



2026 OPEN ENROLLMENT GUIDE

MUNICIPALITY MEMBERS





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Annual Open Enrollment

Annual Open Enrollment is the time of year where Municipality members can review their health plan options, compare plans, and more. The health plan option you choose will provide medical and pharmacy coverage for the upcoming Plan Year, beginning April 1, 2026 through March 31, 2027.

What Action to Take During Open Enrollment

1. **Review Your Health Plan Options: Keep Your Current Plan or Choose a New One**

Think about any upcoming medical procedures, prescriptions, or changes in family coverage, consider how frequently you visit doctors or need treatment, and compare costs between plans such as deductibles and out-of-pocket maximums to determine the one that best fits your budget and healthcare needs.

Municipality members covered under the Operators' Health Center (OHC) Plan are not eligible to select a different health plan option; however, you may change your coverage tier.

2. **Change Coverage Tiers**

Each health plan option offers three coverage tiers (Member Only, Member + 1, and Family)—and you can change your tier during Open Enrollment.

3. **Review Which Plan Options Best Fit Your Budget**

Be sure to choose a health plan that fits your budget to help ensure you maintain eligibility throughout the plan year.

4. **Check Network Status**

Check that your current providers are in-network to avoid higher out-of-pocket costs.

5. **Reset Your My150 Password**

Haven't logged in recently? Reset your password to avoid login issues. For help, call Technical Support at 888-220-3599.

6. **Review Your Dependents**

Open Enrollment is the only time to make dependent changes unless you experience a Life Changing Event during the Plan Year. Refer to [Adding and Removing Dependents](#).

7. **Review Coordination of Benefits Information**

This process determines which health insurance plan is responsible for paying for a patient's medical care when the patient has multiple health plans. Refer to [Coordination of Benefits](#).

8. **Review Your Beneficiary Info**

Ensure all of your beneficiaries are up to date, including their name, Social Security Number, address, and phone number.

9. **Update Your Profile Information**

Make sure your name, address, phone number, and email are current in your My150 account.

When is Open Enrollment?

Annual Open Enrollment is January 12, 2026 through February 28, 2026.

Who is Eligible for Open Enrollment?

As a Municipality member, you have the opportunity during annual Open Enrollment to choose a different health plan option or coverage tier. Your Collective Bargaining Agreement (CBA) outlines the health plan options available to you. We encourage you to attend an Open Enrollment event, where you and your spouse can meet with a Fund Office navigator to review and discuss your available health plan choice.

Open Enrollment Events

The Fund Office will be hosting another round of Open Enrollment events, giving you and your spouse the opportunity to meet one-on-one with a Fund Office navigator. These sessions are a great way to get personalized answers to any questions you may have about Open Enrollment and ensure you feel confident in your choices. Appointments start at 8:00 a.m.

[Click here to register for an Open Enrollment event or call Member Services at 708-579-6600 to register by phone.](#)

2026 Open Enrollment Event Schedule

- January 13: District 3 Union Hall, Lakemoor, IL
- January 24: District 7 Union Hall, Merrillville, IN
- January 30: District 4 Union Hall, Rockford, IL
- February 7: District 5 Union Hall, Utica, IL
- February 10: District 6 Union Hall, Lakeville, IN
- February 14: District 1 Fund Office, Countryside, IL
- February 17: District 8, Union Hall, Rock Island, IL

PLEASE NOTE: The Fund Office navigator is not licensed to recommend which health plan option to select. The Fund Office navigator is available to answer questions regarding all plan benefits.

Resources

Open Enrollment

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

- Monday, Tuesday, Wednesday, Friday: 8:00 a.m. to 5:00 p.m. CST
- Thursday: 9:00 a.m. to 5:00 p.m. CST
- Saturday: 8:00 a.m. to 12:00 p.m. CST

[Click here to register for an appointment at the Fund Office or call Member Services at 708-579-6600 to schedule by phone.](#)

OHC Plan Member Services Representative: If you work under a CBA that includes the OHC plan and you have questions, please contact a specialized OHC Plan Member Services Representative at 708-579-6668.

Municipality members covered under the Operators’ Health Center (OHC) Plan are not eligible to select a different health plan option; however, you may change your coverage tier.

MOE Website: Visit local150.org/moe/ to stay up-to-date on all the latest happenings at the Fund Office.

YouTube: Check out our Open Enrollment YouTube playlist—packed with must-see videos on Open Enrollment hot topics—at youtube.com/@midwestoperatingengineers

Midwest Operating Engineers Municipality Health Plan Options

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

- Plan A PPO
- EPO Plan

There are three coverage tiers for each health plan option:

- Member Only
- Member + 1
- Family

If you are a Municipality member covered under the Operators' Health Center (OHC) Plan, you will not participate in selecting a plan option. You will, however, be able to change your coverage tier, if desired, by [adding a dependent](#) or [removing a dependent](#).

Rates Increase as Healthcare Costs Continue to Climb

To keep pace with evolving healthcare needs and rising expenses, monthly health plan rates will increase for the 2026/2027 Plan Year. After nearly a decade of successfully managing healthcare costs, the Welfare Fund is preparing for a necessary adjustment in medical premiums effective April 1, 2026. This change reflects broader national trends in healthcare spending and the impact of groundbreaking medical innovations.

Since the launch of the MOE Health Plan Marketplace in 2016, the Fund has maintained an impressively low average annual cost increase of just 2.9% through 2024. This achievement stands out in an industry where double-digit increases are common. However, the most recent plan year saw a significant shift, with a 14.4% rise in costs—bringing the ten-year average to 4.1%.

Key Drivers Behind the Increase

Several factors contributed to the recent spike, many of which are tied to improving patient outcomes and expanding access to advanced treatments:

- **High-Cost Claimants:** A growing number of members are receiving treatment for complex conditions such as cancer. These life-saving therapies, while essential, come with higher price tags. This group alone contributed 4% to the overall trend.
- **GLP-1 Medications:** The use of GLP-1 drugs—originally developed for diabetes and now widely used for weight management—has surged. Utilization increased 181% over the prior year, contributing 5% to the cost trend. Between 2023 and 2025, GLP-1 use rose 130% for diabetes and an astounding 315% for weight loss.
- **Global Economic Pressures:** External factors such as inflation and international tariffs have impacted pharmaceutical pricing. With 70–80% of drug ingredients being imported, global supply chain challenges have driven up costs.
- **Medical Advancements:** While new treatments offer hope and improved quality of life, they often come with higher costs. The Fund remains committed to ensuring members have access to the best care available.

Looking Ahead

While the increase in premiums may be unwelcome news, it reflects the Fund's dedication to transparency and sustainability. The expectation is that healthcare costs will continue to rise, but the Welfare Fund remains focused on balancing affordability with access to high-quality care.

**HEALTH PLAN COMPARISON CHART
FOR MUNICIPALITY MEMBERS
Plan Year Beginning April 1, 2026 through March 31, 2027**

Free services are available through the Local 150 Health Centers (Operators' Health Centers, Marathon Health Centers, MCL Health Centers), ATI Physical Therapy facilities, Absolute Solutions Imaging Network, Gateway Foundation/Recovery Centers of America (RCA), or MinuteClinic's (There are some cash-pay services). Eligibility requirements apply and primary plan rules must be followed. Only medically necessary services will be considered for coverage.

	Plan A		EPO
Local 150 Health Centers (not subject to deductible) (ages vary by location)			
Primary care ages 2+, annual/school physicals, lab services, DOT physicals, physical therapy, chiropractic care, behavioral health services, & more. Services vary by location.	100%		100%
	In-Network	Out-of-Network	In-Network ONLY
Medical Annual Deductible (applies to all services unless noted otherwise)			
Person	\$1,000	\$1,000	None
Family	\$2,100	\$2,100	None
Medical Out-of-Pocket Maximum¹ (applies to all services unless noted otherwise)			
Person	\$3,000	\$3,000	\$2,500
Family	\$7,000	\$7,000	\$6,000
Medical Benefits			
Hospital Services	90%	80%	Inpatient: \$500 copay per admission Outpatient: \$40 copay per visit
Emergency Services in a Hospital or Independent Freestanding Emergency Department²	90%		\$200 copay per visit
Preventive Services³ (not subject to the deductible)	100%	100% ⁴	100%
Physician Visits	90%	80%	Primary: \$40 copay per visit Specialist: \$80 copay per visit
Chiropractic Services⁵ (not subject to the deductible) (maximum of \$60 per visit and 24 visits per Plan Year)	90%	80%	\$40 copay per visit
Acupuncture (maximum of \$125 per visit and 12 treatments per Plan Year)	90%	80%	\$40 copay per visit
Outpatient Restorative Speech Therapy	90%	80%	\$40 copay per visit
Outpatient Speech Therapy for Developmental Conditions, including Congenital Neurological Diseases	90%	80%	\$40 copay per visit
Outpatient Physical and Occupational Therapy⁶	90%	80%	\$40 copay per visit
Lab and X-ray	90%	80%	100%

Medical Benefits		Plan A	EPO
Family Supplemental Benefit (per family per Plan Year)		\$1,500	\$1,500
Dental Benefit			
Deductible	\$0		
Calendar-Year Maximum	Age 19 and older: \$2,000; Under 19: no maximum		
Preventive	100%		
Basic and Restorative ⁷	70%		
Orthodontia (dependent children through age 18 only)	50%; \$2,000 lifetime maximum		
Death Benefit			
Member	\$40,000		
Dependent	\$2,000		
Accidental Dismemberment and Disability Benefits			
Accidental Dismemberment	\$1,000 OR \$5,000 based on loss; \$10,000 limit for 1 accident		
Disability Benefit	\$500 per week for the first 30 days of disability (prorated for any paid days off)		
Prescription Drug Benefit			
CVS Caremark Network Retail Pharmacy (Short-term medication - maximum of two 30-day fills, excluding specialty drugs, then must obtain a 90-day supply)			
Generic	\$5 copay	\$5 copay	
Preferred Brand	\$10 copay	\$10 copay	
Non-Preferred Brand	\$25 copay	\$25 copay	
Specialty ⁸ (requires a prior authorization)	\$100 copay	\$100 copay	
CVS Caremark Network Retail Pharmacy & the CVS Caremark Mail Service Pharmacy (90-day supply of Maintenance Medication)			
Generic	\$15 copay	\$15 copay	
Preferred Brand	\$30 copay	\$30 copay	
Non-Preferred Brand	\$45 copay	\$45 copay	
Specialty ⁸ (requires a prior authorization)	\$300 copay ⁹	\$300 copay ⁹	
Prescription Out-of-Pocket Maximum			
	In-Network	Out-of-Network	In-Network ONLY
Person	\$2,000	\$4,000	\$2,000
Family	\$4,000	\$8,000	\$3,200
Medical and Prescription Combined Out-of-Pocket Maximum			
Person	\$5,000	\$7,000	\$4,500
Family	\$11,000	\$15,000	\$9,200

¹ Balance billing from an out-of-network provider does not apply to your out-of-pocket maximum.

² The No Surprises Act protects patients from unexpected medical bills when receiving emergency care or certain services from out-of-network providers at in-network facilities. It ensures patients are only responsible for in-network cost-sharing amounts and promotes transparency in healthcare pricing. To learn more about your rights and protections under this law, visit <http://local150.org/wp-content/uploads/2022/04/NSA-Notice.pdf>.

³ For details on ACA-mandated preventive care services, visit www.healthcare.gov/coverage/preventive-care-benefits/. For details on ACA-mandated preventive care prescription drugs, visit https://local150.org/wp-content/uploads/2025/10/ACA-Preventive-Services-Drug-List_October-2025.pdf. These lists may change periodically.

⁴ Out-of-network preventive services are covered only for adult physical exams for member and eligible spouse and well-childcare for children up to age 2.

⁵ Outpatient chiropractic services are covered at 100% for all health plan options if medically necessary and received at a Local 150 Health Center location.

⁶ Outpatient physical and occupational therapy is covered at 100% for all health plan options if medically necessary and received at a Local 150 Health Center location or an ATI Physical Therapy facility.

⁷ Coinsurance is based on Delta Dental's Allowable Fee. If you use an Out-of-Network provider, you pay the full cost of services above the Allowable Fee.

⁸ The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a \$0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution.

⁹ Specialty medications are limited to a 30-day supply. Copay applies only for medications that must be dispensed in 90-day supplies due to packaging.

Plan A and 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. Choosing in-network providers ensures the most cost-effective care for you and your family. Selecting out-of-network providers and facilities will result in higher out-of-pocket expenses.
- **The EPO Plan is an Exclusive Provider Organization (EPO) Plan.** This plan uses the same Blue Cross Blue Shield network as the Plan A, but it does not have 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 most 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.

To locate an In-Network provider/facility:

- Visit www.bcbs.com
- Hover over the Members tab as shown on the top ribbon and a pop-up will appear for Find A Doctor
- After selecting United States, you are prompted to select **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, or facilities by name or type
 - A list of doctors/facilities will be created based on the above criteria

Be sure to call your provider/facility to receive verbal confirmation that they are in the BCBS network or call BCBS directly at 800-810-2583.

Tap here to compare Plan A PPO and the EPO Plan side by side.

OHC Plan

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

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

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

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

The OHC Plan is designed so that when you use in-network providers, all medically necessary covered services are provided at no cost to you. The plan design is as follows:

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

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

Always verify with your provider or a specialized OHC Plan Member Services representative of the provider/facility’s network status to ensure that they remain in-network.

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

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

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

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

- Acupuncture
- Ambulance
- Ancillary charges related to an in-network admit (anesthesiologist, surgeon, etc.)
- Behavior health/substance abuse (all levels of inpatient/outpatient care)
- Chiropractic care
- Durable Medical Equipment (DME)
- Life-threatening emergency room visit
- Prosthetics
- Skilled nursing facilities
- TMJ

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

If you work under a CBA that includes the OHC plan and you have questions, please contact a specialized OHC Plan Member Services Representative at 708-579-6668.

Free Services Available Under Each Health Plan Option

Regardless of your health plan option, you and your family can use each of the following free services to maximize your benefits and minimize your out-of-pocket expenses:

- **Free best-in-class primary health care at Local 150 Health Centers:**

We are proudly partnered with Premise Health, Marathon Health, and the Midwest Coalition of Labor (MCL) to open access to quality healthcare for all eligible active members, retirees, and their eligible covered dependents. **All services covered under your health plan option are free if received at a Local 150 Health Center location.** Visit <https://local150.org/moe/local-150-health-centers/> for a list of covered services, Health Center locations, and other additional information.

- **Operators' Health Centers (OHC):** Both OHC locations (Countryside, IL and Merrillville, IN) offer primary/acute care, lab work, condition management, DOT physicals, on-site physical therapy services, behavioral health services, chiropractic care, and can provide limited prepack medications at your appointment, when necessary. Visit <https://members.premisehealth.com/moe/> for more information.
- **Marathon Health Centers:** Facilities are in Rockford, IL; Davenport, IA; and six locations in northern Indiana. Each location offers many of the same services as offered at the OHC. Marathon Health also has a nurse line available 24/7 if you need to seek triage after hours. Visit clients.marathon.health/local150 for more information.
- **MCL Health Centers:** Locations in Northbrook, Grayslake, Elgin, Joliet, and Utica. Visit <https://members.premisehealth.com/moe/> for more information.

- **Free preventive health services** at in-network providers. Talk to your provider about these services. Routine services will be paid at 100% when using in-network providers for all ages. Vaccinations will also be paid at 100% if you stay in-network. For a complete list of services for adults, women, and children, visit healthcare.gov/coverage/preventive-care-benefits/.
- **Free MRI, CT, and PET scans**, if medically necessary, through Absolute Solutions Imaging Network.
- **Free plan-covered immediate care services** at MinuteClinics, located within select CVS and Target locations. There are also some cash-pay services.
- **Free physical therapy services** through ATI Physical Therapy, if medically necessary. Primary plan rules must be followed.
- **Free eye exam** if you use an EyeMed Advantage Network provider. The EyeMed Advantage Network also offers numerous discounts on vision services.
- **Five free counseling sessions with a licensed** clinician, per episode, through AllOne Health (formerly ERS). Our Member Assistance Program offers up to five free counseling sessions (per episode).
- **Free type 2 diabetes management program** through Virta (if you qualify)
- **Free substance abuse treatment** through Gateway Foundation & Recovery Centers of America (RCA).

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

For more information regarding our vendors, please visit <https://local150.org/moe/h-w/exclusive-partnerships/>.

Family Supplemental Benefit (FSB)

FSB can be used to receive reimbursement for certain eligible expenses that are medically necessary non-covered expenses. Each of the Marketplace health plan options provides \$1,500 per family per Plan Year in an FSB benefit. If you do not utilize your FSB, the balance will not carry over to the next Plan Year. You can view your FSB usage in your My150 account by selecting “My FSB” beginning April 1, 2026.

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

A Word About the No Surprises Act

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

For benefits subject to the No Surprises Act, any cost-sharing payments count toward your in-network deductible and in-network out-of-pocket expense maximum. Please review the explanation of Your Rights and Protections Against Surprise Medical Bills below.

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

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

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

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

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

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider in an emergency room in a hospital or independent freestanding emergency department, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **cannot** 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 **cannot** 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 **cannot** 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 are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

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

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

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

Adding and Removing Dependents

Open Enrollment is the only time of year to make dependent changes unless you experience a Life Changing Event during the Plan Year. When you add a dependent to your plan during Open Enrollment, you must provide the Fund Office with specific required documents to get them validated. Required documents must be submitted to the Fund Office by **5:00 pm on February 28, 2026**. Failure to upload the required documents in My150 will result in that dependent not being added to the plan.

Adding a Dependent

To add a new dependent to your coverage, start by submitting a Life Changing Event. Log in to your My150 account, select “My Family,” and select “Submit Life Changing Event.” Complete the details of the event and choose “Open Enrollment Add.” After entering and saving your dependent’s information, you’ll see a confirmation pop-up that your dependent has been created successfully. Be sure to select Submit—you’ll then receive another confirmation that your Life Changing Event has been submitted.

A case will be created and can be viewed on your My Cases page with the subject “Life Changing Event.” You’ll also receive an email with a link to upload required documents, such as a birth certificate, adoption letter, Social Security card, or marriage certificate. You can upload these documents directly from the email link or by selecting the case on your My Cases page.

After you have submitted your Life Changing Event to add a new dependent, you must also make an active plan selection. If you do not, and you default your plan choice, your newly requested dependents will not be added to your plan.

Removing a Dependent

If you are currently covering a dependent that you do not wish to cover for the upcoming plan year, you can make changes to your covered dependents during Open Enrollment. First select the appropriate tier from the dropdown under Plan Options (Member, Member + 1, or Family). Next select your health plan (or compare health plan options), then choose the dependents you want to cover for the upcoming year. To remove a dependent, simply uncheck the box next to their name before confirming your selection. If you do not participate in Open Enrollment, your coverage will automatically default to your previous year's plan and dependents.

Required Documents

When you add a dependent to your plan during Open Enrollment, you must provide the Fund Office with specific required documents to get them validated. Required documents must be submitted to the Fund Office by **5:00 pm on February 28, 2026**. Failure to upload the required documents in your My150 account or to provide the Fund Office with photocopies of the required documents by the **5:00 pm on February 28, 2026 deadline** will result in that dependent not being added to the plan.

Dependent Type	Required Documentation
Spouse	<ul style="list-style-type: none"> • County Marriage Certificate – required by 5:00pm CST on 2/28/26 • Spouse’s Social Security Card • Spouse’s County Birth Certificate • Spouse’s employment information, if applicable • Spouse’s other group insurance card, if applicable
Child or Stepchild	<ul style="list-style-type: none"> • County Birth Certificate – required by 5:00pm CST on 2/28/26 • Social Security Card • Custodial Parent Questionnaire – Must be completed for stepchildren and/or natural children that do not reside in the member’s household – include copy of court order, if applicable • Completed ACEF – for Adult Dependent(s) only
Adopted Child	<ul style="list-style-type: none"> • Adoption letter or record showing date of adoption—signed and dated by a court official—required by 5:00pm CST on 2/28/26 • County Birth Certificate • Social Security Card

[Click here](#) to watch a short video on how to upload documents through My150.

Coordination of Benefits (COB)

After selecting a plan, members who are married will see a pop-up asking about other health coverage. If you shared your spouse's other health coverage and/or employment information with us within the past year and nothing has changed, no action is required, so you can select "Skip."

If your spouse's health coverage or employment information has changed in the past year, please select "Update." Once you have entered updated COB information, a case will be created and can be found on your "My Cases" page with the subject "Coordination of Benefits Review 2026." You will receive an email with a link to upload their important documents such as an insurance or Medicare card. You can also select to view the case from your "My Cases" page and upload their required documents.

To update the Coordination of Benefits information for your adult dependents, you can log in to your My150 account, select "My Library," then "My COB Docs," and then "Enter Updated COB Information." Failure to update your spouse's or adult dependent's COB information may result in delayed claims processing or denied claims.

Review Your Beneficiaries

Open Enrollment is the perfect time to review your beneficiaries. Go to Quick Links on your My150 Dashboard and select "My Beneficiaries." Always update this information after a Life Changing Event (marriage, divorce, birth, death). If divorced, contact Benefits & Eligibility Services at 708-937-0327 and submit your divorce decree promptly to avoid responsibility for any overpayments.

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

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

Retirement Enhancement Fund (REF) – To access your plan's benefits and update your beneficiaries through Fidelity Investments, visit www.NetBenefits.com/atwork to set up a username and password. From here, select "Profile" and then scroll down to select "Beneficiaries."

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

PLEASE NOTE: If you are an active dues paying member, you have Life Insurance through the National Coalition of Labor (NCL). 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>.

My150

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

Once you are logged in to your My150 account, you should review your profile information and ensure all the information is correct. Be sure to set your Communication Preferences. Your Communication Preferences allow you to be in control of what you would and would not like sent to you via text message or email when new information is available in your “My Library.” You can also update your [beneficiary information](#).

Navigating My150

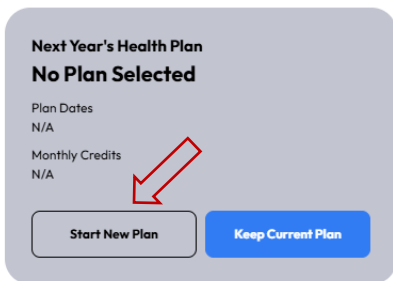
- Explanation of Benefits (EOBs) can be found under “My Claims”
- Your Quarterly Statements can be found under “My Hours”
- Under “My Library,” you can find your annual required notices, form documents, your DocuSigned documents, Summary Plan Descriptions, Coordination of Benefits forms, and tax documents.

Selecting a Health Plan/Coverage Tier

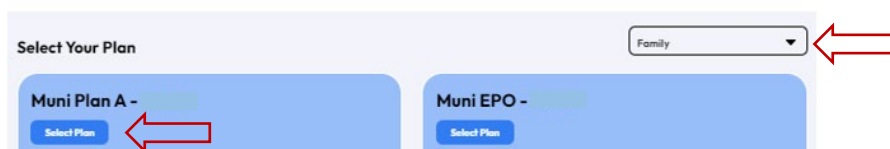
You can select a health plan and coverage tier through your My150 app or at My150.com. Whether you use a laptop, tablet, or mobile phone, you can access many of My150’s features and enroll anytime during Open Enrollment, from anywhere.

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

1. Log in to your My150. If you’re not registered, select “Sign Up” and follow the prompts to create your My150 account.
2. Once logged in, select “Start New Plan” under “Next Year’s Health Plan.”



3. Next you will view a summary of the Plan A PPO and EPO health plan options. Each year, you can also change your coverage tier (Member Only, Member + 1, Family). If you are adding a new dependent, it’s important to upload the required documents by 5:00pm CST on February 28, 2026. Once you are ready, click Select Plan under the health plan option you are selecting for the upcoming Plan Year.



- Next, you will choose the dependents that you would like to be covered under your health plan. You must check the box to the left of each dependent’s name that you would like to cover and then select “Confirm.” If you do not wish to cover a listed dependent, simply leave the box next to their name unchecked. If you would like to add a dependent, you can do so by selecting “Add New Dependent.”

Add Dependents

Using the list below, choose the dependents that will be covered under your selected Health Plan option, or add a dependent that you would like coverage for.

<input checked="" type="checkbox"/>	ERIN WHEELER	<small>Relationship</small> Wife	<small>Age</small> 33	<small>Edit</small>
<input checked="" type="checkbox"/>	JOY WHEELER	<small>Relationship</small> Daughter	<small>Age</small> 4	<small>Edit</small>
<input checked="" type="checkbox"/>	COLTON WHEELER	<small>Relationship</small> Son	<small>Age</small> 10	<small>Edit</small>

Any new dependents added to our family will need to be validated by the MOE Eligibility team before they can be added to your plan. Please provide proper documentation to validate the dependent.

Add New Dependent

Confirm

Cancel Previous

- After selecting “Confirm,” members who are married will see a pop-up asking about other health coverage for their spouse (often referred to as Coordination of Benefits (COB)). If you shared your spouse’s other health coverage and/or employment information with us within the past year and nothing has changed, no action is required, select “Skip.” If this information has changed, select “Update” to ensure your details are current and prevent delays or denied claims during processing. If you are not married, please proceed to the next step.

Verify Information

No action is required if you shared your spouse's or adult dependents' other health coverage and/or employment information with us in the past year and nothing has changed. Click Skip.

Update

Skip

- Next, review your plan. If you are satisfied with your plan selection, tap “Confirm.” If you’re still deciding, you can update your plan selection or add Coordination of Benefits (COB) information.

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

Muni Plan A -

[Select Plan](#)

Annual Deductible

Per Person
In-Network: \$
Out of Network: \$

Per Family
In-Network: \$
Out of Network: \$

Medical Out-of-Pocket Maximum

Per Person
In-Network: \$

Based on your estimated hours and future credits, you can afford this plan. This is not a guarantee of coverage for the Plan Year. You must review your hours worked and credits earned monthly.

Not sure yet?
If you would like to compare other health plan options click the button below.

[Change Plan Selection](#) [Enter COB Information](#)

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

ERIN WHEELER
Age: 33

JOY WHEELER
Age: 4

COLTON WHEELER
Age: 10

[Edit Dependent\(s\)](#)

Cancel
Previous
Confirm

- Next, you’ll be directed to DocuSign, where you’ll have one final opportunity to review your health plan information and summary of health plan benefits. If everything looks correct, click **Sign**, then **Finish**.

Enrollment Agreement

By signing this document I acknowledge that I have selected the plan listed below. I understand I am able to change my plan to a lower cost plan once during the benefit year unless I have a life event which qualifies me to change my plan.

Health Plan Information

MOE Medical ID	
Benefit Plan Name	Muni Plan A -
Coverage Tier	Family
Coverage Start Date	4/1
Coverage End Date	3/31
Covered Dependents	ERIN WHEELER JOY WHEELER COLTON WHEELER

Summary of Health Plan Benefits

	In Network Benefits	Out of Network Benefits
Annual Deductible- Single	\$	\$
Annual Deductible- Family	\$	\$
Medical Max- Single	\$	\$
Medical Max- Family	\$	\$
Hospital Services		
Preventive Care		

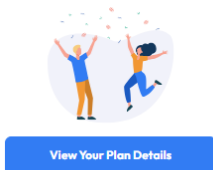
Sign

Signature _____ Today's Date _____

By signing above, I hereby authorize the credits in my Credit Bank to be used to pay for the coverage election I have chosen, above. Further, my signature certifies that the information I have provided on this form is true and correct, and that I and my dependents listed on this form are entitled to the coverage I have chosen. I declare that all statements and information made herein are complete and true to the best of my knowledge. I understand that any misstatements or omissions may void all coverage applied for me and my dependents shown on this form.

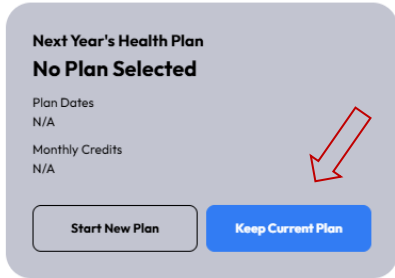
- Once you complete the DocuSign process, you’ll see a confirmation message indicating that you’ve successfully enrolled in your health plan.

Success!
You have successfully enrolled with the following Health Plan: Muni Plan A – Family



Keep Current Plan

If you are satisfied with your current plan and would like to keep it for 2026/2027, please log in to your My150 account and select “Keep Current Plan.” You’ll review your plan coverage details, your coverage tier, and covered dependents, and then confirm your choice for the upcoming Plan Year.



Medical ID Cards & Vendor Cards

If you change your health plan option for the upcoming Plan Year, you will receive new BCBS Medical ID cards to use starting April 1, 2026. If you keep your current health plan option, you will not receive a new Medical ID card. You can also download a digital copy of your card any time through your My150 account.

New for 2026! Physical vendor cards will no longer be mailed. Instead, you can easily access your vendor card through My150—right from your device. Simply select “Vendor Card” on your My150 dashboard to view and download it.

If you need additional cards, please contact Member Services at 708-579-6600.

Appendix - Open Enrollment Checklist

2026 Municipality Open Enrollment Checklist

This checklist is here to assist you through the Open Enrollment process if you'd like to tackle Open Enrollment on your own. Please remember if you have questions or need assistance, Fund Office staff are available by phone and in-person.

Section 1 – My150

Are you registered on My150?

- No. Get registered immediately.
 - ▶ Download the My150 app from the app store or
 - ▶ Visit my150.com and create an account
- Yes! Awesome, you're set to proceed to the next section

Reminder: Through My150, you can pay your dues, update your personal profile, update certain fringe benefit beneficiaries, update your Communication Preferences, and more.

Section 2 – Open Enrollment Participation

Your Collective Bargaining Agreement (CBA) should outline which health plan options are available to you. If your CBA indicates that you have coverage under the Operators' Health Center (OHC) Plan, you will need to validate your dependents and change your coverage tier ONLY, if desired, by adding/removing a dependent, as noted in Section 4.

If you can select another health plan option, you can do either of the following beginning January 12, 2026:

1. **Keep Current Plan:** Log in to your My150 account and tap Keep Current Plan. Be sure to review your plan coverage details, coverage tier, and select which dependents you would like covered under your plan. Lastly, verify your spouse or adult dependents coordination of benefits information. Please be sure to verify/update that information to ensure that there is not a delay in claims processing or denied claims. If everything looks good, tap Add Signature then Confirm.
2. **Explore Other Health Plan Options.** If eligible, you can select from the following health plan options for coverage beginning April 1, 2026.

Health Plan Option #1: **Plan A PPO**

Coverage Tier: _____

Pros: _____

Cons: _____

Health Plan Option #2: **EPO Plan**

Coverage Tier: _____

Pros: _____

Cons: _____

Section 3 – Updating Eligible Spouse/Adult Dependents Coordination of Benefits Info

You will be prompted at the time of selecting your plan to update coordination of benefits information, if you have an eligible spouse or adult dependent.

If you have a spouse or adult dependents, we strongly encourage you to review and update their coordination of benefits information.

1. Login to your My150 account
2. Tap on MY LIBRARY
3. Then My COB Documents
4. Lastly, Enter Updated COB Information

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

Section 4 – Adding Dependents During Open Enrollment

When you add a dependent to your plan, you must provide the Fund Office with specific required documents to get them validated. The Fund Office will accept photocopies of the required documents, or you can upload them directly in your My150 account. **After you have submitted your Life Changing Event to add a new dependent, you must also make an active plan selection. If you do not, and you default your plan choice, your newly requested dependents will not be added to your plan.**

Required documents must be submitted to the Fund Office by 5:00pm CST on February 28, 2026, to add your dependents for coverage beginning April 1, 2026. If documents are received after this date, you will not be able to add your dependents until next year’s open enrollment unless you experience a Life Changing Event (LCE).

Below is a list of required documents by dependent type.

Dependent Type	Required Documentation
Spouse	<ul style="list-style-type: none"> • County Marriage Certificate – required by 5:00pm CST on 2/28/26 • Spouse’s Social Security Card • Spouse’s County Birth Certificate • Spouse’s employment information, if applicable • Spouse’s other group insurance card, if applicable
Child or Stepchild	<ul style="list-style-type: none"> • County Birth Certificate – required by 5:00pm CST on 2/28/26 • Social Security Card • Custodial Parent Questionnaire – Must be completed for stepchildren and/or natural children that do not reside in the member’s household - copy of court order, if applicable • Completed ACEF - for Adult Dependent(s) only
Adopted Child	<ul style="list-style-type: none"> • Adoption letter or record showing date of adoption—signed and dated by a court official – required by 5:00pm CST on 2/28/26 • County birth certificate • Social Security card

Scan the QR code to watch a short video on how to upload documents through My150

