MIDWEST OPERATING ENGINEERS
FRINGE BENEFIT FUNDS

Important Information Regarding the Annual Open Enrollment Process

Municipality (Monthly)

January 16 – February 28, 2023

The information provided in this document is of general nature only and does not replace or alter the official rules and policies contained in the official Plan Documents (including amendments) that legally govern the terms and operations of the Midwest Operating Engineers Welfare Fund. If this publication differs in any way from the official Plan Documents, the official Plan Documents will always govern. The Board of Trustees have the right to modify the Midwest Operating Engineers Welfare Fund at any time. [2023 OE Guide Edition]

Important Information Regarding the Annual Open Enrollment Process

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Open Enrollment Information

What is Annual Open Enrollment?

Annual open enrollment will be held from January 16 through February 28, 2023. During this time, you can review your health plan option and coverage tier. Keep in mind that the available health plan option(s) is dependent on your negotiated Collective Bargaining Agreement (CBA). If you can choose a different health plan option, this is the time to compare the 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, 2023 through March 31, 2024.

During open enrollment, you can:

- Select a new health plan option or retain the same health plan option
- Select your coverage tier (Member Only, Member + 1, Family)
- You can dis-enroll dependents from your health plan – You may need to contact the Fund Office to complete a 2023 Dependent Disenrollment form, depending on your specific situation
- You can add dependents to your health plan for the upcoming Plan Year
- If you are married, you will need to complete the Coordination of Benefits information
- **NEW!** You will have the opportunity to complete the Communication Preferences under your My Profile

Who is Eligible for Open Enrollment?

As a Municipality member, your eligibility will continue each month, if your Employer makes the required monthly contributions to the Fund on your behalf. Once you are eligible, each year you may be given the opportunity 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 health plan option(s) available.

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 2:00 p.m. Please bring your spouse; however, you must make alternative childcare arrangements.

The event schedule is as follows:
Midwest Operating Engineers Fringe Benefit Funds Office – 6150 Joliet Road, Countryside, IL 60525 – Saturday, January 21, 2023
District 7 Union Hall – 2193 W. 84th Place, Merrillville, IN 46410 - Saturday, February 4, 2023
District 5 Union Hall – 740 E. Route 5, Utica, IL 61373 - Saturday, February 18, 2023

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

Additional Resources Available During Open Enrollment

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

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

If you are a Municipality member covered under the Operators' Health Center (OHC) Plan, you will be able to change your coverage tier, if desired, by adding a dependent or removing a dependent. If you have any questions regarding the OHC Plan, you can speak to a specialized OHC Plan Member Services Representative at 708-579-6668.

Important Reminders

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

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

Once you are in your My150 account, you should:

- Review your profile information and ensure all the information is correct. Set your **COMMUNICATION PREFERENCES.** This is a **NEW** feature to your My150 account.
- Review and/or update your beneficiary information.
- Review your dashboard and your My Claims to determine if you optimized the coverage under the health plan option that you selected for the 2022/2023 Plan Year.

Features of Your MOE Health Plan Options

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

Depending on your negotiated CBA, you may have two different health plan options to choose from:

- Plan A PPO
- EPO Plan

You have a choice of three coverage tiers for each health plan option:

- Member Only
- Member + 1
- Family

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

PLEASE NOTE: For those Municipality members covered under the OHC Plan, you will ONLY be able to change your coverage tier.

Overview of Health Plan Options Plan A PPO or the EPO Plan

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

- **Plan A is a Preferred Provider Organization (PPO) Plan.** This plan uses the Blue Cross Blue Shield network of providers. With this health plan option, 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 EPO Plan is an Exclusive Provider Organization.** It uses the same Blue Cross Blue Shield network as the Plan A, but it works like a Health Maintenance Organization (HMO). You **must use** In-Network providers; otherwise, the plan **will not pay benefits**, except for life-threatening emergencies. There is no deductible, but you pay for medical services through copays. However, unlike an HMO, you do not have to choose a primary care physician (PCP) or get referrals to see specialists.

If you are thinking about choosing Plan A PPO or the EPO Plan, refer to Finding In-Network Providers to make sure your current health care providers are in the network.

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

Regardless of which health plan option you select, be sure to utilize the FREE services that are available under the Welfare Fund.

Overview of the OHC Plan for Select Municipality Members

This health plan option is only available under certain negotiated CBAs.

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

  Members enrolled in the OHC Plan will have access to In-Network providers at:
  - **Operators' Health Centers.** Both the Countryside and Merrillville locations perform primary/acute care, lab work, condition management and DOT physicals. Both centers also provide on-site physical therapy services. Visit operatorshealthcenter.com for more information.
  - **Everside Health Centers.** Facilities are in Rockford, Illinois, Davenport, Iowa, and six locations in northern Indiana. Visit eversidehealth.com/local150.com for more information.
  - **HST Care Connect network** for providers/facilities at:
    Advocate Health Care system, including Advocate Clinics at Walgreens
    Community Hospital system
    Methodist Hospital system

  Members should also take advantage of the FREE services that are available under the Welfare Fund.

PLEASE NOTE: The OHC Plan **does not** use the Blue Cross Blue Shield network. For additional details on this health plan option, see section Operators' Health Center (OHC) Plan Details.

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

Yes!

Free Services Available Under the Welfare Fund

Regardless of the health plan option that you select during open enrollment, for coverage starting April 1, 2023 through March 31, 2024, be sure to use the following free services for you and your family.

- Under the Affordable Care Act, preventive services are covered at 100% if you see an In-Network provider. Talk to your provider about these services. Also, effective November 1, 2022, the Welfare Fund Board of Trustees approved to remove limitations from Plans for routine services; will be paid at 100% when using in-network providers for all ages. Vaccinations will also be paid at 100% if you stay in-network.
- Services covered by your plan are free if performed at one of the Operators' Health Center locations. Both health centers
  - offer free DOT physicals
  - offer free physical therapy services

- can provide limited prepack medications at your appointment, when necessary
- behavioral health services at the Countryside, IL OHC

❖ Services covered by your plan are free if performed at one of the Everside Health Centers
- All facilities offer free DOT physicals
- Through our partnership with Everside, you can also utilize the 24/7 nurse line to seek triage after hour services.
- Providers can prescribe and distribute generic medication, if necessary
- The Rockford, IL and the Davenport, IA facilities offer free chiropractic services

❖ Absolute Solutions Imaging Network will provide FREE MRI, CT, and PET scans, if medically necessary, when you use one of their facilities.

❖ MinuteClinics, located in CVS and Target retail stores, cover several services for free. There are some cash-pay services.

❖ ATI Physical Therapy covers physical therapy services for free, if medically necessary.

❖ If you use an EyeMed Advantage Network provider, you and your covered dependents will receive a FREE eye exam. In addition, the EyeMed Advantage Network offers numerous discounts on vision services.

❖ The Member Assistance Program through Employee Resource Systems, Inc. (ERS) offers up to five free counseling sessions (per episode) with master's-level clinicians for you and any family member, regardless of eligibility.

❖ **NEW!** Gateway Foundation or Recovery Centers of America (RCA) offer free substance abuse treatment co-occurring mental health treatment, if necessary

Exclusive Vendor Partnerships

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

UPDATED! Absolute Solutions Imaging Network

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

<table>
<tr><th colspan="5">Absolute Solutions Imaging Network – Effective January 1, 2023</th></tr>
<tr><th rowspan="2">Eligible Active Members and Covered Dependents</th><th colspan="3">Lives within a 30-mile radius of an Absolute Solutions Facility</th><th colspan="2">Does NOT live within a 30-mile of an Absolute Solutions Facility</th></tr>
<tr><th>Decides to use an Absolute Solutions Facility</th><th>Decides NOT to use an Absolute Solutions Facility but stays within the Health Plan Option's Network</th><th>Decides NOT to use an Absolute Solutions Facility and goes Out-of-Network</th><th>Utilizes the Health Plan Option Network</th><th>Does NOT utilize the Health Plan Option's Network</th></tr>
<tr><td>CT/MRI Scan</td><td rowspan="2">100% Paid by the Welfare Fund: NO deductible, NO coinsurance, NO copayment</td><td colspan="2">Deductible applies, must pay coinsurance or copayment, subject to the out-of-pocket maximum</td><td rowspan="2">100% Paid by the Welfare Fund: NO deductible, NO coinsurance, NO copayment</td><td rowspan="2">Deductible applies, must pay coinsurance or copayment, subject to out-of-pocket maximum</td></tr>
<tr><td>PET Scan</td><td>Deductible applies and then covered at 100%</td><td>Deductible applies, must pay coinsurance or copayment, subject to the out-of-pocket maximum</td></tr>
</table>

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

NEW! Substance Abuse Partnerships

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

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

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

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

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

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

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

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

Gateway Foundation
Contact Sandra Beecher at (309) 296-3053 or call (877) 379-9225
Visit Gatewayfoundation.org for more information.

Recovery Centers of America (RCA)
Contact Ross Bacon at (773) 490-6488
Visit Recoverycentersofamerica.com for more information.

Operators' Health Center (OHC) Plan Details

Recap of the OHC Plan

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

- The OHC Plan is a customized network and **not affiliated with the BCBS PPO network**.
- **By using the customized network, members pay nothing!** No deductibles, no co-insurance/co-payments. In other words, you receive all covered services for free, if you use the customized network.
- To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Community, or Methodist Hospital.

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

Expanded OHC Plan Network

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

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

OHC Plan Design

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

The OHC Plan **plan design is as follows:**

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

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

How the OHC Plan Works

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

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

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

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

What services have limited or no In-Network access?

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

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

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

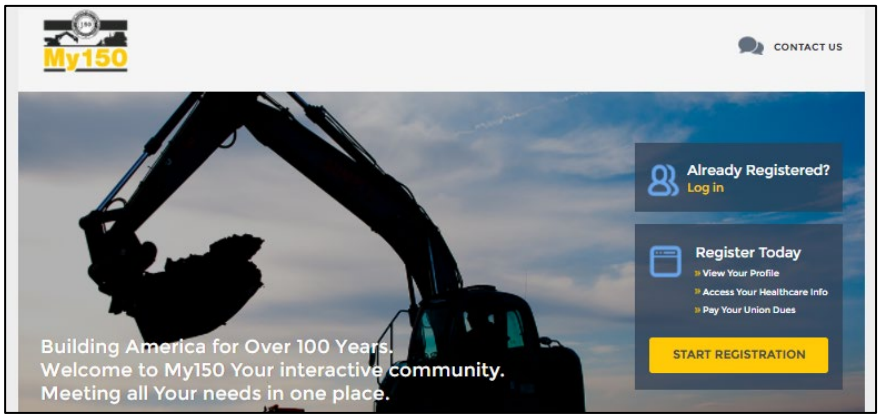
If you use an out-of-network provider or facility, you will pay more. The out-of-network provider or facility may balance bill you. If you are balance billed, contact the Patient Advocacy Center (PAC) at **888-837-2237** or **pac@hstechnology.com**. The PAC will be responsible for negotiating the VBP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

Selecting a Health Plan Option/Coverage Tier

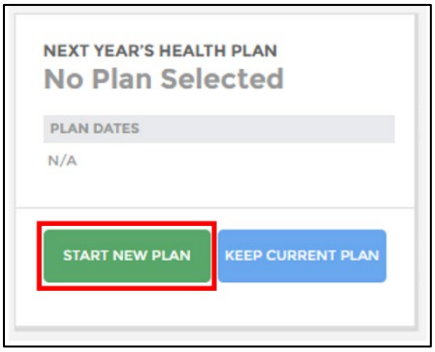
You can enroll for coverage through the My150 community website at: www.My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime, from anywhere.

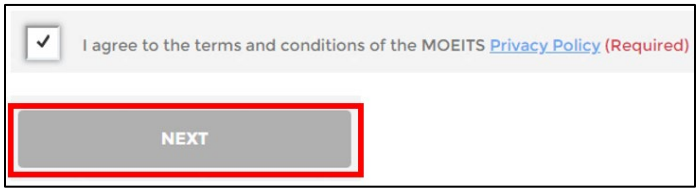
Follow these steps to enroll:

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

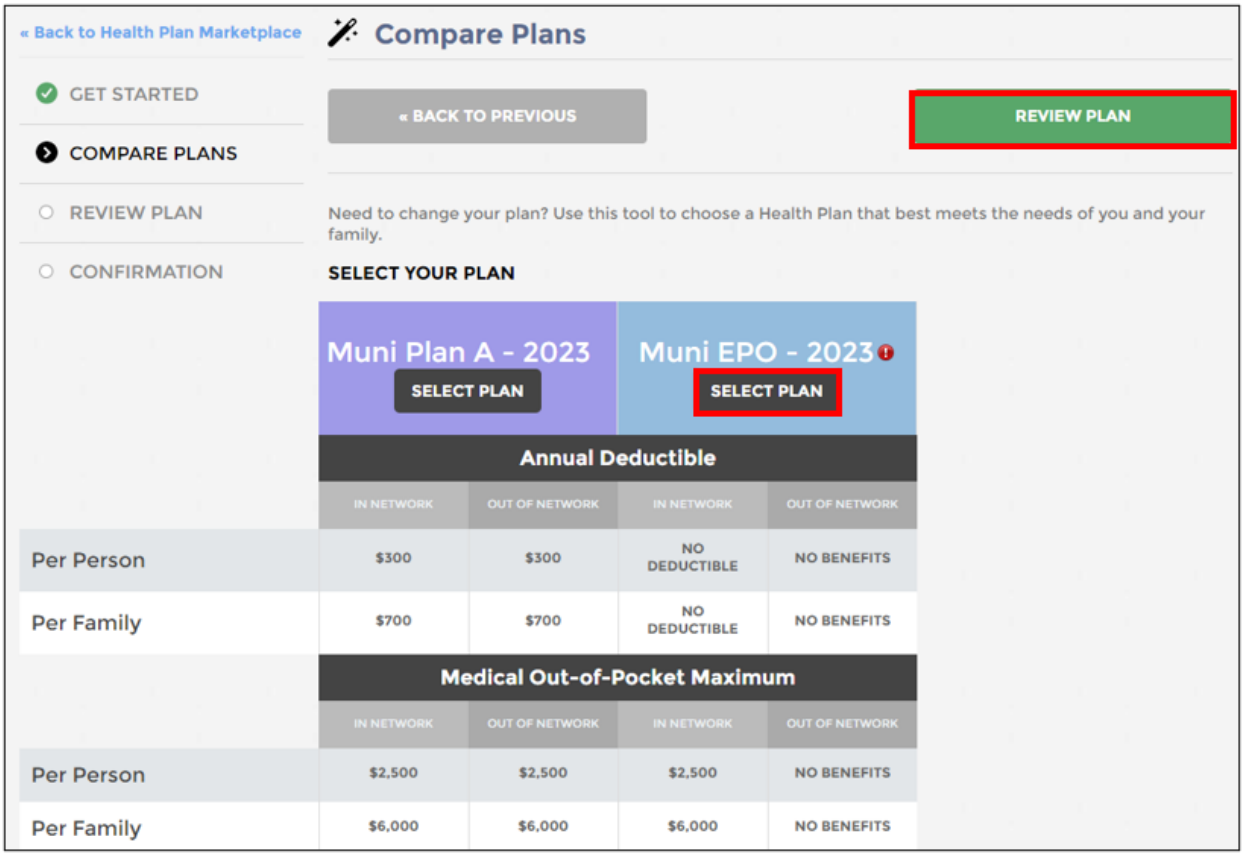


2. Click **START NEW PLAN,** check the Terms and Conditions box, and then click NEXT.





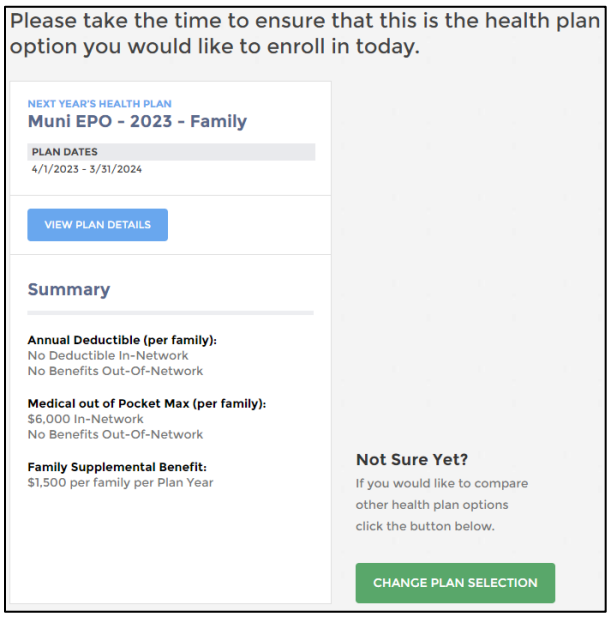
3. Compare the two health plan options and then click **SELECT PLAN** once you have made your decision.

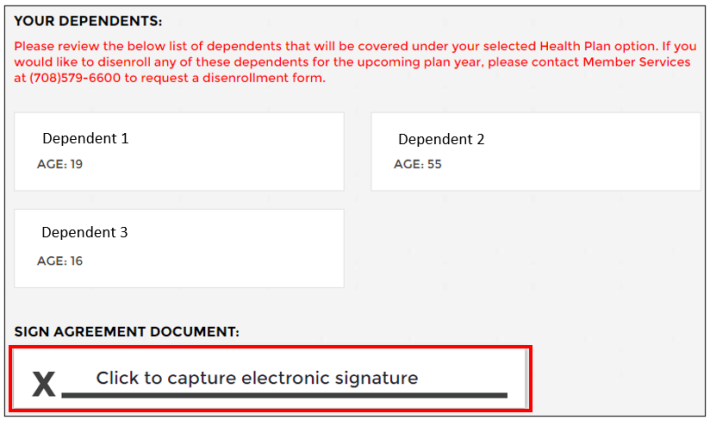


PLEASE NOTE:

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

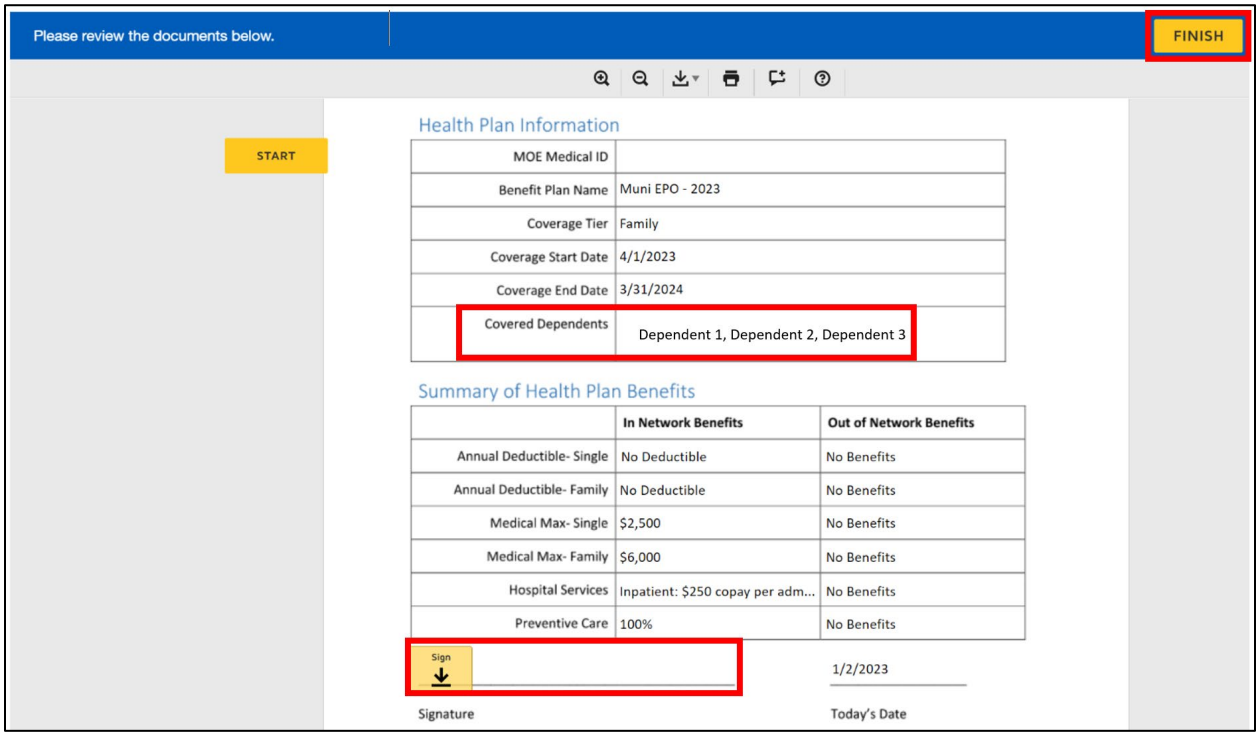
4. After you select a health plan option and reviewed your covered dependents, click on the **SIGN AGREEMENT** section.



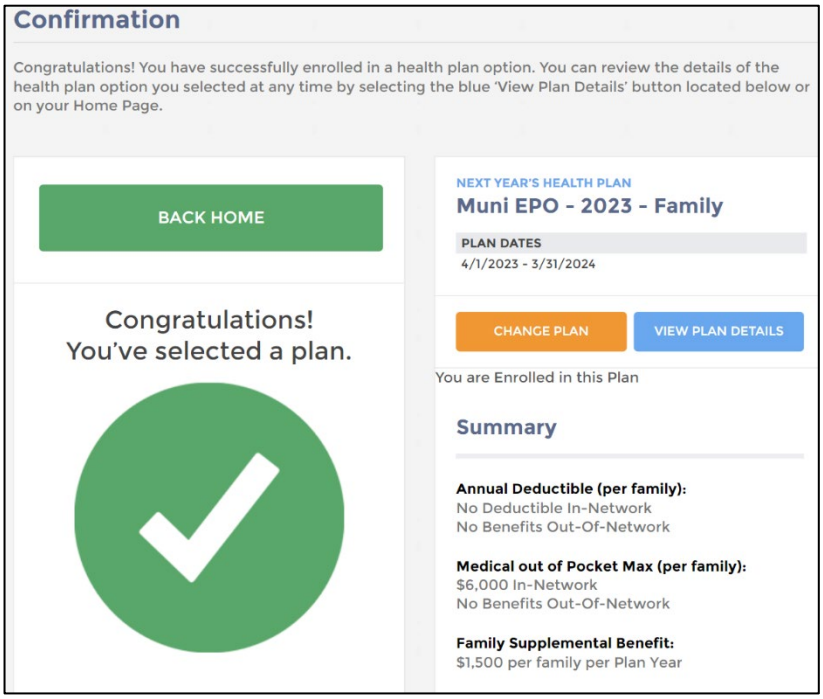


Each year, you can change your coverage tier (Member Only, Member + 1, Family). If you are adding a new dependent, you will need to ensure that you upload the required documents as noted in the Adding a Dependent During Open Enrollment section.

This will transition over to the DocuSign Agreement. Be sure to review the selected plan details and review your covered dependents. If your selection looks good, be sure to complete the DocuSign agreement and click FINISH.

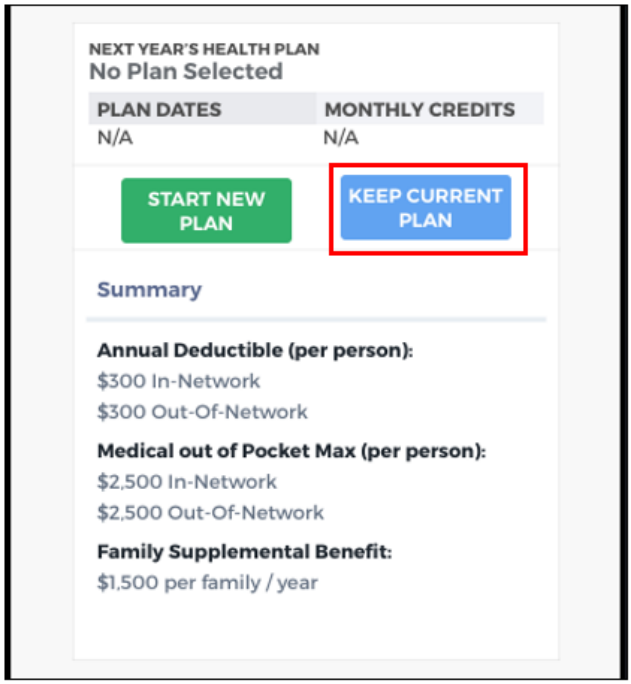


5. Once you decide, click **Adopt** and **Sign**. You will receive a confirmation pop-up that you have successfully selected a health plan option. You will also receive an email confirmation. The document you sign will be added to the **My LIBRARY** page.



Keep Current Plan

If you are satisfied with the health plan option that you had for the 2022/2023 Plan Year, we request that you actively log in to your My150 account and click the **KEEP CURRENT PLAN** to start the re-enrollment process. You'll review your plan coverage details, your coverage tier and covered dependents, then confirm your choice for the upcoming Plan Year. You can refer to Steps 4 and 5 above to complete your selection.

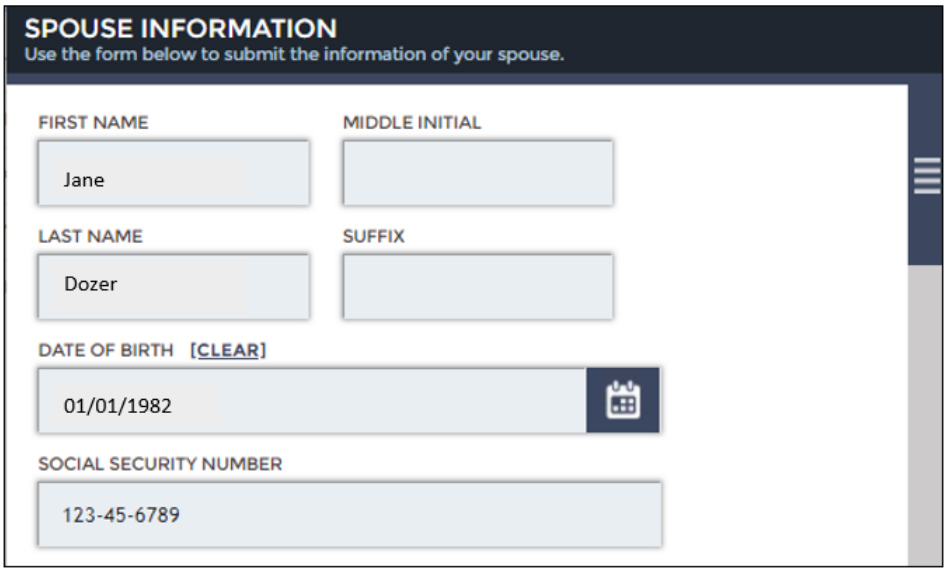


Coordination of Benefits (COB)

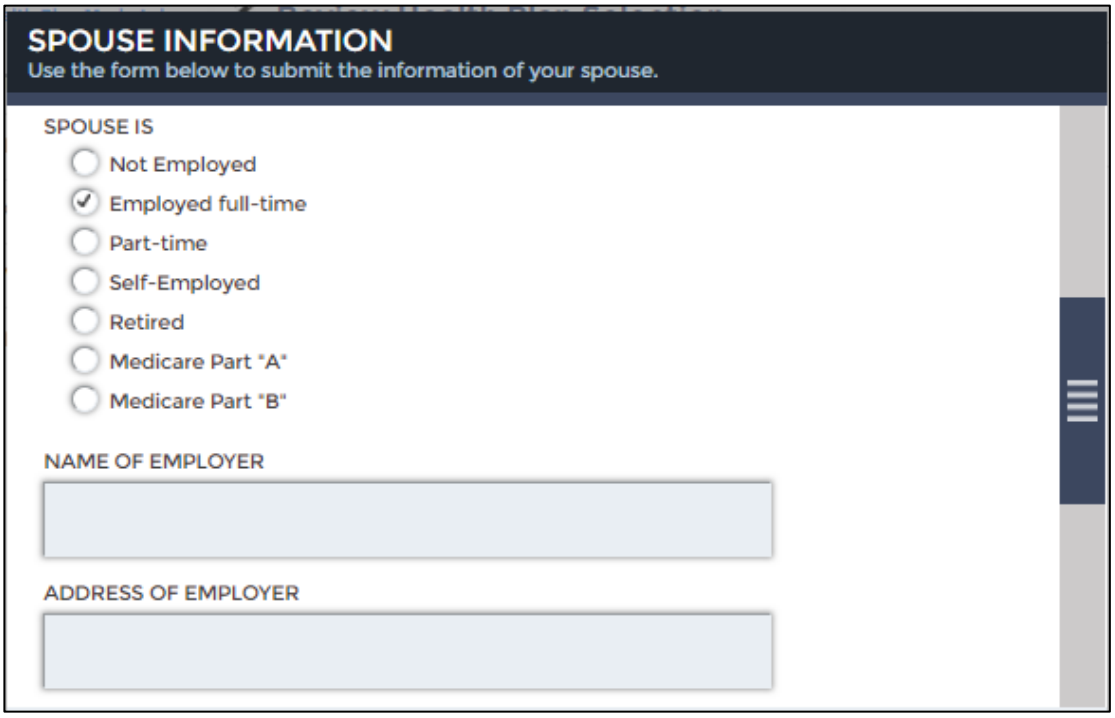
During Open Enrollment, we will be gathering Coordination of Benefits information to process your claims more efficiently.

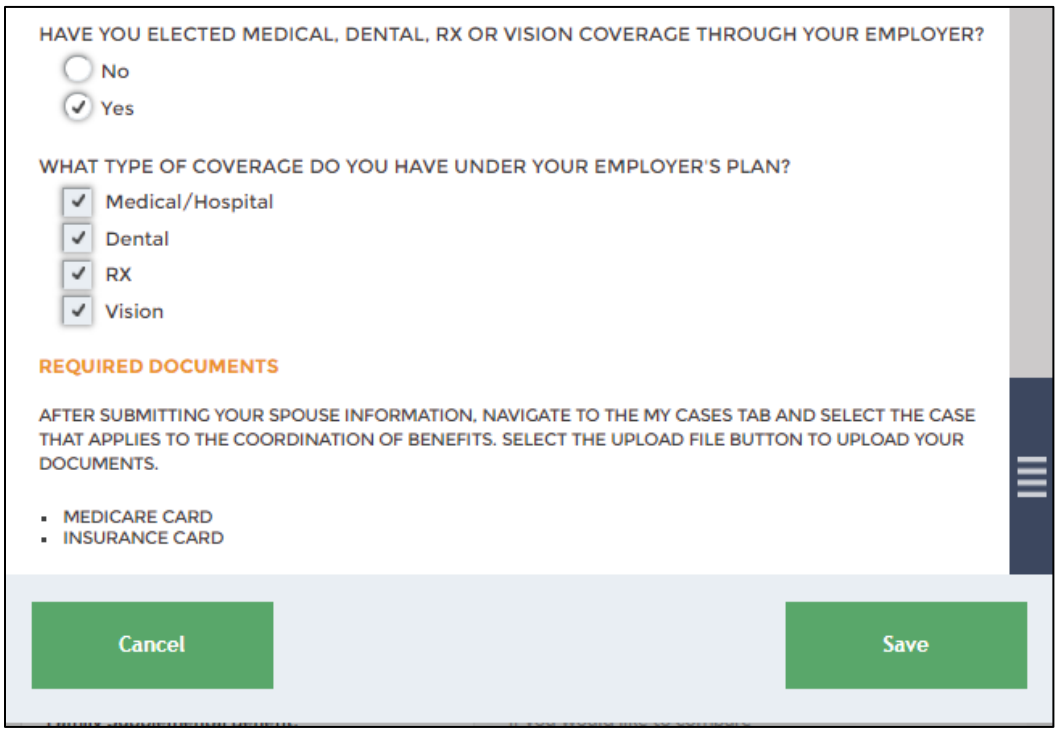
If you are married, and once you complete the open enrollment process (i.e., select a health plan option/coverage tier), you will be prompted to complete the Coordination of Benefits (COB) process.

The following screens will appear for you to complete.



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





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

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

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

My150

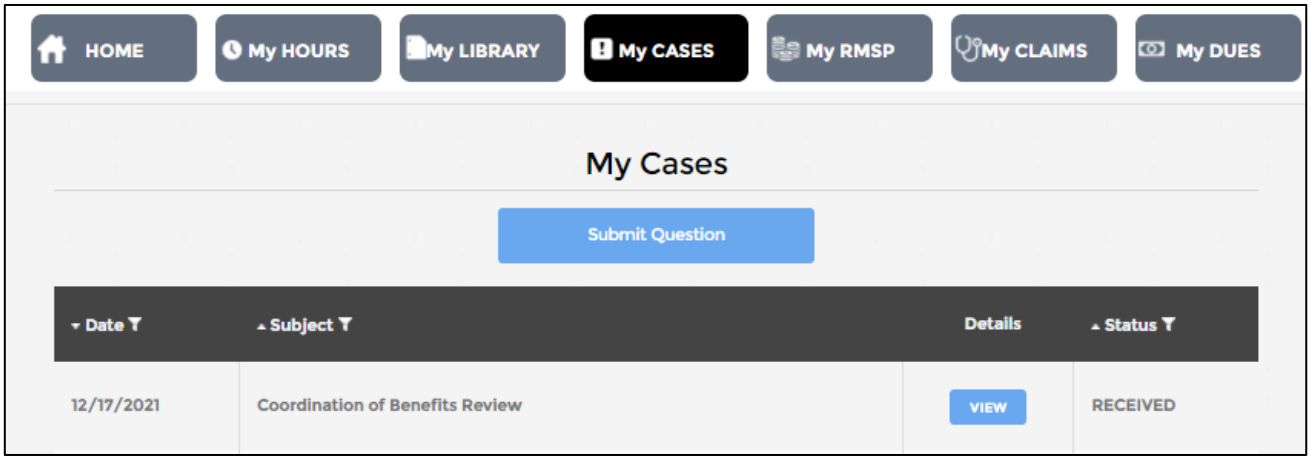
Dear JOHN,

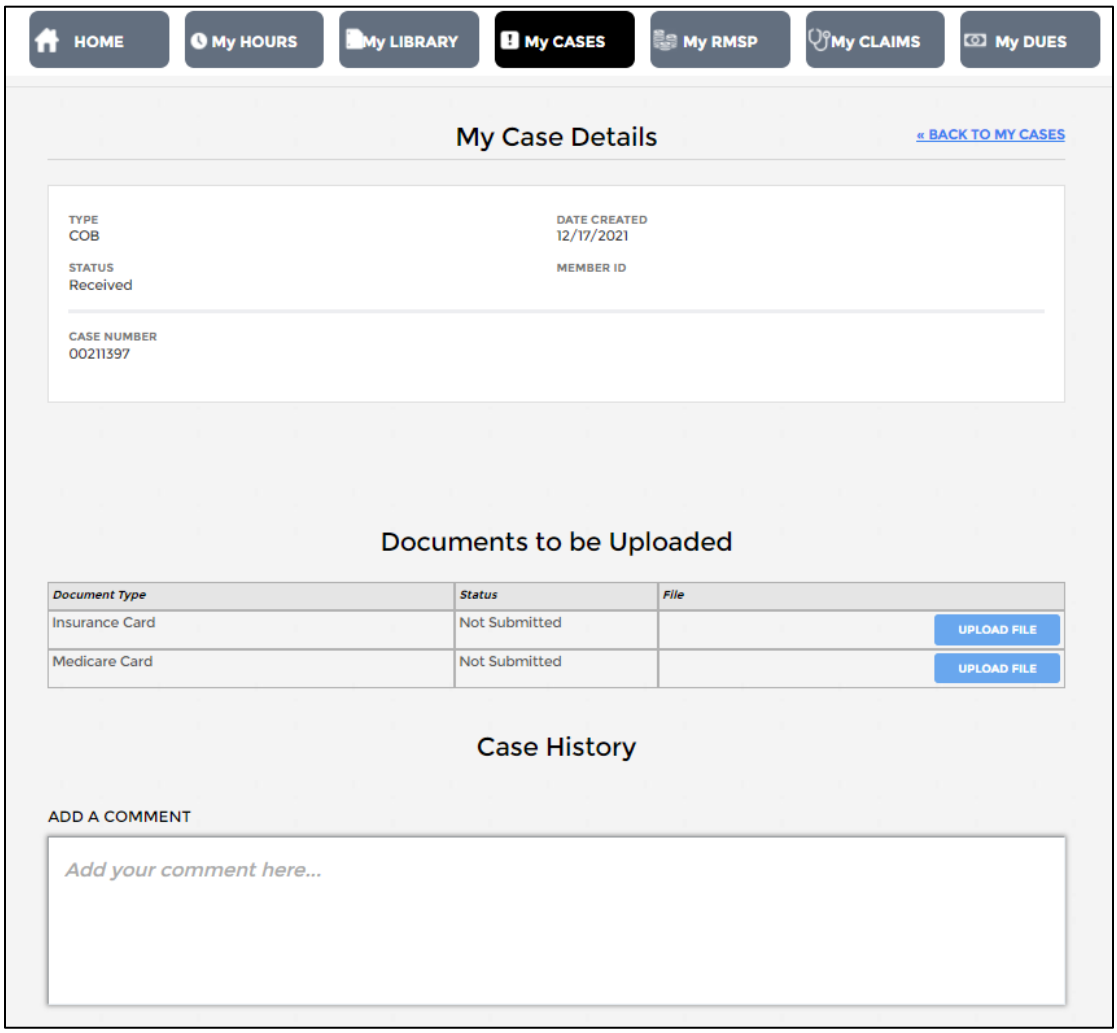
Thank you for submitting your Spousal Coordination of Benefits information. Please upload the required documents at Case link.

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

Sincerely,
MOE Welfare Fund Staff

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





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

Adding a Dependent During Open Enrollment

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

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

Removing a Dependent During Open Enrollment

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

Finding In-Network Providers

Plan A PPO and EPO health plan options:

- These health plan options BOTH 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)

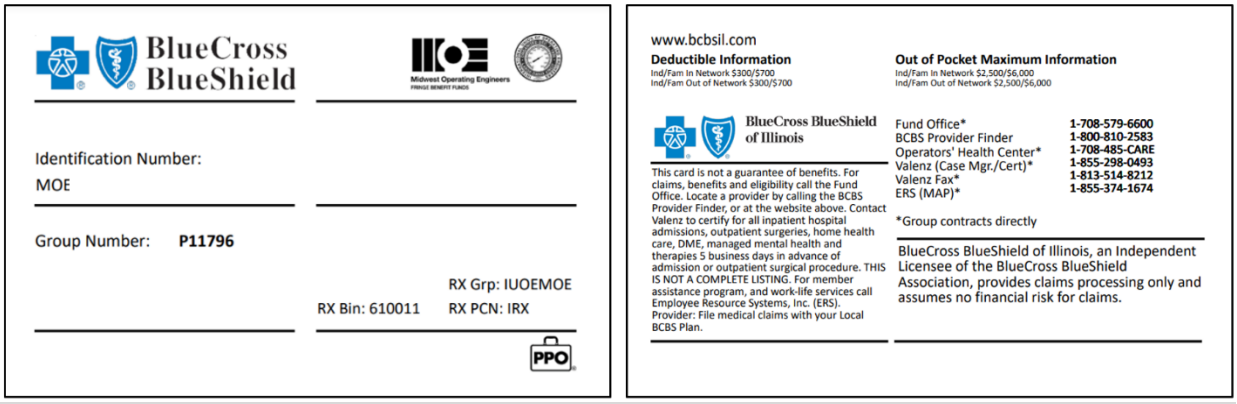
If your CBA indicates that you are in the OHC Plan:

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

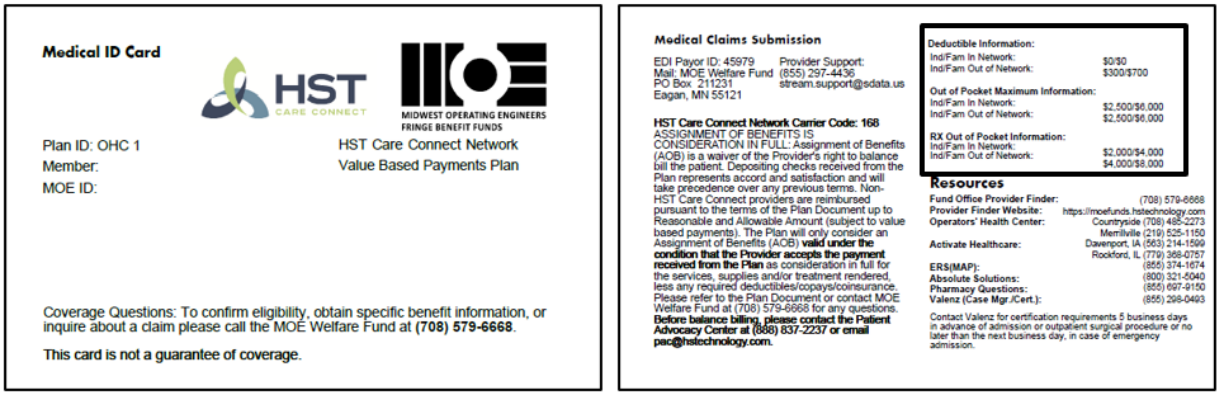
Medical ID Cards

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

For Plan A or the EPO, you will receive a BCBS of Illinois medical ID card.



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



Medical ID Card

HST CARE CONNECT

MIDWEST OPERATING ENGINEERS FRINGE BENEFIT FUNDS

Plan ID: OHC 1
Member:
MOE ID:

HST Care Connect Network
Value Based Payments Plan

Coverage Questions: To confirm eligibility, obtain specific benefit information, or inquire about a claim please call the MOE Welfare Fund at **(708) 579-6668**.

This card is not a guarantee of coverage.

Medical Claims Submission

EDI Payor ID: 45979
Mail: MOE Welfare Fund
PO Box 211231
Eagan, MN 55121

Provider Support:
(855) 297-4436
stream.support@sdata.us

HST Care Connect Network Carrier Code: 168

ASSIGNMENT OF BENEFITS IS CONSIDERATION IN FULL: Assignment of Benefits (AOB) is a waiver of the Provider's right to balance bill the patient. Depositing checks received from the Plan represents accord and satisfaction and will take precedence over any previous terms. Non-HST Care Connect providers are reimbursed pursuant to the terms of the Plan Document up to Reasonable and Allowable Amount (subject to value based payments). The Plan will only consider an Assignment of Benefits (AOB) **valid under the condition that the Provider accepts the payment received from the Plan** as consideration in full for the services, supplies and/or treatment rendered, less any required deductibles/copays/coinsurance. Please refer to the Plan Document or contact MOE Welfare Fund at (708) 579-6668 for any questions. **Before balance billing, please contact the Patient Advocacy Center at (888) 837-2237 or email pac@hstechnology.com.**

Deductible Information:

Ind/Fam In Network:	$0/$0
Ind/Fam Out of Network:	$300/$700

Out of Pocket Maximum Information:

Ind/Fam In Network:	$2,500/$6,000
Ind/Fam Out of Network:	$2,500/$6,000

RX Out of Pocket Information:

Ind/Fam In Network:	
Ind/Fam Out of Network:	$2,000/$4,000 $4,000/$8,000

Resources

Fund Office Provider Finder:	(708) 579-6668
Provider Finder Website:	https://moefunds.hstechnology.com
Operators' Health Center:	Countryside (708) 485-2273 Merrillville (219) 525-1150
Activate Healthcare:	Davenport, IA (563) 214-1599 Rockford, IL (779) 368-0757
ERS(MAP):	(855) 374-1674
Absolute Solutions:	(800) 321-5040
Pharmacy Questions:	(855) 697-9150
Valenz (Case Mgr./Cert.):	(855) 298-0493

Contact Valenz for certification requirements 5 business days in advance of admission or outpatient surgical procedure or no later than the next business day, in case of emergency admission.

Family Supplemental Benefit (FSB)

Each of the Municipality health plan options provide $1,500 in an FSB benefit. This amount is renewed at the start of each Plan Year. Unused balances at the end of the Plan Year will be forfeited; the amounts do not rollover to the next Plan Year. You can use the FSB benefit to pay for medically necessary services that are not covered under your health plan option, or for services that have a benefit maximum.

For example: You can use your FSB benefit to receive reimbursement for vision and hearing services: none of the health plan options of the Midwest Operating Engineers Welfare Fund cover these types of services.

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

Review Your Beneficiaries

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

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 – This benefit is not available to Municipality members since you are not covered under the Midwest Operating Engineers Pension Fund. Be sure to review your pension beneficiary(ies) with the Pension Fund you are covered under.

IUOE Vacation Savings – This benefit is not available to Municipality members.

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

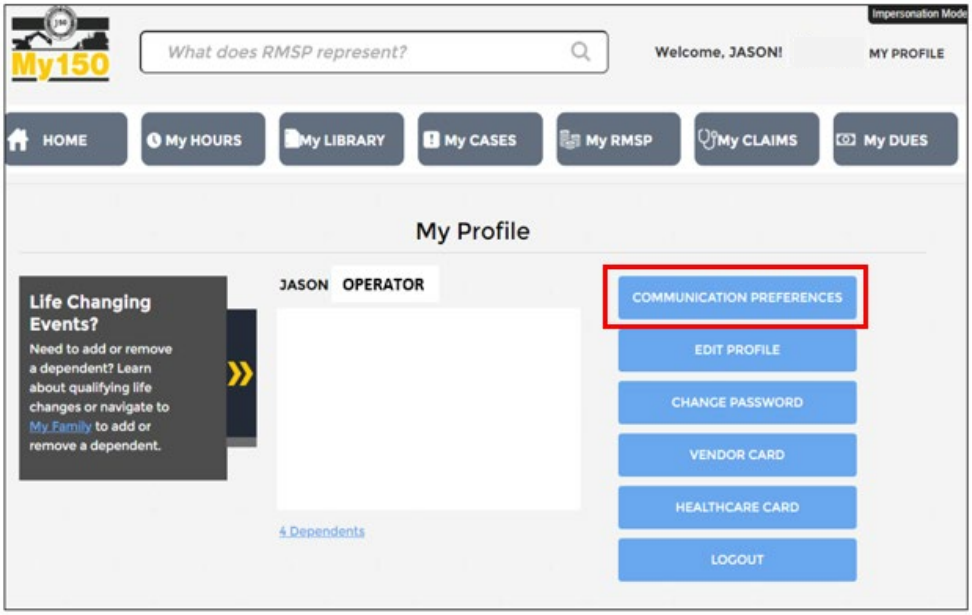
Retirement Enhancement Fund – Fidelity Investments is responsible for maintaining beneficiary information for this fringe benefit. To access your plan's benefits and update your beneficiary, visit www.NetBenefits.com/atwork to setup a username and password. From here, click on "Profile" and then scroll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

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

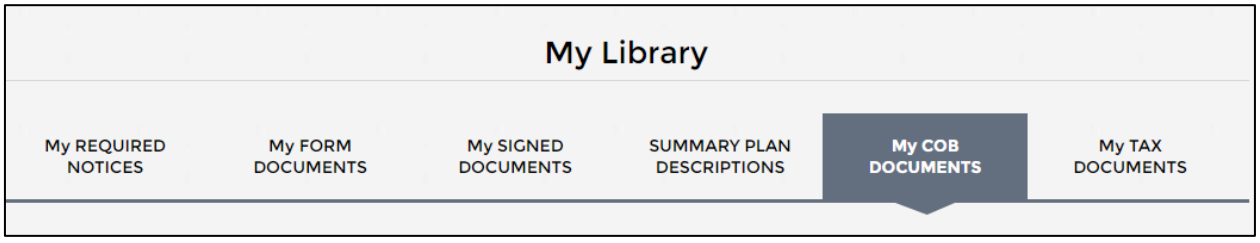
PLEASE NOTE: If you are an active dues paying member, you also have $10,000 of Life Insurance through the Midwest Coalition of Labor (MCL). The Fund Office does not administer this benefit but for more information, visit coalitionoflabor.org. You can also access the beneficiary designation form to download,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

NEW! Communication Preferences

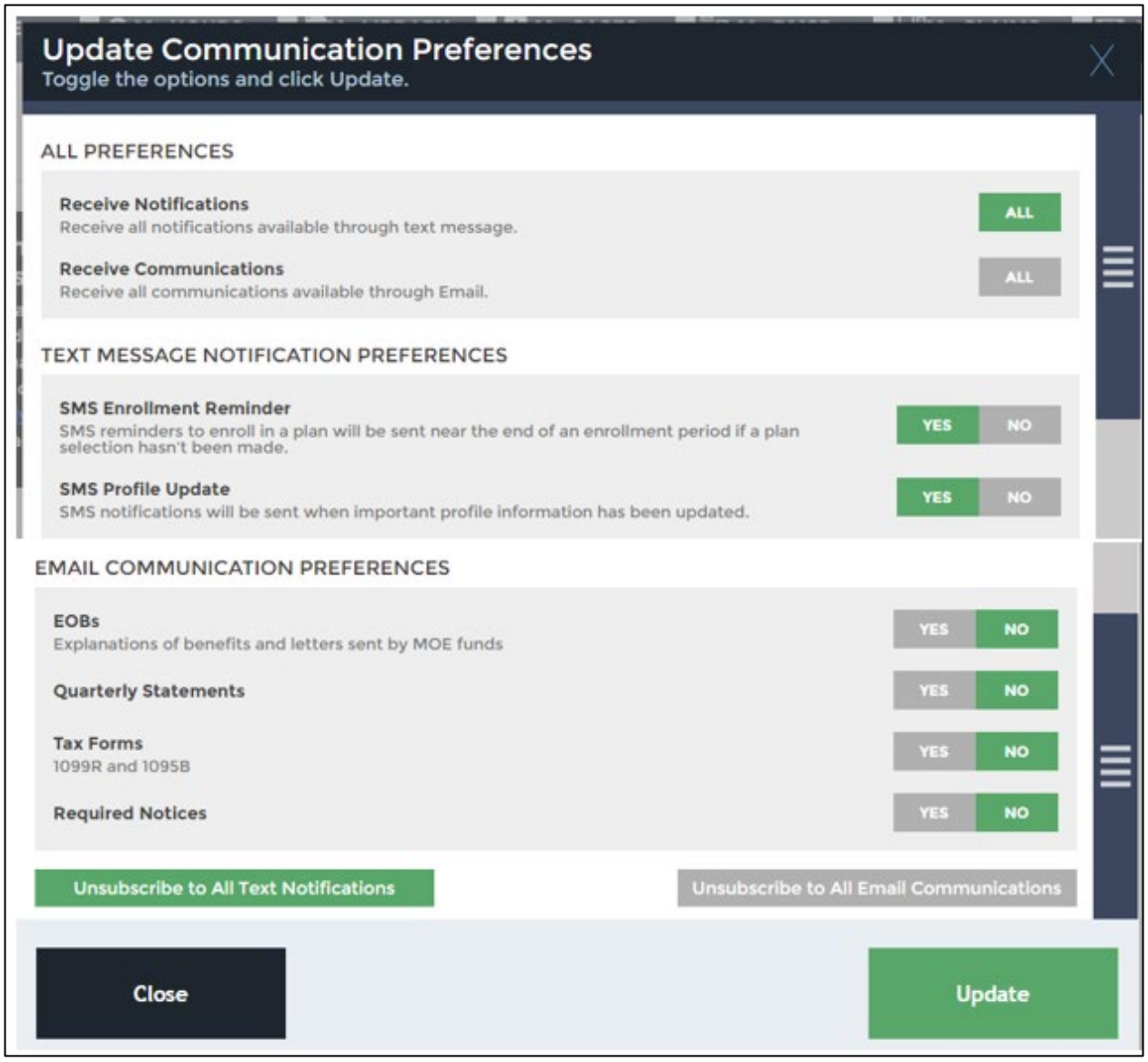
The Communication Preferences is a new feature in your My150 account under your MY PROFILE. When clicking on the blue tile, COMMUNICATION PREFERENCES, you will be able to select how you wish to be notified of when new information is dropped to your My CLAIMS, your My HOURS tab, or your My LIBRARY tab.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



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



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



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

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

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

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

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

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