episode)
 - **Free type 2 diabetes management program**, through Virta (if you qualify)
 - **Free substance abuse treatment** through Gateway Foundation & Recovery Centers of America (RCA)
- If you have any questions about any of the free services, please contact Member Services at 708-579-6600.
- For more information regarding our vendors, please visit <https://local150.org/moe/h-w/exclusive-partnerships/>.

Family Supplemental Benefit (FSB)

FSB can be used to receive reimbursement for certain eligible expenses that are medically necessary non-covered expenses. Each of the Marketplace health plan options provide \$2,000 per family per Plan Year in an FSB benefit. If you do not utilize your FSB, the balance will not carry over to the next Plan Year. Your My150 dashboard will display the current utilization of your FSB for the Plan Year.

For more information regarding FSB, please visit <https://local150.org/moe/family-supplemental-benefit/>.

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 in an Emergency Room in a Hospital or Independent Freestanding Emergency Department, 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 (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.