

Important Information Regarding the Annual Open Enrollment Process

Owner Operator/Relative Shareholder (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 all the Owner Operator/Relative Shareholder health plan options and compare plans, to determine which health plan option will best fit your family's needs. The health plan option that you select will be for medical and pharmacy coverage for the new Plan Year effective April 1, 2023 through March 31, 2024.

During open enrollment, you can:

- Select a new health plan option or retain the same health plan option
- **NEW!** 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 an Owner Operator/Relative Shareholder 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 various health plan options.

Open Enrollment Events

The Fund Office will be hosting open enrollment events. The purpose of these events is for you to meet one-on-one with a Fund Office navigator to discuss the health plan option(s), answer any questions you may have regarding the available health plans, and assist you with the enrollment process. To register for one of the events, visit <https://local150.org/moe/about/benefit-seminar-open-enrollment-information/>. Appointments will start at 8:00 a.m. with the last appointment at 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 enrolling and transferring credits to your RMSP account, if eligible. Translators are available upon request. To get started, call **844-693-1467** toll-free during open enrollment:

- Monday–Friday: 8 a.m. to 7 p.m. CST
- Saturday: 8 a.m. to 12 p.m. CST

Fund Office Marketplace Call Center: Call 708-579-6675 with a question or to schedule an appointment at the Fund Office. During the open enrollment period, staff will be available during the following hours to assist members with the open enrollment process:

- Monday, Tuesday, Wednesday, Friday: 8 a.m. to 5 p.m. CST
- Thursday: 9 a.m. to 5 p.m. CST
- Saturday: 8 a.m. to 12 p.m. CST

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

Important Reminders

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

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

Once you are in your My150 account, you should:

- Review your profile information and ensure all the information is correct. Set your [COMMUNICATION PREFERENCES](#). This is a **NEW** feature to your My150 account.
- Review and/or update your [beneficiary information](#).
- Review your 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 are available to an eligible Owner Operator/Relative Shareholder during the open enrollment period?

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

- The Operators' Health Center (OHC) Plan
- Plan A PPO
- Platinum PPO
- EPO Plan
- Gold PPO
- Silver PPO
- Bronze PPO

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

- Member Only
- Member + 1
- Family

PLEASE NOTE: It is imperative that you review your dependents and take an active role in selecting a health plan option and coverage tier. **Do not default;** if you do, your coverage tier will default to those eligible dependents that are on file with the Fund Office.

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

Updated Monthly Costs Effective April 1, 2023 through March 31, 2024

The updated monthly costs are shown below.

Updated Monthly Costs							
Health Plan Option	OHC Plan	Plan A	Platinum	EPO	Gold	Silver	Bronze
Updated Rates from April 1, 2023 – March 31, 2024							
Family	\$2,152	\$2,595	\$2,465	\$2,479	\$2,245	\$2,100	\$1,859
Member + 1	\$1,891	\$2,280	\$2,166	\$2,179	\$1,973	\$1,845	\$1,634
Member Only	\$1,630	\$1,966	\$1,867	\$1,878	\$1,701	\$1,591	\$996
Current Rates through March 31, 2023							
Family	\$2,088	\$2,458	\$2,345	\$2,312	\$2,152	\$2,024	\$1,674

Overview of Health Plan Options

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

- ❖ **The OHC Plan uses a customized network, which includes the Operators' Health Center and HST Care Connect providers and facilities.** It gives you the flexibility to go In- or Out-of-Network, but you and your eligible dependents will receive all medical services covered by the plan for free when you

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

Members enrolled in the OHC Plan will have access to In-Network providers at:

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

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

- ❖ **Plan A, Platinum, Gold, Silver, and Bronze plans are Preferred Provider Organization (PPO) Plans.** These plans use the same Blue Cross Blue Shield network of providers. The main difference between these options is the amount of the deductibles and coinsurance. With these plans, once you meet the deductible, you pay your share of covered medical expenses through coinsurance. You can see any provider you want, but you save money if you use In-Network providers.
- ❖ **The Bronze Plan does not include dental, life insurance, accidental death and dismemberment, or disability benefits.** Under this health plan option, you need to optimize the available [FREE services](#).
- ❖ **The EPO Plan is an Exclusive Provider Organization.** It uses the same Blue Cross Blue Shield network as the PPO plans, but it does not use coinsurance; instead, it uses copayments. You **must use** In-Network providers; otherwise, the plan will not pay benefits, except for life-threatening emergencies. There is no deductible, but you pay for medical services through copayments. The copayment is a flat fee for service and the flat fee will vary depending on what type of service you receive. You also **do not** have to choose a primary care physician (PCP) and you **do not** need to receive referrals to see specialists.

If you are thinking about choosing one of the PPO Plans or the EPO Plan, refer to [Finding In-Network Providers](#) to make sure your current health care providers are in the network.

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

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

Yes!

Free Services Under ALL Health Plan Options

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

- ❖ Under the Affordable Care Act, preventive services are covered at 100% if you see an In-Network provider. Talk to your provider about these services. Also, effective November 1, 2022, the Welfare Fund Board of Trustees approved to remove limitations from Plans for routine services; will be paid at 100% when using in-network providers for all ages. Vaccinations will also be paid at 100% if you stay in-network.
- ❖ Services covered by your plan are free if performed at one of the Operators' Health Center locations. Both health centers
 - offer free DOT physicals
 - offer free physical therapy services
 - can provide limited prepack medications at your appointment, when necessary
 - behavioral health services at the Countryside, IL OHC
- ❖ Services covered by your plan are free if performed at one of the Everside Health Centers
 - All facilities offer free DOT physicals
 - Through our partnership with Everside, you can also utilize the 24/7 nurse line to seek triage after hour services.
 - Providers can prescribe and distribute generic medication, if necessary
 - The Rockford, IL and the Davenport, IA facilities offer free chiropractic services
- ❖ [Absolute Solutions Imaging Network](#) will provide FREE MRI, CT, and PET scans, if medically necessary, when you use one of their facilities.
- ❖ MinuteClinics, located in CVS and Target retail stores, cover several services for free. There are some cash-pay services.
- ❖ ATI Physical Therapy covers physical therapy services for free, if medically necessary.
- ❖ If you use an EyeMed Advantage Network provider, you and your covered dependents will receive a FREE eye exam. In addition, the EyeMed Advantage Network offers numerous discounts on vision services.
- ❖ The Member Assistance Program through Employee Resource Systems, Inc. (ERS) offers up to five free counseling sessions (per episode) with master's-level clinicians for you and any family member, regardless of eligibility.
- ❖ **NEW!** [Gateway Foundation or Recovery Centers of America \(RCA\)](#) offer free substance abuse treatment co-occurring mental health treatment, if necessary

Exclusive Vendor Partnerships

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

UPDATED! Absolute Solutions Imaging Network

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

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

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

NEW! Substance Abuse Partnerships

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

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

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

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

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

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

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

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

Gateway Foundation

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

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

Recovery Centers of America (RCA)

Contact Ross Bacon at (773) 490-6488

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

Operators' Health Center (OHC) Plan Details

Recap of the OHC Plan

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

- The OHC Plan is a customized network and **not affiliated with the BCBS PPO network**.
- **By using the customized network, members pay nothing!** No deductibles, no co-insurance/co-payments. In other words, you receive all covered services for free, if you use the customized network.
- The monthly credit cost deductions are significantly less than Plan A PPO. The OHC Plan cost is approximately 15% less than Plan A PPO.
- To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Community, or Methodist Hospital; otherwise, this health plan option will not appear as one of the health plan options in My150.

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

Expanded OHC Plan Network

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

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

PLEASE NOTE:

- The monthly credit cost deduction from your Credit Bank will be the same for both Illinois and Indiana residents.
- To be eligible to select this health plan option, you must live within a 30-mile radius of an Advocate, Community, or Methodist Hospital. If you live outside this established mile radius, the OHC Plan will not appear as one of the health plan options available to select in My150.

OHC Plan Design

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

For those eligible active members that can select the Operators' Health Center (OHC) Plan as a health plan option, the **plan design is as follows:**

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

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

How the OHC Plan Works

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

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

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

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

What services have limited or no In-Network access?

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

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

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

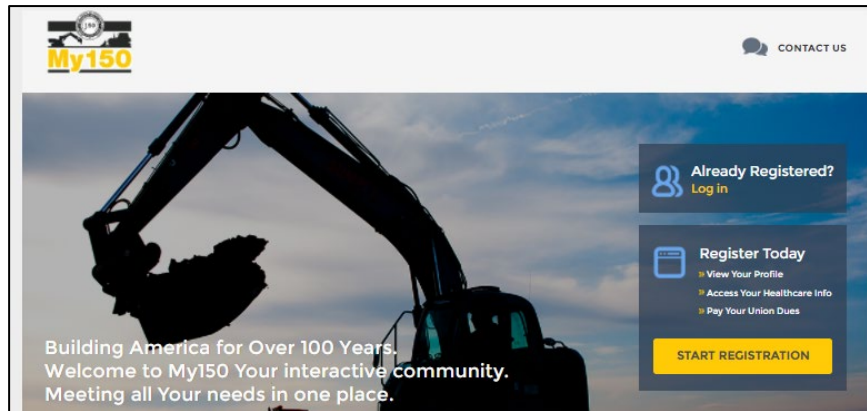
If you use an out-of-network provider or facility, you will pay more. The out-of-network provider or facility may balance bill you. If you are balance billed, contact the Patient Advocacy Center (PAC) at **888-837-2237** or **pac@hstechnology.com**. The PAC will be responsible for negotiating the VBP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

Selecting a Health Plan Option

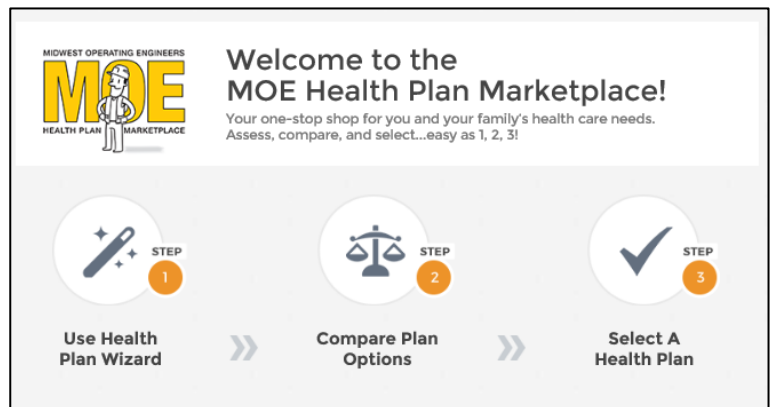
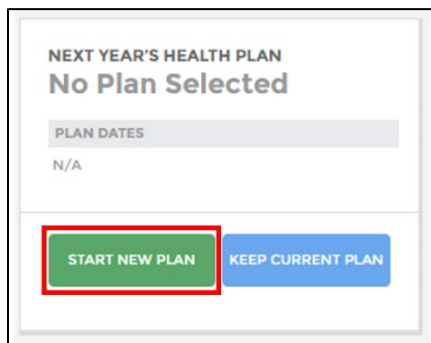
You can enroll for coverage through the My150 community website at: www.My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll anytime, from anywhere.

Follow these steps to enroll:

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



2. Click **START NEW PLAN** and follow the steps to compare up to three health plan options. Explore your health plan options with the Health Plan Wizard.



3. Select your coverage tier and compare up to three health plan options.

MY SELECTED COVERAGE TIER

Member + 1

SELECT YOUR PLAN

OO - Plan A - 2023

SELECT PLAN

OO - EPO - 2023

SELECT PLAN

OO - Gold - 2023

SELECT PLAN

	Annual Deductible					
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Per Person	\$300	\$300	NO DEDUCTIBLE	NO BENEFITS	\$1,000	\$2,000
Per Family	\$700	\$700	NO DEDUCTIBLE	NO BENEFITS	\$2,500	\$5,000

Medical Out-of-Pocket Maximum

	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Per Person	\$2,500	\$2,500	\$2,500	NO BENEFITS	\$4,000	\$8,000
Per Family	\$6,000	\$6,000	\$6,000	NO BENEFITS	\$8,000	\$16,000

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, click on the **SIGN AGREEMENT** section.

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

NEXT YEAR'S HEALTH PLAN

OO - Gold - 2023 - Member + 1

PLAN DATES

MONTHLY CREDITS

4/1/2023 - 3/31/2024

1,973

VIEW PLAN DETAILS

Summary

Annual Deductible (per person):

\$1,000 In-Network

\$2,000 Out-Of-Network

Medical out of Pocket Max (per person):

\$4,000 In-Network

\$8,000 Out-Of-Network

Family Supplemental Benefit:

\$1,000 per family per Plan Year

Not Sure Yet?

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

CHANGE PLAN SELECTION

YOUR DEPENDENTS:

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

Dependent 1

AGE: 44

EDIT DEPENDENTS

SIGN AGREEMENT DOCUMENT:

X

Click to capture electronic signature

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.

Please review the documents below. FINISH

START

Health Plan Information

MOE Medical ID	
Benefit Plan Name	OO - Gold - 2023
Coverage Tier	Member + 1
Coverage Start Date	4/1/2023
Coverage End Date	3/31/2024
Covered Dependents	Dependent 1

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

Sign 1/2/2023

Signature Today's Date


- 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.

Confirmation

Congratulations! You have successfully enrolled in a health plan option. You can review the details of the health plan option you selected at any time by selecting the blue 'View Plan Details' button located below or on your Home Page.

BACK HOME

Congratulations!
You've selected a plan.



NEXT YEAR'S HEALTH PLAN

OO - Gold - 2023 - Member + 1

PLAN DATES	MONTHLY CREDITS
4/1/2023 - 3/31/2024	1,973

CHANGE PLAN VIEW PLAN DETAILS

You are Enrolled in this Plan

Summary

Annual Deductible (per person):
\$1,000 In-Network
\$2,000 Out-Of-Network

Medical out of Pocket Max (per person):
\$4,000 In-Network
\$8,000 Out-Of-Network

Family Supplemental Benefit:
\$1,000 per family per Plan Year

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 covered dependents, then confirm your choice for the upcoming Plan Year. You can refer to Steps 4 and 5 above to complete your selection.

The screenshot shows a web interface for selecting a health plan for the next year. At the top, it says 'NEXT YEAR'S HEALTH PLAN' and 'No Plan Selected'. Below this are two columns: 'PLAN DATES' with 'N/A' and 'MONTHLY CREDITS' with 'N/A'. There are two buttons: a green 'START NEW PLAN' button and a blue 'KEEP CURRENT PLAN' button, which is highlighted with a red rectangular box. Below the buttons is a 'Summary' section with the following details:

Annual Deductible (per person):	
\$300 In-Network	
\$300 Out-Of-Network	
Medical out of Pocket Max (per person):	
\$2,500 In-Network	
\$2,500 Out-Of-Network	
Family Supplemental Benefit:	
\$1,500 per family / year	
Months to Depletion:	20 Months

Coordination of Benefits (COB)

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

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

The following screens will appear for you to complete.

The screenshot shows a form titled 'SPOUSE INFORMATION' with the instruction 'Use the form below to submit the information of your spouse.' The form contains the following fields:

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

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

SPOUSE INFORMATION

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

SPOUSE IS

☐ Not Employed

☒ Employed full-time

☐ Part-time

☐ Self-Employed

☐ Retired

☐ Medicare Part "A"

☐ Medicare Part "B"

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

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

☐ No

☒ Yes

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

☒ Medical/Hospital

☒ Dental

☒ RX

☒ Vision

REQUIRED DOCUMENTS

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

- MEDICARE CARD
- INSURANCE CARD

Cancel Save

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

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

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



Dear JOHN,

Thank you for submitting your Spousal Coordination of Benefits information. Please upload the required documents at [Case link](#).

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

Sincerely,
MOE Welfare Fund Staff

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

HOME	My HOURS	My LIBRARY	My CASES	My RMSP	My CLAIMS	My DUES
My Cases						
Submit Question						
Date ▼	Subject ▲	Details		Status ▼		
12/17/2021	Coordination of Benefits Review	VIEW		RECEIVED		

HOME

My HOURS

My LIBRARY

My CASES

My RMSP

My CLAIMS

My DUES

My Case Details

[BACK TO MY CASES](#)

TYPE

COB

DATE CREATED

12/17/2021

STATUS

Received

MEMBER ID

CASE NUMBER

00211397

Documents to be Uploaded

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

Case History

ADD A COMMENT

Add your comment here...

With the 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.

Finding In-Network Providers

Plan A, Platinum, Gold, Silver, Bronze, and EPO health plan options:

- These health plan options ALL use the BCBS PPO network of providers and facilities.
- Go to www.bcbs.com
- Hover over **Find a Doctor** tab as shown on the top ribbon and a pop-up will appear
- After selecting United States, you are prompted click on **Choose a location and plan**
 - Enter an address, city or zip code
 - Enter the three-letter prefix on your BCBS medical ID card
 - **Example: MOE123456789 → Enter M O E**
 - You will be able to search for doctors, specialty, facilities by name or type
 - A list of doctors/facilities will be created based on the above criteria
- **REMINDER:** Be sure to call your provider/facility to receive verbal confirmation that they are in the BCBS network, or call BCBS directly at 800-810-2583 (as shown on the back of your BCBS medical ID card)

OHC Plan:





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

Medical ID Cards



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

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

Example: Bronze PPO Plan

 BlueCross BlueShield of Illinois Identification Number: MOE Group Number: P11796 RX BIN: 610011 RX Grp: IUOEMOE RX PCN: IRX 	<p>www.bcbsil.com</p> <table border="1"><tr><td>Deductible Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000</td><td>Out of Pocket Maximum Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000</td></tr></table>  BlueCross BlueShield of Illinois <small>This card is not a guarantee of benefits. For claims, benefits and eligibility call the Fund Office. Locate a provider by calling the BCBS Provider Finder, or at the website above. Contact Valenz to certify for all inpatient hospital admissions, outpatient surgeries, home health care, DME, managed mental health, and therapies 5 business days in advance of admission or outpatient surgical procedure. THIS IS NOT A COMPLETE LISTING. For member assistance program, and work-life services call Employee Resource Systems, Inc. (ERS). Provider: File medical claims with your local BCBS Plan.</small> 	Deductible Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000	Out of Pocket Maximum Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000	<table border="1"><tr><td>Fund Office*</td><td>1-708-579-6600</td></tr><tr><td>BCBS Provider Finder</td><td>1-800-810-2583</td></tr><tr><td>Valenz (Case Mgr./Cert)*</td><td>1-855-298-0493</td></tr><tr><td>Absolute Solutions*</td><td>1-800-321-5040</td></tr><tr><td>ERS (MAP)*</td><td>1-855-374-1674</td></tr><tr><td>Pharmacy Questions*</td><td>1-855-697-9150</td></tr></table> <small>*Group contracts directly</small> BlueCross BlueShield of Illinois, an Independent Licensee of the BlueCross BlueShield Association, provides claims processing only and assumes no financial risk for claims.	Fund Office*	1-708-579-6600	BCBS Provider Finder	1-800-810-2583	Valenz (Case Mgr./Cert)*	1-855-298-0493	Absolute Solutions*	1-800-321-5040	ERS (MAP)*	1-855-374-1674	Pharmacy Questions*	1-855-697-9150
Deductible Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000	Out of Pocket Maximum Information Ind/Fam In Network \$5,000/\$10,000 Ind/Fam Out of Network \$10,000/\$20,000															
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Absolute Solutions*	1-800-321-5040															
ERS (MAP)*	1-855-374-1674															
Pharmacy Questions*	1-855-697-9150															

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

<p>Medical ID Card</p>   HST Care Connect Network Value Based Payments Plan Plan ID: OHC 1 Member: MOE ID: <small>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.</small>	<p>Medical Claims Submission EDI Payor ID: 45979 Mail: MOE Welfare Fund PO Box: 211231 Eagan, MN 55121 Provider Support: (855) 297-4436 stream.support@eddata.us</p> <p>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/concurrence. 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.</p>	<table border="1"><tr><td>Deductible Information: Ind/Fam In Network: \$0/\$0 Ind/Fam Out of Network: \$300/\$700</td><td>Out of Pocket Maximum Information: Ind/Fam In Network: \$2,500/\$6,000 Ind/Fam Out of Network: \$2,500/\$6,000</td></tr><tr><td>RX Out of Pocket Information: Ind/Fam In Network: \$2,000/\$4,000 Ind/Fam Out of Network: \$4,000/\$8,000</td><td></td></tr></table> Resources Fund Office Provider Finder: (708) 579-6668 Provider Finder Website: https://moefunds.hstechnology.com Operators' Health Center: Countryside (708) 488-2273 Merrillville (219) 525-1150 Davenport, IA (563) 214-1599 Rockford, IL (779) 366-0757 Activate Healthcare: (855) 374-1674 ERS(MAP): (800) 321-5040 Absolute Solutions: (855) 697-9150 Pharmacy Questions: (855) 298-0493 Valenz (Case Mgr./Cert.): <small>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.</small>	Deductible Information: Ind/Fam In Network: \$0/\$0 Ind/Fam Out of Network: \$300/\$700	Out of Pocket Maximum Information: Ind/Fam In Network: \$2,500/\$6,000 Ind/Fam Out of Network: \$2,500/\$6,000	RX Out of Pocket Information: Ind/Fam In Network: \$2,000/\$4,000 Ind/Fam Out of Network: \$4,000/\$8,000	
Deductible Information: Ind/Fam In Network: \$0/\$0 Ind/Fam Out of Network: \$300/\$700	Out of Pocket Maximum Information: Ind/Fam In Network: \$2,500/\$6,000 Ind/Fam Out of Network: \$2,500/\$6,000					
RX Out of Pocket Information: Ind/Fam In Network: \$2,000/\$4,000 Ind/Fam Out of Network: \$4,000/\$8,000						

Family Supplemental Benefit (FSB)

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

For example:

- ❖ You can use your FSB benefit to receive reimbursement for vision and hearing services: none of the health plan options of the Midwest Operating Engineers Welfare Fund cover these types of services.
- ❖ If you select the Bronze PPO Plan, this plan does not cover any dental services. Therefore, you can use your FSB benefit to receive reimbursement for dental services.

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

Review Your Beneficiaries

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

Welfare Fund Death Benefit – If you die as an active eligible member of the Welfare Fund, your named beneficiary will receive a \$40,000 tax-free death benefit. You can name anyone as your primary beneficiary(ies) and anyone as your contingent beneficiary(ies).

Pre-Retirement Pension Death Benefit – If you are married, this benefit is automatically paid to your spouse as the primary beneficiary. However, you can also name contingent beneficiary(ies) should your spouse die. If you are single, you can name anyone as your primary beneficiary(ies) and anyone as your contingent beneficiary(ies).

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

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

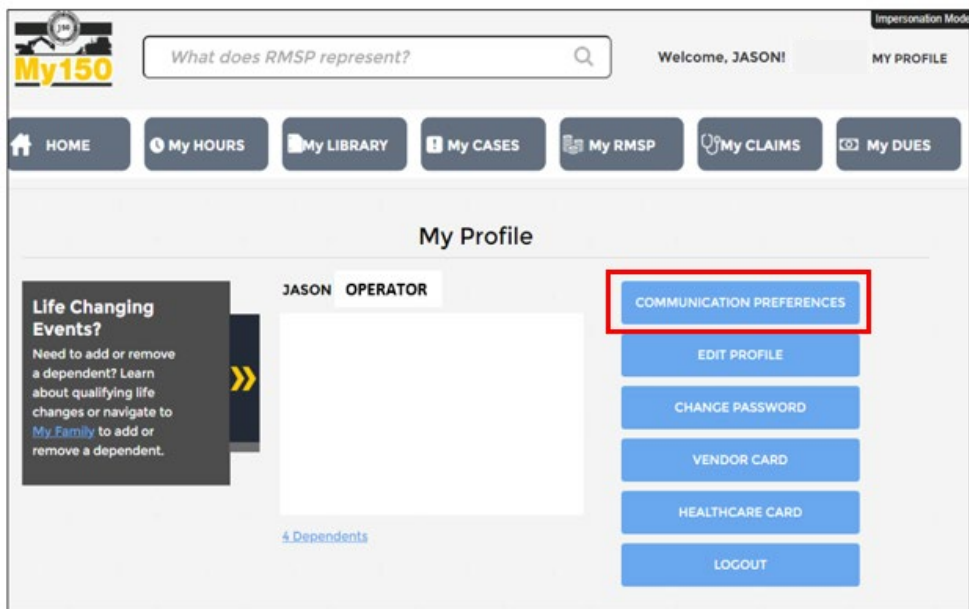
Retirement Enhancement Fund – Fidelity Investments is responsible for maintaining beneficiary information for this fringe benefit. To access your plan's benefits and update your beneficiary, visit www.NetBenefits.com/atwork to setup a username and password. From here, click on "Profile" and then scroll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

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

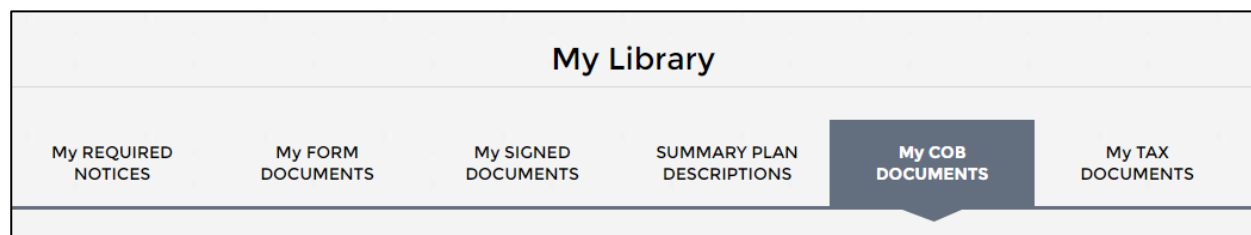
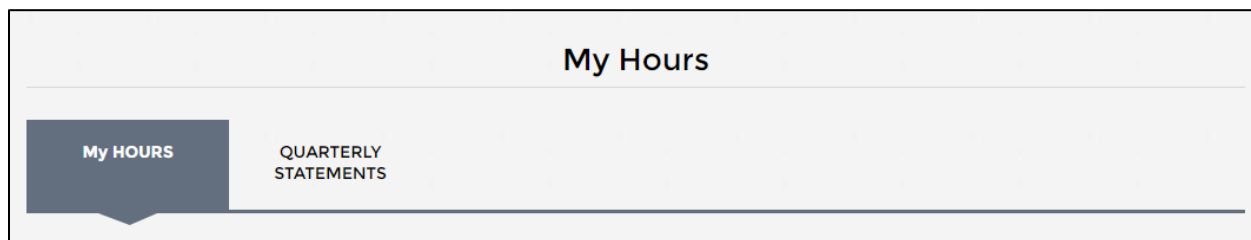
PLEASE NOTE: If you are an active dues paying member, you also have \$10,000 of Life Insurance through the Midwest Coalition of Labor (MCL). The Fund Office does not administer this benefit but for more information, visit coalitionoflabor.org. You can also access the beneficiary designation form to download,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

NEW! Communication Preferences

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



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



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

Update Communication Preferences

Toggle the options and click Update.

ALL PREFERENCES

Receive Notifications
Receive all notifications available through text message.

ALL

Receive Communications
Receive all communications available through Email.

ALL

TEXT MESSAGE NOTIFICATION PREFERENCES

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

YESNO

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

YESNO

EMAIL COMMUNICATION PREFERENCES

EOBs
Explanations of benefits and letters sent by MOE funds

YESNO

Quarterly Statements

YESNO

Tax Forms
1099R and 1095B

YESNO

Required Notices

YESNO

Unsubscribe to All Text Notifications

Unsubscribe to All Email Communications

Close

Update

A word about the No Surprises Act

Special rules apply to any benefits subject to the No Surprises Act (NSA). The No Surprises Act protects patients who receive emergency services at a hospital, at an independent freestanding emergency department and from air ambulances. In addition, the law protects patients who receive emergency services from an Out-of-Network provider at an In-Network facility. In certain circumstances, non-emergency items or services that are otherwise covered by the Plan from an Out-of-Network provider who is working at an In-Network facility are also subject to the No Surprises Act.

For benefits subject to the No Surprises Act, any cost-sharing payments count toward your In-Network deductible and In-Network Out-of-Pocket Expense Maximum. Please review the explanation of [Your Rights and Protections Against Surprise Medical Bills](#).

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

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

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

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

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