OPEN ENROLLMENT GUIDE

OWNER-OPERATOR OR RELATIVE

MIDWEST OPERATING ENGINEERS
OPEN ENROLLMENT 2025

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]

Table of Contents

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 Owner-Operator or Relative Marketplace health plan options, compare plans and 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 remove a dependent from your plan, you will 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
- 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?

As an Owner-Operator or Relative, 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 options, answer any questions you may have regarding the various health plans, assist you with the enrollment process and updating dependents. 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. The Fund Office navigator is available to answer questions on the plan benefits.

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.

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

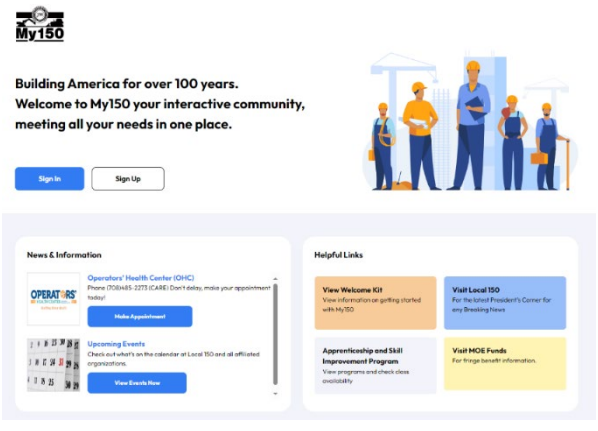
- Explanation of Benefits (EOBs) can be found under MY CLAIMS
- Your Quarterly Statements can be found under MY HOURS
- Under MY LIBRARY, you can find your annual required notices, form documents, your DocuSigned documents, Summary Plan Descriptions, Coordination of Benefits forms, and tax documents

Selecting a Health Plan Option/Coverage Tier

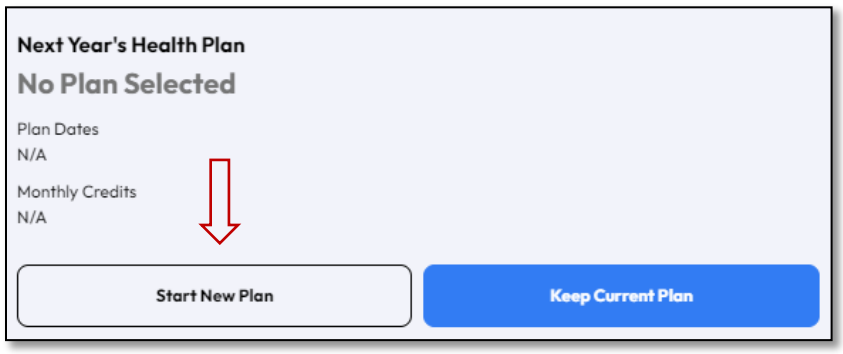
You can select a health plan option and coverage tier through your My150 app or at My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime during Open Enrollment, from anywhere.

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.

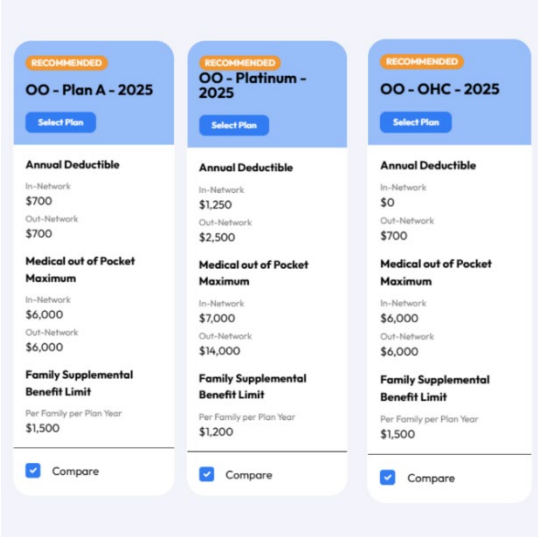


2. Click Under Next Year's Health Plan, select Start New Plan and follow the steps to compare up to three health plan options with the Health Plan Wizard.

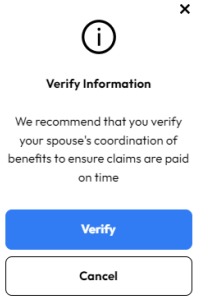


3. If you know which health plan option you would like to select, you can skip the wizard and continue with your plan selection. If you are unsure about the health plan option that you would like to select, you can utilize the Health Plan Wizard. You will be asked some questions about you and your family's 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.**

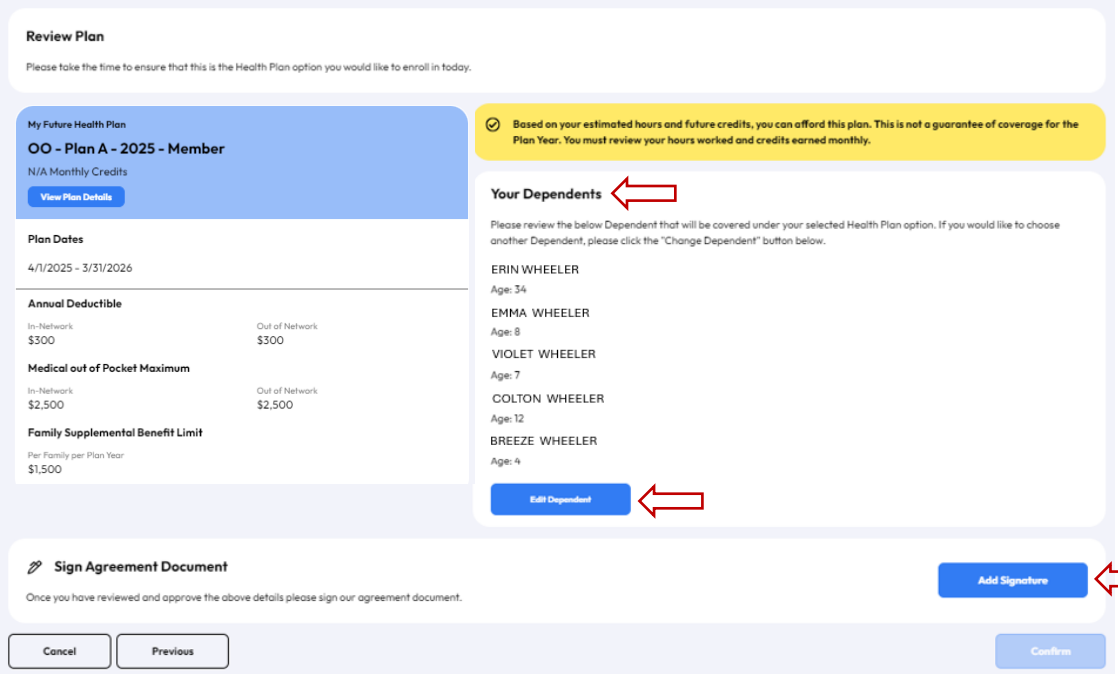
4. Based on your responses, three health plan options will be recommended for you to compare and review. If you know the health plan option you would like to select, click Select Plan.



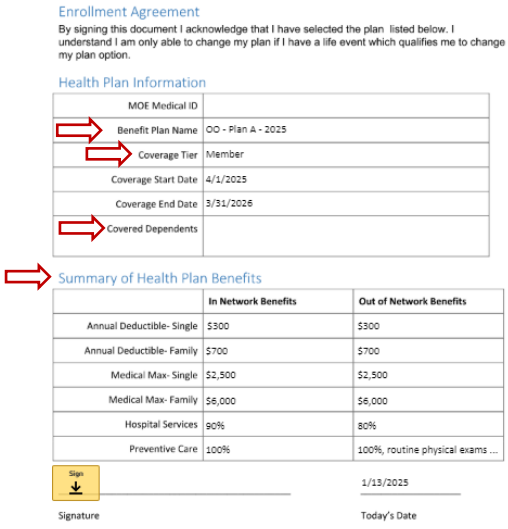
5. Once you have selected a health plan option and coverage tier, a prompt will appear recommending that you verify your spouse's coordination of benefits information, if you have a spouse that is eligible for coverage. Please be sure to verify/update that information to ensure that there is not a delay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



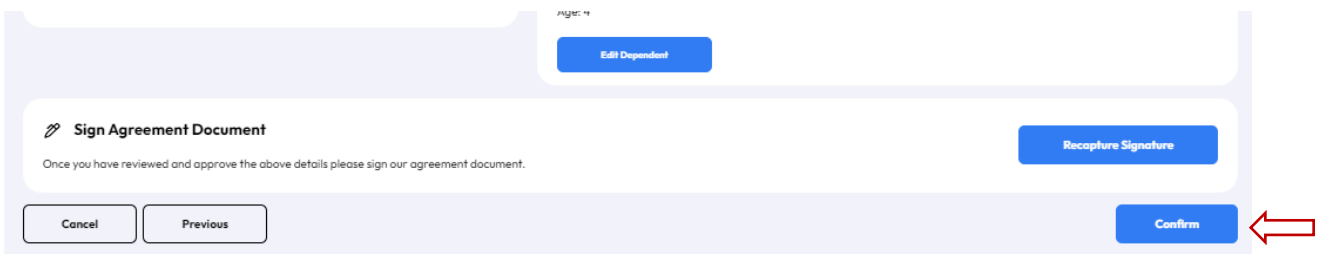
6. **New for 2025 Open Enrollment!** You can review your dependents and select the dependents that will be covered under your health plan option for the Plan Year. If you would like to de-select one of your listed dependents or add a new dependent, select Edit Dependent. If you would like to cover all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



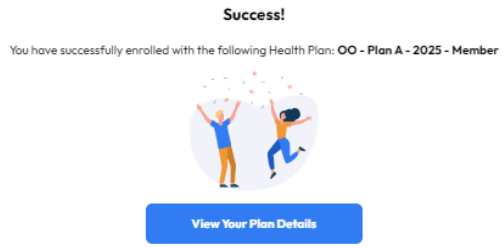
7. You will be given one last opportunity to review the details of the health plan option that you selected, the coverage tier, and covered dependents. If your selection looks good, click to sign, and then Finish.



8. The last and final step is click Confirm in the lower righthand side of the screen below Recapture Signature.



9. You will see Success, confirming that you have successfully selected your health plan option for the upcoming 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.

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.

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.

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

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 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".

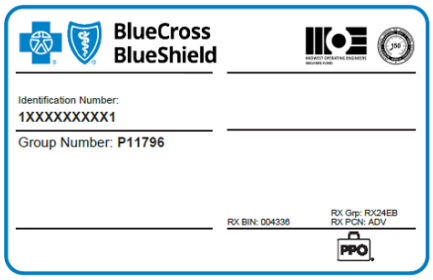
If you require any assistance with updating your beneficiaries, you can call Member Services at 708-579-6600.

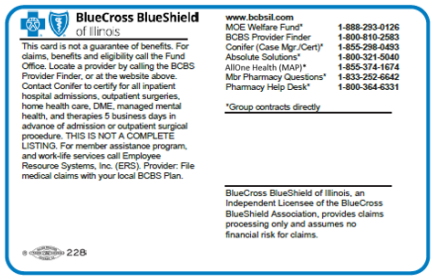
PLEASE NOTE: If you are an active dues paying member, you also have $10,000 of Life Insurance through the Midwest Coalition of Labor (MCL). The Fund Office does not administer this benefit but for more information, visit coalitionoflabor.org. You can also access the beneficiary designation form to download,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

Medical ID Cards

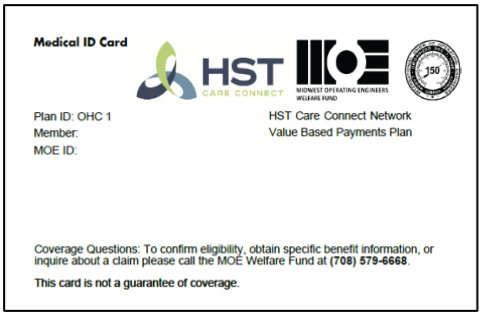
If you are changing your health plan option for the upcoming Plan Year, you will receive new BCBS Medical ID cards to use beginning April 1, 2025. You will also be able to download a copy of your card through your My150 account. If you need additional cards, please contact Member Services at (708) 579-6600.

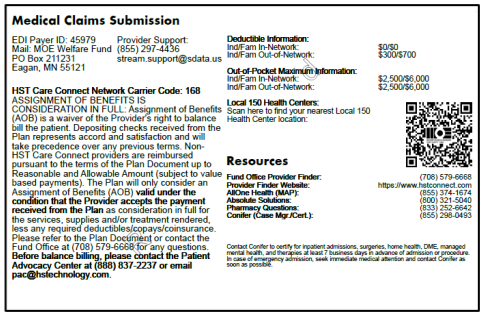
If you select one of the BCBS PPO Plans, you will receive a BCBS Medical ID card.





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 enroll in the EPO Plan for the upcoming Plan Year, you will receive a new Medical ID card.

Midwest Operating Engineers Health Plan Options

There are seven different health plan options for Owner-Operator or Relatives to choose from:

- 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 Owner-Operator or Relative 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.

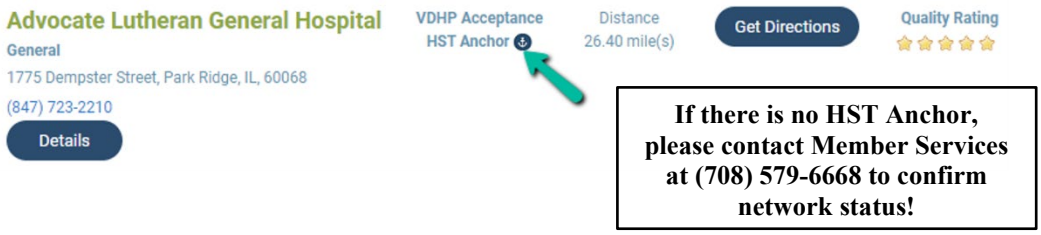
How the OHC Plan Works

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:



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% of the Value Based Pricing. For example, you can utilize any licensed chiropractor or acupuncturist, and the services will be covered at 100% of the value based pricing. 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 are still subject to balance billing. 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-information/, and click on the Marketplace tile.

Owner-Operator or Relative Monthly Rates Effective April 1, 2025

The updated monthly rates are outlined below:

Updated Monthly Rates							
Health Plan Option	**Plan A**	**Platinum**	**EPO**	**Gold**	**OHC Plan**	**Silver**	**Bronze**
Updated Rates Effective April 1, 2025 – March 31, 2026							
Member Only	$2,101	$1,997	$2,009	$1,822	$1,748	$1,706	$1,081
Member + 1	$2,437	$2,316	$2,330	$2,114	$2,027	$1,979	$1,773
Family	$2,773	$2,636	$2,651	$2,405	$2,307	$2,252	$2,017
Current Rates Effective through March 31, 2025							
Member Only	$1,996	$1,897	$1,908	$,1731	$1,660	$1,620	$1,019
Member + 1	$2,315	$2,200	$2,213	$2,007	$1,925	$1,879	$1,671
Family	$2,634	$2,503	$2,518	$2,284	$2,190	$2,138	$1,900

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 Owner-Operator or Relative Marketplace health plan option includes the FSB benefit. The FSB benefit amount is per family per Plan Year, and 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. Refer to the Schedule of Benefits for each health plan's FSB amount.

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 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.