MOE HEALTH PLAN MARKETPLACE ENROLLMENT GUIDE

Great Benefits, Great Coverage, Lots of Choices!

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This guide provides a summary of benefits available to eligible members of Local 150 and their eligible dependents under the Midwest Operating Engineers Welfare Fund Health Plan Marketplace, effective April 1, 2017. The information provided in this guide is of a general nature only and does not replace or alter the official rules and policies contained in the official plan documents that legally govern the terms and operation of the Midwest Operating Engineers Welfare Fund. If this publication differs in any way from the official plan documents, the official plan documents always govern. Receipt of this publication does not guarantee eligibility for benefits. The Trustees have the right to modify benefits at any time.

Introducing Your MOE Health Plan Marketplace

Welcome to your MOE Health Plan Marketplace. Your Marketplace offers a variety of health plan options and three coverage tiers (member only, member plus one, family), so you can choose the coverage that works for your situation.

Having health plan options means you need to think like a consumer, by looking at your family's health care needs, weighing the costs and features of each health plan option, and deciding which option and coverage tier is right for you. The Fund Office staff provides a number of resources and guidance to help you select a health plan option. Please continue reading for important details.

MOE Health Plan Marketplace

Information: www.moefunds.com
Questions: (708) 579-6675
Enrollment: www.My150.com

Eligibility and Participation

Who Is Eligible

All hourly members are eligible for the MOE Health Plan Marketplace.

Who Can Be Covered Under Your Health Plan Option

If you are eligible for coverage, and depending on the coverage tier you select, you can also enroll your eligible dependents. Eligible dependents include your spouse and children, as defined below:

- Your legally married spouse.
- Your children up to the last day of the month that the child reaches age 26, including natural, adopted and stepchildren, regardless of student status, marital status or residence.
- Your handicapped children age 26 or older. While coverage normally ends on the last day of the month in which a dependent child reaches age 26, you can continue coverage for a handicapped dependent child. Children are considered handicapped when they are primarily dependent on you for financial support and maintenance because of a mental or physical condition that started before age 26. You must provide proof to the Fund Office that your child's handicap began before the child reached age 26. Coverage stays in force for as long as dependent coverage under the plan continues and the child remains handicapped, as defined above. In order to maintain coverage for your disabled child, you must submit proof of your child's physical handicap or mental incapacity to the Fund Office within 31 days of your child's 26th birthday.

When Your Participation Begins

You are eligible for the MOE Health Plan Marketplace once you have worked 300 hours in a rolling consecutive 12-month period. Once you're eligible, you can start using the credits in your Credit Bank to buy coverage based on when the Fund Office receives contributions from your Employer. See page 4 for details.

Generally, your Employer makes contributions during the month following the month your hours are worked. The month following receipt of your 300th hour is followed by a one-month Administrative Period during which you will enroll in the health plan option you choose. Your coverage, and the use of your credits, begins on the first of the month after the Administrative Period. **If you fail to enroll during the Administrative Period, you will be enrolled automatically in the highest credit cost plan based on the appropriate coverage tier.**

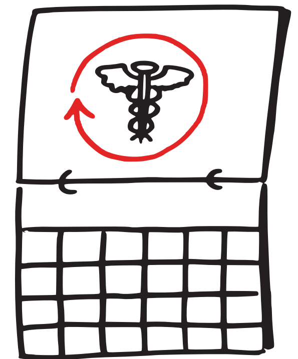
Example 1	Example 2	Example 3
May Work Hours: 100	May Work Hours: 100	May Work Hours: 50
June Work Hours: 200	June Work Hours: 100	June Work Hours: 100
—	July Work Hours: 100	July Work Hours: 100
300 Hours Received: July	300 Hours Received: August	250 Hours Received: August
Administrative Period for Initial Enrollment Only: August	Administrative Period for Initial Enrollment Only: September	NOT YET Eligible because total hours worked are not at least 300
Coverage Begins September 1	Coverage Begins October 1	

If you never reach 300 hours in a rolling consecutive 12-month period, you will not become eligible under the Welfare Fund and will not be able to use the credits deposited on your behalf.

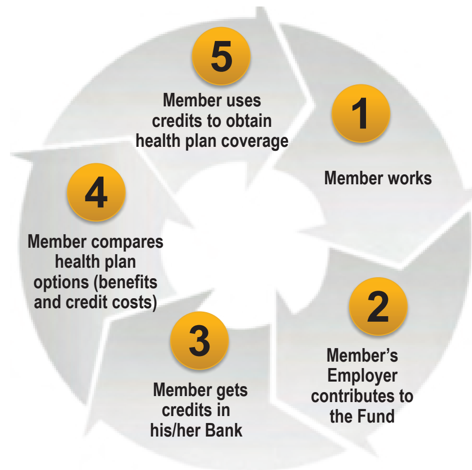
When Your Eligibility Ends

Your eligibility will end if you:

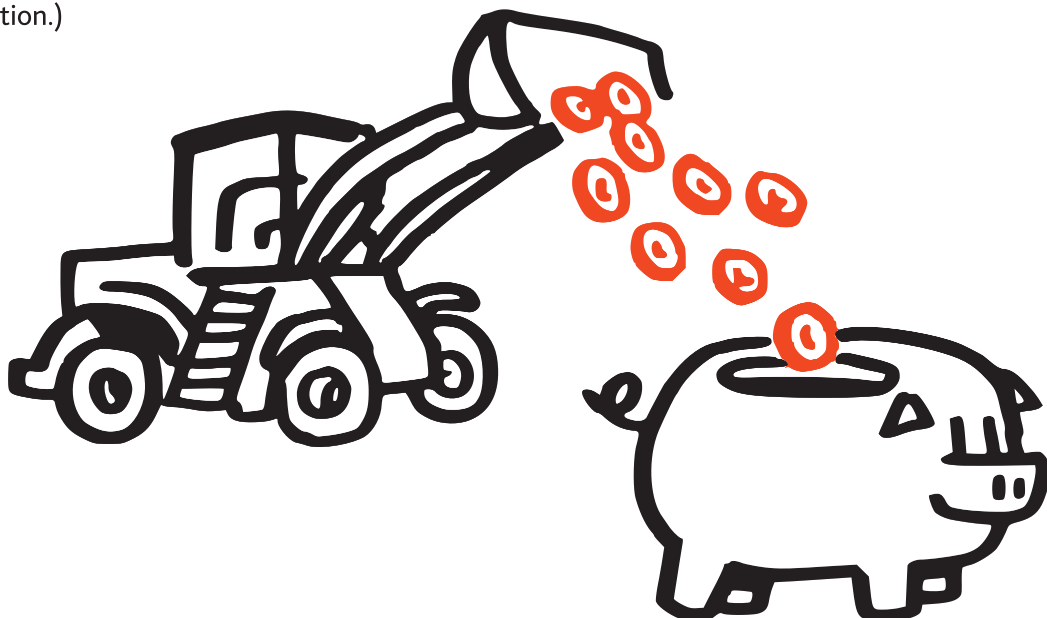
- Have a lapse in coverage.
- Use up your Credit Bank. This can happen if you select a costly plan and don't have enough work hours to cover the cost.
- Decide to buy coverage through the Public Health Exchange.
- Start working for a non-signatory contractor (i.e., non-union).
- Die. **Please note:** An eligible surviving spouse/dependents of an active plan member can continue coverage under the Marketplace until the member's Credit Bank is exhausted. At that point, the eligible surviving spouse and eligible dependent children can become covered under the Retiree Welfare Plan (RWP) until other coverage becomes available. The surviving spouse can use the member's Retiree Medical Savings Plan (RMSP) account to make self-payments under the RWP. For details on RWP eligibility, please contact the Fund Office.



How the MOE Health Plan Marketplace Works



- **For each hour you work**, your Employer will contribute to the Welfare Fund.
- **Employer contributions, in the form of "credits," will be deposited into your Credit Bank.** The credits you receive will be based on the number of hours you work and your negotiated hourly contribution rate minus the retiree subsidy. (See page 4 for more information.)
- **Before you enroll,** compare your health plan options and consider the coverage and credit costs for each option.
- **You'll use the credits in your Credit Bank** to buy coverage under the health plan you choose. If you don't have enough credits to buy coverage, you may make a self-payment, elect COBRA coverage, elect coverage under another group health plan, or buy coverage under the Public Health Exchange. (See page 16 for more information.)



How Credits Will Be Added to Your Credit Bank

Once you become eligible for the MOE Health Plan Marketplace, your credits become available in your Credit Bank for you to use during the month following the month the Fund Office receives the Employer contributions for the hours you work.

For example, let's say your coverage begins on July 1. The Fund Office will receive Employer contributions for the hours you work in July during August. These will be available in your Credit Bank for you to use in September. Credits will be subtracted from your Credit Bank for July and August coverage (based on your selected plan and coverage tier).

Monthly Credits = Hourly Contribution Rate
- Retiree Subsidy
x Number of Hours per Month You Work

EXAMPLE: HEAVY HIGHWAY

$14.55	Hourly Contribution Rate
- 3.45	Retiree Subsidy (23.7% x $14.55)*
11.10	Credits per Hour
x145	Hours Worked per Month
1,610	**Monthly Credits Earned**

*Retiree subsidy is 23.7% effective April 1, 2017.

You can find out how many credits are in your Credit Bank by going to **www.My150.com**.

What Happens to Credits You Don't Use?

Your Credit Bank will change each month—credits will be added based on your hours worked; credits will be subtracted to pay for the coverage you choose. Credits you don't use will stay in your Credit Bank.

Having more credits in your Credit Bank than you need to pay for a current month's coverage will help ensure you have enough credits to pay for coverage in future months. So if you don't need coverage under Plan A (which provides the highest level of coverage among all plan options) and/or you don't need family coverage, you'll be better off choosing a lower credit cost option.

As you get closer to retirement, you may transfer your extra credits to your Retiree Medical Savings Plan (RMSP) account annually during the open enrollment period. (See page 15 for more information about open enrollment.) Once you retire, you can use your RMSP account toward your Retiree Welfare Plan (RWP) premiums.

Please note: If you are running low on credits, your Credit Bank will be forfeited if:

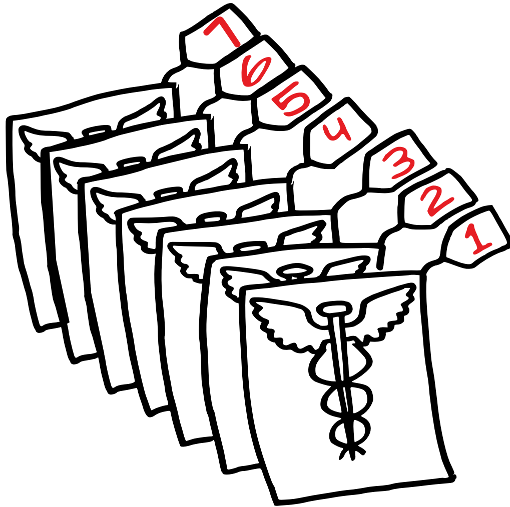
- You do not make a self-payment,
- You elect COBRA or other group health coverage, or
- You buy coverage under the Public Health Exchange.

Your Coverage Tier Choices

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

- Member only,
- Member plus one (coverage for you and your spouse or you and one eligible dependent child),
- Family (coverage for you, your spouse and/or all of your eligible dependent children).

Your Health Plan Options



The MOE Health Plan Marketplace offers seven health plan options, as shown in the overview chart below. At a minimum, as required under the Affordable Care Act, you must choose "member only" coverage under the plan with the lowest credit cost. (See page 12 for Health Plan Option Monthly Credit Costs.)

<table>
<tr><th></th><th>Type of Plan</th><th>How You Pay Your Share of Expenses</th><th>Provider Network</th><th>Dental, Life, AD&D and Disability Coverage</th></tr>
<tr><td>Plan A PPO</td><td rowspan="6">Preferred Provider Organization</td><td rowspan="6">Pay deductible then pay coinsurance</td><td rowspan="4">Flexibility to go in or out of network

Save money when using in-network providers</td><td rowspan="4">Included</td></tr>
<tr><td>Platinum PPO</td></tr>
<tr><td>Gold PPO</td></tr>
<tr><td>Silver PPO</td></tr>
<tr><td>Bronze PPO</td><td>Plan A PPO BlueCross BlueShield network</td><td rowspan="2">Not included</td></tr>
<tr><td>Silver PPO II (Narrow Network)</td><td>Flexibility to go in or out of network

Save money when using in-network providers

Network is smaller</td></tr>
<tr><td>EPO (Modified HMO)</td><td>Exclusive Provider Organization</td><td>No deductible; copays apply for most services</td><td>Must use EPO network providers; otherwise plan will not pay benefits except for emergencies</td><td>Included</td></tr>
</table>

Understanding Your Health Plan Options

To make your health plan option selection, you need to understand the main differences among the plans. Here's a brief overview of the differences, followed by detailed comparison charts showing the coverage and credit costs for each plan. Keep in mind that the Welfare Fund provides a number of additional resources to help you compare your options and choose the one that's best for you, including online decision tools and personalized assistance, described on pages 13 and 14.

- **Plan A and the Platinum, Gold, Silver and Bronze plans are Preferred Provider Organization (PPO) plans**. They each work the same way: when you use BlueCross BlueShield of Illinois PPO network providers, you save money on medical expenses because those providers discount their charges. However, **each plan has different annual deductibles and benefit payments.**
- **The Silver PPO II plan (also referred to as the Illinois Blue Choice PPO Network) works much like the other PPO plans; however the network is smaller.** This plan is only available in limited geographic areas. **If you are thinking of choosing this plan, make sure it is available in your area by reviewing the Network Map and Hospital Member Brochure available at www.moefunds.com under Marketplace Resources. Also, follow the instructions in the box to the right to make sure your current health care providers (e.g., doctors, specialists, hospitals) are in the network.**
- **The Silver PPO II and Bronze plans do not include dental, life, accidental death and dismemberment and disability benefits.**
- **The EPO is an Exclusive Provider Organization.** It has the same BlueCross BlueShield network as most of our PPOs, but it works like a Health Maintenance Organization (HMO). You must use in-network providers to receive benefits; otherwise the plan **will not** pay benefits, except for emergencies. There is no annual deductible and you pay for medical services through copays. However, unlike an HMO, you do not have to choose a primary care provider (PCP) or get referrals to see specialists. **If you are thinking about choosing the EPO, follow the instructions in the box to the right to make sure your current health care providers are in the network.**

How to Confirm Your Provider Is in Your Plan's Network

- Go to **www.bcbsil.com**.
- Click on Find a Doctor or Hospital and follow the instructions.
- When you reach the Select Network or Plan screen, click on Plan Networks and choose the following network from the drop-down list:
  - **For the Silver PPO II Narrow Network:** Blue Choice PPO (BCS)
  - **For all other MOE Health Plan Marketplace plans:** Participating Provider Organization (PPO)

We strongly encourage you to also call your provider or facility to make sure they are in-network.

Free Medical Services Available at OHC and MinuteClinics

Keep in mind that you and your eligible dependents can get many medical services for free at the Operators' Health Center (OHC) and MinuteClinics™ in CVS or Target retail stores. The goal is to use the Operators' Health Center (OHC) as your patient-centered medical home with a MinuteClinic as another means for acute/urgent after-hours care to avoid emergency room visits. Please note, cash payment will be required for certain MinuteClinic services. For details, visit **www.moefunds.com**.

About the Family Supplemental Benefit

The Family Supplemental Benefit (FSB) provides reimbursement to you and your eligible dependents for non-covered, medically necessary and unreimbursed medical, dental and pharmacy expenses that are considered deductible medical expenses by the IRS. You are **not** required to meet a deductible before the FSB pays benefits.

Please note: Your FSB amount will vary depending on which health plan option you select under the MOE Health Plan Marketplace. See pages 8 to 9 for the FSB amounts for each health plan option.

FSB expenses include, but are not limited to, the following:

- Eye exams and prescription eyeglasses or contact lenses
- Hearing tests and hearing aids
- Orthodontic expenses in excess of your dental coverage's lifetime orthodontia maximum (if applicable)
- Dental benefits in excess of the Plan Year maximum benefit
- Medically necessary genetic testing

Note: Your FSB will not reimburse copays or deductibles.

To file an FSB claim, submit a Family Supplemental Benefit Claim Form with your itemized bill or your Explanation of Benefits (EOB) form that relates to the claim, and your paid receipt. The Fund Office must receive your FSB claim within twelve months of the date of service.

For more information about the FSB, including non-covered expenses, visit www.moefunds.com/family-supplemental-benefit.

A Note about Preventive Care Coverage

The Affordable Care Act (ACA) requires that certain preventive care services are covered at 100% by all Marketplace plans when you see an in-network provider. All Marketplace plans except Plan A do not cover these services if you see an out-of-network provider.

Under Plan A only, adult physical exams and well child care are covered at 100% even if you see an out-of-network provider, but all other ACA-mandated preventive care services are not covered if they are received out-of-network.

Examples of ACA-mandated preventive care services include services for alcohol misuse, tobacco use, obesity, heart disease, depression, diabetes, and breast, prostate and colorectal cancer as well as certain immunizations. You can find the full list of ACA-mandated preventive care services at www.healthcare.gov/coverage/preventive-care-benefits/ or www.caremark.com/portal/asset/NoCost_Preventive_List_OE.pdf

This information is also posted on www.moefunds.com or contact the Fund Office.

Health Plan Option Comparison Chart

Services Offered	Plan A		Platinum		Gold	
OPERATORS' HEALTH CENTER (NOT SUBJECT TO DEDUCTIBLE)						
Annual/School Physical Exams, Preventive Care/Wellness Visits, Immunizations, Blood Draws, Condition Management *(Ages two and up)*	100%		100%		100%	
MEDICAL BENEFIT						
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (applies to all services unless noted otherwise)						
Person	$300	$300	$500	$1,000	$1,000	$2,000
Family	$700	$700	$1,250	$2,500	$2,500	$5,000
Medical Out of Pocket Maximum (applies to all services unless noted otherwise)						
Person	$2,500	$2,500	$3,500	$7,000	$4,000	$8,000
Family	$6,000	$6,000	$7,000	$14,000	$8,000	$16,000
Hospital Services	90%	80%	90%	80%	80%	60%
Emergency Room	90%	90%	$100 copay; balance considered at 90%		$100 copay; balance considered at 80%	
Preventive Services*	100%	100%[1]	100%	No benefit	100%	No benefit
Physicians Visits	90%	80%	90%	80%	80%	60%
Chiropractic Services (Limited to maximum of $60 per visit and 24 spinal manipulations for the 4/1/17 Plan Year)	90%	80%	90%	80%	80%	60%
Outpatient Restorative Speech Therapy	90%	80%	90%	80%	80%	60%
Outpatient Speech Therapy (25 visit limit)**	90%	80%	90%	80%	80%	60%
Outpatient Physical and Occupational Therapy for Congenital Neurological for Dependent Children***	90%	80%	90%	80%	80%	60%
Lab and X-ray	90%	80%	90%	80%	80%	60%
Family Supplemental Benefit— per family per plan year	$1,500		$1,200		$1,000	

* Not subject to deductible. 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 **www.caremark.com/portal/asset/NoCost_Preventive_List_OE.pdf**. These lists may change annually.

[1] For adult physical exams and well child care; no benefit for other ACA-mandated preventive services; covered services may change periodically, and any changes will be effective April 1, 2017.

** Outpatient speech therapy for developmental conditions including congenital neurological diseases for dependent children are limited to 25 visits for the 2017/2018 plan year. For children between the ages of 2 through age 18.

*** Limited to children through age 18.

Benefits Effective April 1, 2017 through March 31, 2018

Silver		Silver II Narrow Network		Bronze		EPO
100%		100%		100%		100%
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
$2,000	$4,000	$2,000	$4,000	$5,000	$10,000	None
$5,000	$10,000	$5,000	$10,000	$10,000	$20,000	None
$4,000	$8,000	$4,000	$8,000	$5,000	$10,000	$4,000
$8,000	$16,000	$8,000	$16,000	$10,000	$20,000	$10,000
70%	50%	70%	50%	100%		Inpatient: $250 copay per admission Outpatient: $20 copay per visit
$100 copay; balance considered at 70%		$100 copay; balance considered at 70%		$100 copay per visit		$100 copay per visit
100%	No benefit	100%	No benefit	100%	No benefit	100%
70%	50%	70%	50%	100%		Primary: $20 copay per visit Specialist: $40 copay per visit
70%	50%	70%	50%	100%		Primary: $20 copay per visit
70%	50%	70%	50%	100%		$20 copay per visit
70%	50%	70%	50%	100%		$20 copay per visit
70%	50%	70%	50%	100%		$20 copay per visit
70%	50%	70%	50%	100%		100%
$500		$300		$250		$500

Services Offered	Plan A		Platinum		Gold	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
DENTAL BENEFIT						
Deductible	$0		$0		$0	
Calendar Year Maximum	Age 19 and older $1,000 Under 19 no maximum		Age 19 and older $1,000 Under 19 no maximum		Age 19 and older $1,000 Under 19 no maximum	
Preventive	100%		100%		100%	
Basic & Restorative	70%		70%		70%	
Orthodontia	50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		50% $2,000 lifetime maximum	
DEATH BENEFIT						
Member	$30,000		$30,000		$30,000	
Dependent	$2,000		$2,000		$2,000	
ACCIDENTAL DISMEMBERMENT	$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident					
DISABILITY BENEFIT	$250 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks					
PRESCRIPTION DRUG BENEFIT****						
Retail***** (30-day supply)	Generic $5 Preferred Brand $10 Non-Preferred Brand $25 Specialty $100		Generic $5 Preferred Brand $10 Non-Preferred Brand $25 Specialty $100		Generic $5 Preferred Brand $10 Non-Preferred Brand $25 Specialty $100	
Maintenance Choice (either CVS or Target retail pharmacy stores or Caremark Mail Service Pharmacy ONLY; 90-day supply)	Generic $15 Preferred Brand $30 Non-Preferred Brand $45 Specialty N/A		Generic $15 Preferred Brand $30 Non-Preferred Brand $45 Specialty N/A		Generic $15 Preferred Brand $30 Non-Preferred Brand $45 Specialty N/A	
PRESCRIPTION OUT OF POCKET MAXIMUM						
Person	$2,000	$4,000	$2,000	$4,000	$2,000	$4,000
Family	$4,000	$8,000	$4,000	$8,000	$4,000	$8,000
COMBINED OUT OF POCKET MAXIMUM (INCLUDES BOTH MEDICAL AND PRESCRIPTIONS)						
Person	$4,500	$6,500	$5,500	$11,000	$6,000	$12,000
Family	$10,000	$14,000	$11,000	$22,000	$12,000	$24,000

**** The new specialty drug copay will apply to all new utilizers of specialty drug prescriptions that are filled on or after April 1, 2017. Specialty drugs require prior authorization through Caremark's Specialty Guideline Management (SGM) program.

***** Maximum of up to two 30-day fills before the member is required to obtain a 90-day supply.

	Silver		Silver II Narrow Network		Bronze		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
	$0		No benefit		No benefit		$0
	Age 19 and older $1,000 Under 19 no maximum		No benefit		No benefit		Age 19 and older $1,000 Under 19 no maximum
	100%		No benefit		No benefit		100%
	70%		No benefit		No benefit		70%
	50% $2,000 lifetime maximum		No benefit		No benefit		50% $2,000 lifetime maximum
	$30,000		No benefit		No benefit		$30,000
	$2,000		No benefit		No benefit		$2,000
			No benefit		No benefit		$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident
			No benefit		No benefit		$250 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks
	Generic $5 Preferred Brand $10 Non-Preferred Brand $25 Specialty $100		Generic $20 Preferred Brand $40 Non-Preferred Brand $55 Specialty $100		Generic $20 Preferred Brand $40 Non-Preferred Brand $55 Specialty $100		Generic $5 Preferred Brand $10 Non-Preferred Brand $25 Specialty $100
	Generic $15 Preferred Brand $30 Non-Preferred Brand $45 Specialty N/A		Generic $50 Preferred Brand $100 Non-Preferred Brand $115 Specialty N/A		Generic $50 Preferred Brand $100 Non-Preferred Brand $115 Specialty N/A		Generic $15 Preferred Brand $30 Non-Preferred Brand $45 Specialty N/A
	$2,000	$4,000	$2,000	$4,000	$1,600	$4,000	$2,000
	$4,000	$8,000	$4,000	$8,000	$3,200	$8,000	$3,200
	$6,000	$12,000	$6,000	$12,000	$6,600	$14,000	$6,000
	$12,000	$24,000	$12,000	$24,000	$13,200	$28,000	$13,200

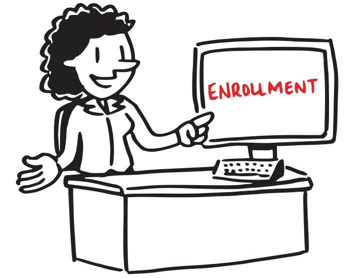
Health Plan Option Monthly Credit Costs

Depending on the plan and coverage tier you select, there will be an associated monthly credit cost, as shown below. For example, for the Plan Year from April 1, 2017 through March 31, 2018, the monthly credit cost for family coverage under the Plan A PPO is 1,468.

MONTHLY CREDIT COST DEDUCTIONS FOR THE 2017/2018 PLAN YEAR			
	Member	Member + 1	Family
Plan A PPO	1,112	1,290	1,468
Platinum PPO	1,060	1,230	1,400
EPO (Modified HMO)	1,045	1,213	1,380
Gold PPO	974	1,129	1,285
Silver PPO	916	1,062	1,209
Silver PPO II (Narrow Network)	712	826	940
Bronze PPO	756	878	999

Enrollment

When to Enroll



To be covered under the MOE Health Plan Marketplace, you must enroll during the Administrative Period, which is the month following receipt of your 300th hour. See page 2 for more information about the Administrative Period.

How to Enroll

You will enroll for coverage through the My150 community website at www.My150.com. This website is mobile-friendly. Whether you use a laptop, tablet, or mobile phone, you can access many of My150's features and enroll—anytime, from anywhere. Most of the My150 pages adjust to your screen size.

Here's an overview of how to enroll. The website will provide detailed instructions.

- You'll need to register on the website before you can enroll. For registration instructions, go to www.My150.com and click on **"View Your Welcome Kit"**. You will need your union Registration ID number or your Medical ID number and the last four digits of your Social Security number. If you do not know your Medical ID number, please call the Fund Office at (708) 579-6675.

- After logging in, click on the **"My MARKETPLACE"** tab.
- Click **"Start New Plan"** then review and sign off on the Privacy Policy.
- You'll then have two choices: **"Skip Wizard, Pick Plan"** or **"Start Wizard"**.
- If you click **"Start Wizard"**:
  - You'll answer a series of health-related questions to help you determine the best plan for you and/or your family's needs. Based on the answers selected, the Wizard will suggest up to three health plan options that may meet your needs. **Although the Wizard provides suggested health plan options, it is your responsibility to review and compare all of the options available to ultimately select the one you believe is best for your family.**
  - You'll then select the health plan options you would like to compare.
  - You'll see a side-by-side comparison of these options.
  - You'll also have the option of using an **Affordability Calculator** to project how long your Credit Bank will last based on a specific plan and the hours you project to work. And, you can use it to plan for future life changing events by changing your coverage tier.
  - To enroll in a health plan option, click the **"Select Plan"** button under the option name and then **"Review Plan"** at the bottom of the page.
  - Review and confirm your health plan option and dependent elections.
  - Once you review your plan, you'll sign for your selection, then click **"Adopt and Sign"**. At that point, you'll be directed to the confirmation page. You'll also receive a confirmation email. The document you signed will be added to your **My LIBRARY** page.
- If you click **"Skip Wizard, Pick Plan"**, you'll go directly to the health plan option comparison page. There you'll have the choice of selecting a plan or completing the last four steps noted above (side-by-side comparison, **Affordability Calculator**, Reviewing and Selecting a Plan). However, the Fund Office encourages all members to use the Wizard. **You should only click "Skip Wizard, Pick Plan" if you are returning to the website after already using the Wizard.**

Getting Help With Your Decision

In addition to the online decision tools described above, you can call the Fund Office at (708) 579-6675 for assistance with making an enrollment choice and enrolling in a plan. You can get help over the phone or schedule a meeting at the office if needed.

Please visit www.moefunds.com for more information.
If you have an address change, update your address on the My150 community website ("My PROFILE") or call the Fund Office.

What Happens if You Do Not Enroll

If you do not enroll in the MOE Health Plan Marketplace, you will be enrolled automatically in the highest credit cost plan based on the appropriate coverage tier. But automatic enrollment may not be the right choice for you. Remember: if you don't make an active choice, your automatic coverage will stay in effect until the end of the Plan Year (if you have enough credits in your Credit Bank), unless you have a life changing event or use the option to downgrade to a lower credit-cost plan (the downgrade option is only available once per Plan Year; see page 15 for details). Don't miss your chance to make sure you have the best, most affordable health plan option for you and your family!

Note: We strongly encourage you to enroll on time to ensure you have the coverage you want and that you'll receive your Medical ID card without delay.

Be Sure to Complete the Consent Form

Your enrollment packet will include an Electronic Disclosure Consent Form. Please complete and return this form in the enclosed self-addressed envelope as soon as possible. This will give the Fund Office permission to send important information electronically—so you'll get it much faster and the Welfare Fund will save money.

How to Enroll if You Don't Have Computer Access

Computer kiosks are available at all the District Offices as well as the Fund Office. Also, Fund Office staff can assist you with the enrollment process. If you need a paper enrollment form, please contact the Fund Office at (708) 579-6675.

Changing Your Health Plan Option

Outside of open enrollment, you can change your health plan option as follows:

- Once each Plan Year, for any reason, to a lower credit cost option (for example, moving from the Plan A PPO to the Bronze PPO). You will **not** be able to change your coverage tier (i.e., who is covered).
- To any plan option whenever you have a life changing event (such as marriage, divorce, death, birth, adoption, your eligible dependent gains/loses employment-based coverage, or you become eligible for state premium assistance, Medicaid or Children's Health Insurance Program (CHIP) subsidies). If you have a life changing event, you can also change your coverage tier (for example, if you have a child, you can move from member plus one to family coverage to cover both your spouse and newborn child). Please note, there is a 90-day timeframe for you to notify the Fund Office and provide the required documentation for the life changing event. If you fall outside of this 90-day timeframe, you will not be able to add or remove your dependent until the next open enrollment period.

If you change your coverage during the Plan Year, any amounts you've paid toward your annual deductibles (except the EPO Plan), out-of-pocket maximums and other Plan Year benefit limits will be transferred to the new plan. Please note: Each plan has different annual deductibles and out-of-pocket maximums that you will need to meet even after the transfer to the new plan is made.

To change your health plan option, just log on to My150 and you will see these choices:

You have 2 options for changing your health plan:

Downgrade

As a member, you have the ability to change to a lower credit cost health plan option **once** per plan year (Apr 1 - Mar 31) to better suit your needs.

DOWNGRADE

Life Changing Event

Please notify the Fund Office of any of the following Life Changing Events:

- Marriage/Divorce
- New or Adopted Children
- Military Service
- Disability
- Becoming Medicare Eligible
- Death
- Dependent Gaining / Losing Coverage outside of MOE

Click below to submit a life changing event.

LIFE CHANGING EVENT

What Is Open Enrollment?

Once you become eligible for the Marketplace, you will select a health plan option and coverage tier for the first time. Then, you will have an annual opportunity to change your health plan option and coverage tier during open enrollment, which is usually held in January and February preceding each Plan Year. For example, open enrollment for the April 1, 2018 through March 31, 2019 Plan Year will be in January and February 2018. It's important to think through your choices every year, since your health needs and/or work hours may change in the future.

How Long Your MOE Health Plan Marketplace Coverage Will Continue

Your coverage in the MOE Health Plan Marketplace will continue as long as you have credits in your Credit Bank, whether or not you are working. You must buy coverage through the Marketplace as long as you have credits in your Credit Bank.

If you run short of credits, you can make a self-payment as described below to cover the shortfall for the month; otherwise, you will forfeit your remaining Credit Bank immediately.

If you lose coverage, you can regain eligibility by meeting the initial eligibility requirement of 300 hours in a rolling consecutive 12-month period. See page 2 for details.

Options for Continuing Medical Coverage

If you don't work enough hours and your Credit Bank becomes too low for you to continue eligibility for MOE Health Plan Marketplace coverage, you have the following options:

- **Self-pay option.** You can make a self-payment to cover the shortfall for the month. Consecutive monthly self-payments are not allowed in the Marketplace. If you have a self-payment opportunity, the Fund Office will contact you regarding the amount of payment and the payment due date.

EXAMPLE

1,200	Monthly Credit Cost for Coverage
- 800	Credits Remaining in Credit Bank
$400	**Self-Pay Amount**

- **Elect COBRA coverage.** You can elect COBRA coverage immediately after your Credit Bank becomes too low for you to continue Marketplace coverage eligibility, or after making a self-payment. You can elect to continue coverage in the plan you enrolled in or you may select a different coverage tier and/or different plan, as long as it is a lower credit cost option. **You cannot use your Credit Bank to pay for COBRA coverage.**
- **Elect coverage under another group health plan.** Whether or not you elect to self-pay or you elect COBRA coverage, you can choose coverage under your spouse's employer's plan, if available to you.
- **Choose coverage through the Public Health Exchange.** If you do not elect any of the options above, you can buy coverage under the Public Health Exchange. If you do so, you will forfeit any credits in your Credit Bank. If you lose Fund coverage, you will have a special enrollment opportunity under the Public Health Exchange. This means you do not have to wait until the Exchange's annual enrollment period to elect coverage. You may be eligible for a premium assistance tax credit that can be used to help pay the cost of coverage through the Public Health Exchange.

Credit Bank Maximum

Starting with the Plan Year when you become age 55, the maximum amount of credits you can have in your Credit Bank is calculated each April by multiplying the cost of the coverage you have elected by the number of months from the following April 1 through the month when you turn age 65, plus 12 months.

At the end of each Plan Year, on March 31, credits over the maximum will be automatically transferred to your Retiree Medical Savings Plan (RMSP) account.

EXAMPLE

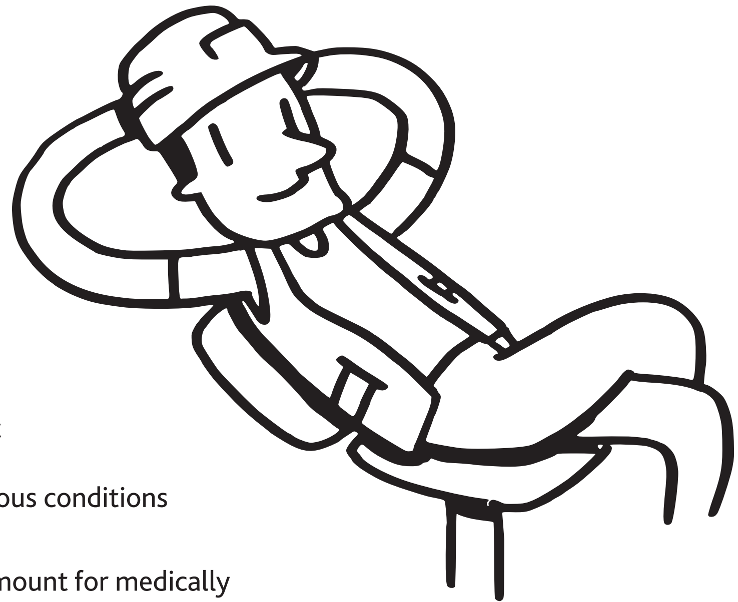
Assume you are age 60 and have accumulated 120,000 credits in your Credit Bank. You elect the Plan A PPO with family coverage, so your monthly credit cost is 1,468. Since you are age 60, you have 60 months until you become Medicare-eligible at age 65.

- Your Credit Bank maximum = 105,696: 1,468 x (60 months until age 65 + 12 months)
- Credits transferred to your RMSP account on the following March 31 = 14,304 (120,000 - 105,696).

Terms to Know

It's easiest to understand your health plan options when you're familiar with the terms most commonly used to explain your coverage. Here are terms to know:

- **Deductible:** The amount of covered charges you must pay during a Plan Year before the plan begins to pay benefits.
- **Out-of-Pocket Maximum:** The most you pay for covered services during a Plan Year. It includes your deductible, copays and coinsurance.
- **Copay:** A flat dollar amount you must pay for a medical service such as an office visit, emergency room visit, etc.
- **Coinsurance:** The percentage of covered charges you and the plan pay after you meet the deductible. For example, if a plan pays 90% of covered charges after the deductible, you would pay the remaining 10%.
- **Preventive Care:** Periodic health evaluations and associated diagnostic tests (annual physicals), routine pre-natal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight-loss programs and screening services for various conditions and diseases.



- **Reasonable and Customary Charge:** The allowed amount for medically necessary services and supplies to which your coinsurance is applied. This amount is based on what providers in a geographic area usually charge for the same or similar medical service. For out-of-network care, you pay any amounts over the Reasonable and Customary charge. You do not pay amounts over the Reasonable and Customary charge when you receive in-network care.

April 2017