Open Enrollment: January 14 – February 28, 2019

YOUR MOE HEALTH PLAN MARKETPLACE ENROLLMENT GUIDE

Great Benefits, Great Coverage—Lots of Choices!

MIDWEST OPERATING ENGINEERS

MOE

HEALTH PLAN MARKETPLACE

What's Inside

This guide provides a summary of benefits available to hourly eligible members of the Midwest Operating Engineers (MOE) Local 150 and their eligible dependents under the Midwest Operating Engineers Welfare Fund Health Plan Marketplace, effective April 1, 2019. 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.

It's Time to Think about Your MOE Health Plan Coverage

MOE Health Plan Marketplace Open Enrollment: January 14 – February 28, 2019

Information: www.moefunds.com

Enrollment: www.My150.com

Call Center: (844) 693-1467

Fund Office Staff: (708) 579-6675

Specialized OHC Plan Member Services Representative: (708) 579-6668

Welcome to open enrollment for the MOE Health Plan Marketplace, which will take place from January 14 through February 28, 2019. The choices you make during open enrollment will be effective on April 1, 2019.

For the coming Plan Year (April 1, 2019 through March 31, 2020), the Marketplace will continue to offer excellent benefits and the coverage that you deserve and expect from MOE. As before, you'll have a variety of health plan options and three coverage tiers (Member Only, Member + 1, Family).

It's important to think through your choices every year at open enrollment. Keep in mind that your health care situation may change from year to year due to new medical needs and/or changes to dependents, plus your work hours could change, too.

If you're in one of the higher credit cost plans and/or have Member + 1 or Family coverage, think about whether you really need it. If not, you'd be better off with a lower credit cost option and/or Member Only coverage tier. This keeps more credits in your Credit Bank, which can help you stay covered if your work hours decrease.

The Fund Office staff will provide a number of resources to help you select a health plan option. Please continue reading for important details.

Questions?

Visit www.moefunds.com or call the MOE Health Plan Marketplace Call Center's toll-free number at (844) 693-1467, starting January 14, 2019, from 8:00 a.m. to 7:00 p.m. CST, Monday through Friday or 8:00 a.m. to 12:00 p.m. CST, Saturdays, including holidays.

What's New for 2019/2020

Here's an overview of Marketplace changes **starting April 1, 2019**. For more information about the changes noted below, see the Marketplace FAQs posted at www.moefunds.com.

Starting October 1, 2018

100% Coverage for Physical and Occupational Therapy

Whichever Plan you enroll in, you'll pay nothing for covered outpatient physical and occupational therapy received at an ATI Physical Therapy facility, with no deductible and no copay/coinsurance. If you don't use an ATI Physical Therapy facility for your covered therapy needs, you will be required to pay toward your deductible and pay the percentage of in-network or out-of-network charges required by your health plan.

Starting January 1, 2019

Increased Life Insurance Coverage

Voya Financial is the Welfare Fund's new life insurance provider. The Welfare Fund Board of Trustees has increased the member life insurance benefit from $30,000 to $40,000. This benefit is available to all members with Marketplace health care coverage, except those in the Bronze PPO Plan.

New Prescription Drug Provider: OptumRx

Earlier this year, you received information about OptumRx, the Fund's new prescription drug network provider. This change will save Local 150 members $50 million over a three-year period! The prescription program rules will remain the same, and CVS is still the preferred retail pharmacy. Be sure to give your new vendor card, containing OptumRx's billing information, to your pharmacy when obtaining prescriptions on or after January 1, 2019. You have already been notified if you need to take any other action regarding the OptumRx transition.

My150 Enhancements

You've probably already experienced the convenience of using My150 to enroll for benefits, update your family and contact information, check your reported hours and pay your union dues. Starting January 14, you'll also be able to use My150 to designate a beneficiary for each applicable fringe benefit and set your PHI (Protected Health Information) PIN number—anytime, 24/7 through your computer, tablet or phone.

Starting April 1, 2019

Increased Family Supplemental Benefit

For all Marketplace health plan options, the Family Supplemental Benefit (FSB) will increase to $2,000. The FSB reimburses 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 (examples include eyeglasses, contacts or hearing aids). Increasing your FSB amount means you'll have more money to spend on health expenses not covered by your health plan!

Monthly Credit Cost Deductions and Retiree Subsidy for the 2019/2020 Plan Year

Due to medical and prescription drug cost increases, monthly credit cost deductions will increase for all Marketplace health plan options and coverage tiers for the upcoming Plan Year. See page 14 for the new credit cost deduction amounts.

However, the retiree subsidy for the upcoming Plan Year will decrease from 22.6% to 20%. This means your Credit Bank will receive an increased amount of monthly credits during the upcoming Plan Year, which will help to offset the increased monthly credit cost deductions. See page 4 for details on how monthly credits are calculated.

Need to Reset Your My150 Password?
For security purposes, if you have not logged into My150 recently, you may have to reset your password before you can enroll. Be sure to do this before the open enrollment period so you can enroll in the Marketplace easily!

Eligibility

Who Is Eligible

Hourly eligible members who work 300 hours within a rolling consecutive 12-month period are eligible for coverage through 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:

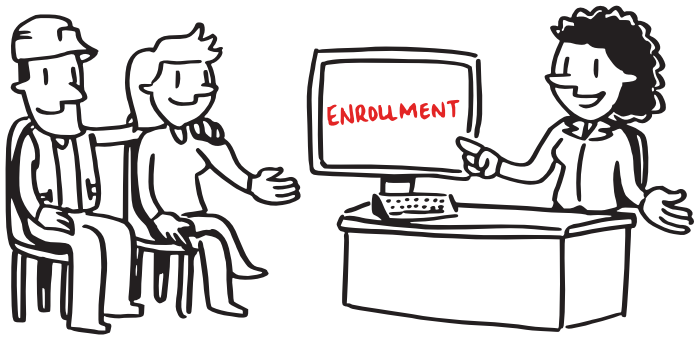
- Your legally married spouse.
- Your children up to the last day of the month that the child reaches age 26, including natural, adopted and stepchildren, regardless of student status, marital status or residence.
- Your handicapped children age 26 or older. While coverage normally ends on the last day 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 Eligibility Ends

Your eligibility will end if you:

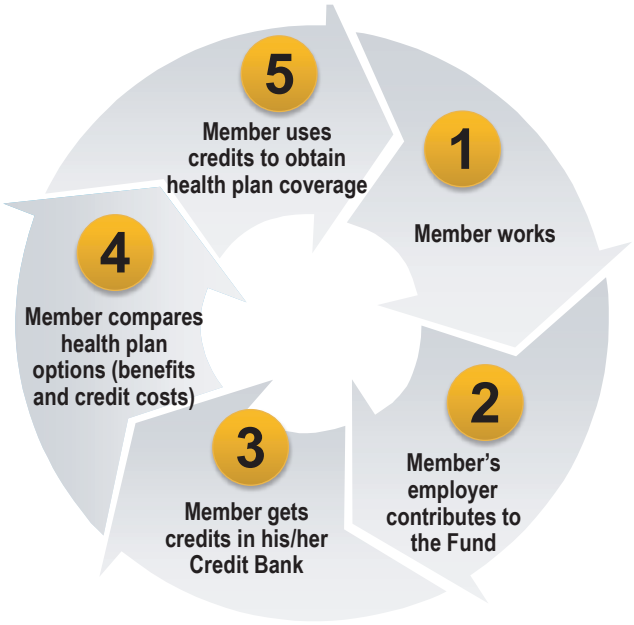
- Have a lapse in coverage.
- Use up your Credit Bank. This can happen if you select a costly plan and don't have enough work hours to cover the cost.
- Decide to buy coverage through the Public Health Exchange.
- Start working for a non-signatory contractor (i.e., non-union).
- Die. **Please note:** 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, if the RWP eligibility requirements are met. 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 Retirement Services at **(708) 937-0327**.

If you have a lapse in coverage and regain eligibility, you will be enrolled automatically in the Bronze PPO Plan based on your appropriate coverage tier.



How the MOE Health Plan Marketplace Works

- **For each hour you work**, your employer contributes to the Welfare Fund.
- **Employer contributions, in the form of "credits," are deposited into your Credit Bank.** The credits you receive are based on the number of hours you work and your negotiated hourly contribution rate minus the retiree subsidy. (See below for more information.)
- **Before you enroll,** you should compare your health plan options and consider the coverage and credit costs for each option.
- **You 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 one-time-only self-payment per eligibility period to deplete your Credit Bank, elect COBRA coverage, elect coverage under another group health plan or buy coverage under the Public Health Exchange. (See page 5 for more information.)



How Credits Are Added to Your Credit Bank

Your credits are 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, the Fund Office will receive employer contributions for the hours you work in November during December. These will be available in your Credit Bank for you to use in January. Credits will be subtracted from your Credit Bank for January 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

$15.65	Hourly Contribution Rate
- 3.13	Retiree Subsidy (20% x $15.65)*
12.52	Credits per Hour
x 145	Hours Worked per Month
1,815	**Monthly Credits Earned**

*Retiree subsidy is 20% effective April 1, 2019.

What Happens to Credits You Don't Use?

Your Credit Bank will change each month—credits will be added based on your hours worked and 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.

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

- **You do not make a one-time self-payment per eligibility period to deplete your Credit Bank,**
- **You elect COBRA or other group health coverage, or**
- **You buy coverage under the Public Health Exchange.**

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

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. However, please note: You will be enrolled automatically in the Bronze PPO Plan based on your appropriate coverage tier.

Options for Continuing Medical Coverage

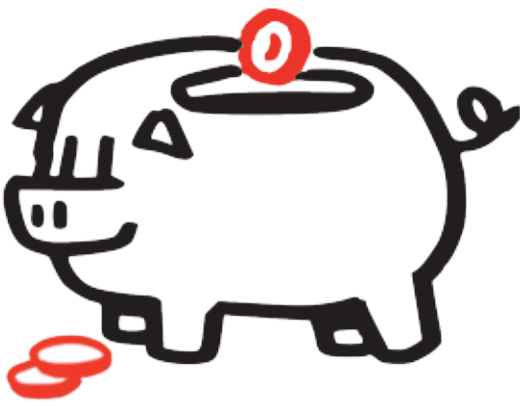
If you don't work enough hours and your Credit Bank becomes too low for you to continue eligibility for MOE Health Plan Marketplace coverage, you have the following options:

- **Make a self-payment.** 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 payment amount and due date. This one-time self-payment is to zero out your current Credit Bank and fill in the shortage between your Credit Bank and your monthly credit cost deduction.

EXAMPLE

1,719	Monthly Credit Cost for Plan A PPO Family Coverage
- 800	Credits Remaining in Credit Bank
$919	**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 lower coverage tier and/or lower credit cost health plan 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.



Your Coverage Tier Choices

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

- Member Only,
- Member + 1 (coverage for you and your spouse or you and one eligible dependent child), or
- 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 14 for Health Plan Option Monthly Credit Costs.)

	Type of Plan	How You Pay Your Share of Expenses	Provider Network*	Dental, Life, AD&D, and Disability Coverage
Plan A PPO	Preferred Provider Organization	Pay deductible then pay coinsurance	Flexibility to go in- or out-of-network Save money when using in-network providers BlueCross BlueShield network	Included
Platinum PPO				
Gold PPO				
Silver PPO				
Bronze PPO				Not included
Operators' Health Center (OHC) Plan	Preferred Provider Organization with Customized Network	Pay nothing for in-network providers Pay significantly more for out-of-network providers	Must use OHC, MinuteClinic or Advocate Health Care providers; otherwise, you will pay significantly more for services except for life threatening emergencies	Included
EPO (Modified HMO)	Exclusive Provider Organization	No deductible; copays apply for most services	Must use EPO network providers; otherwise, plan will not pay benefits except for life threatening emergencies	

***All plans include the ATI Physical Therapy network.**

Understanding Your Health Plan Options

Here's a brief overview of the differences among your health plan options, followed by detailed comparison charts showing the coverage and credit costs for each plan. Keep in mind that the Welfare Fund is providing 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 14 and 15.

For all Plans, you'll pay nothing for covered outpatient physical and occupational therapy received at an ATI Physical Therapy facility, with no deductible and no copay/ coinsurance.

To find ATI physical and occupational therapy providers:

- **Go to www.ATIpt.com/MOE.**
  - **Click on Find a Location and enter your address or zip code.**

- **The OHC Plan uses a customized network, which includes the OHC, MinuteClinic and Advocate Health Care providers.** 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! Please note: If you choose to see an out-of-network provider, you will pay significantly more for services, except for a life threatening emergency. It is extremely important that you take an active role to ensure that your providers are in HST Care Connect (Advocate network for the OHC Plan). Follow the instructions in the box on page 8 to make sure your current health care providers are in the network. If you have questions regarding this health plan option, please contact a specialized OHC Plan Member Services Representative at **(708) 579-6668**.
- **The Plan A, Platinum, Gold, Silver and Bronze plans are Preferred Provider Organization (PPO) plans**. These plans use the same BlueCross BlueShield network of providers. The main difference between these options is the amount of deductible 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, accidental death and dismemberment, and disability benefits.** However, you can optimize coverage under this plan by taking advantage of the following:
  - Preventive services are covered at 100% if you see an in-network provider as mandated by the Affordable Care Act. Talk to your provider about these services.
  - Services covered by your plan are free if performed at the Operators' Health Center.
  - MinuteClinics, located in either CVS or Target retail stores, cover several services for free.
  - ATI Physical Therapy covers physical and occupational therapy services for free, if medically necessary.
  - EyeMed Advantage Network providers offer discounts on vision services.
  - The increased Family Supplemental Benefit (FSB) amount can help pay for dental expenses.
  - The Member Assistance Program through Employee Resource Systems, Inc. (ERS) offers up to five free counseling sessions per episode, with master-level clinicians.
- **The EPO is an Exclusive Provider Organization.** It has the same BlueCross BlueShield network as the PPO plans, but it works like a Health Maintenance Organization (HMO). You must use in-network providers; otherwise, the plan **will not** pay benefits, except for life threatening emergencies. There is no deductible and you pay for medical services through copays. However, unlike an HMO, you do not have to choose a primary care physician (PCP) or get referrals to see specialists, except for an acupuncturist. **If you are thinking about choosing the EPO, follow the instructions in the box on the next page to make sure your current health care providers are in the network.**

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

Plan A, Platinum, Gold, Silver, Bronze and EPO plans:

- Go to **www.bcbsil.com**.
  - Click on Find a Doctor or Hospital.
  - Login or continue as a guest and search for providers in the Participating Provider Organization (PPO) network.
  - Be sure to call your provider to receive verbal confirmation that **they are in the BCBS network**.

OHC Plan:

- Go to **moefunds.hstechnology.com**.
  - Click either Doctor or Facility/Location.
  - Enter your search criteria.
  - Be sure to call your provider to receive verbal confirmation that **they are in HST Care Connect** (Advocate network for the OHC Plan).

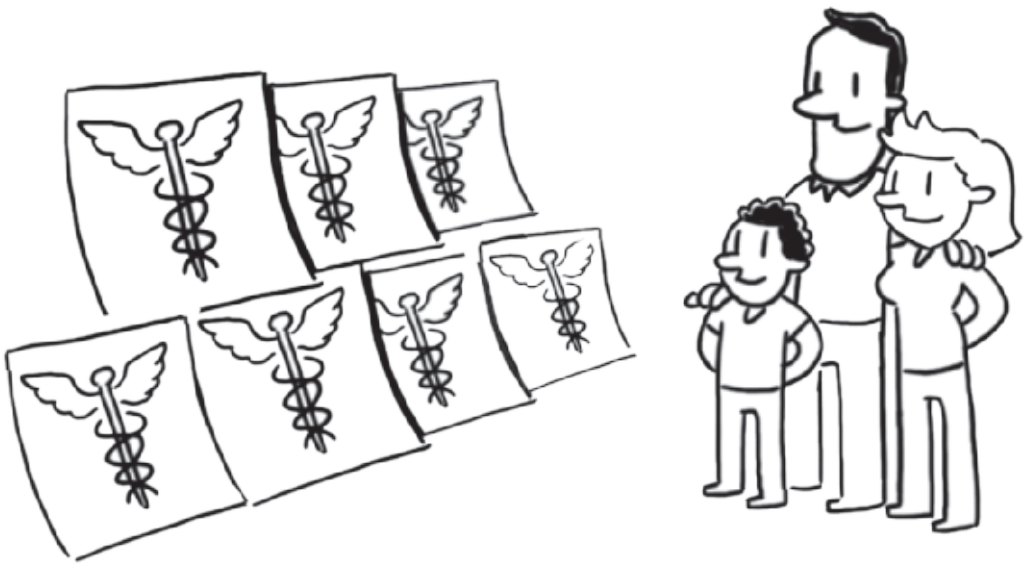
How the OHC Plan Works

The Operators' Health Center (OHC) Plan allows you and your covered family members to receive routine health care and urgent care at the AAAHC-accredited Operators' Health Center—located at the Countryside campus—at no cost to you.

For after-hours urgent care, you can visit a MinuteClinic in either CVS or Target retail stores. For medical services not provided at the Operators' Health Center, such as specialist visits or hospitalization, the OHC will refer you to an Advocate Health Care provider. Please note, the OHC can refer you to any chiropractor or acupuncturist, and the services will be covered at 100%. (Advocate currently does not have a network of chiropractors or acupuncturists.)

If you choose to see an out-of-network provider, you will pay significantly more for services, except for a life threatening emergency.

Regardless of the Marketplace health plan option you choose, we strongly encourage you to also call your provider or facility to make sure they are in the applicable network.



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.

NEW for 2019/2020 Plan Year! FSB amounts for all Marketplace plans will increase to $2,000 effective April 1, 2019.

FSB eligible 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 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. For details on ACA-mandated preventive care prescription drugs, visit www.moefunds.com. These lists may change annually.

Health Plan Option Comparison Chart

Services Offered	Operators' Health Center[1]		Plan A		Platinum	
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	None	$4,000	$300	$300	$500	$1,000
Family	None	$10,000	$700	$700	$1,250	$2,500
Medical Out-of-Pocket Maximum (applies to all services unless noted otherwise)						
Person	$2,500	$8,000	$2,500	$2,500	$3,500	$7,000
Family	$6,000	$16,000	$6,000	$6,000	$7,000	$14,000
Hospital Services	100%	50%	90%	80%	90%	80%
Emergency Room (if life threatening emergency; if not a true emergency, Hospital Services coinsurance and copays apply)	100%*		90%		$100 copay; balance considered at 90%	
Preventive Services (Not subject to deductible. See page 9 for details.)	100%	Not covered if available at OHC, MinuteClinic or Advocate provider; otherwise covered at 50%	100%	100%**	100%	No benefit
Physician Visits	100%	50%	90%	80%	90%	80%
Chiropractic Services (limited to maximum of $60 per visit and 24 spinal manipulations per Plan Year)	100% Advocate does not have network chiropractors at this time, so in- and out-of-network benefits are covered at 100%		90%	80%	90%	80%
Acupuncture (limited to maximum of $125 per visit and 12 treatments per Plan Year; **MD referral required**)	100% Advocate does not have network acupuncture providers at this time, so in- and out-of-network benefits are covered at 100%		90%	80%	90%	80%
Outpatient Restorative Speech Therapy	100%	50%	90%	80%	90%	80%
Outpatient Speech Therapy (25-visit limit)	100%	50%	90%	80%	90%	80%
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological for Dependent Children age 2 through age 18 (25-visit limit)	100%	50%	90%	80%	90%	80%
Outpatient Physical and Occupational Therapy* **	100%	50%	90%	80%	90%	80%
Outpatient Physical and Occupational Therapy for Congenital Neurological for Dependent Children age 2 through age 18* **	100%	50%	90%	80%	90%	80%
Lab and X-ray	100%	50%	90%	80%	90%	80%
Family Supplemental Benefit—per family per Plan Year	$2,000		$2,000		$2,000	

* Out-of-network services are not subject to the deductible if a life threatening emergency.

** 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, 2019.

*** Covered at 100% for all health plan options if medically necessary and received at an ATI Physical Therapy facility; not subject to the deductible.

Benefits Effective April 1, 2019 through March 31, 2020

	Gold		Silver		Bronze		EPO
	100%		100%		100%		100%
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**
	$1,000	$2,000	$2,000	$4,000	$5,000	$10,000	None
	$2,500	$5,000	$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
	80%	60%	70%	50%	100%		Inpatient: $250 copay per admission Outpatient: $20 copay per visit
	$100 copay; balance considered at 80%		$100 copay; balance considered at 70%		$100 copay per visit		$100 copay per visit
	100%	No benefit	100%	No benefit	100%	No benefit	100%
	80%	60%	70%	50%	100%		Primary: $20 copay per visit Specialist: $40 copay per visit
	80%	60%	70%	50%	100%		$20 copay per visit
	80%	60%	70%	50%	100%		$20 copay per visit
	80%	60%	70%	50%	100%		$20 copay per visit
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	80%	60%	70%	50%	100%		$20 copay per visit
	80%	60%	70%	50%	100%		$20 copay per visit
	80%	60%	70%	50%	100%		100%
	$2,000		$2,000		$2,000		$2,000

(1) In-network services are services available through the Operators' Health Clinic (OHC), CVS MinuteClinic (CVS/Target retail stores), ATI Physical Therapy or Advocate Health System providers. Most out-of-network services will be subject to HST's negotiated Value-Based Price (VBP) amount. Out-of-network benefits apply when services are sought outside of the OHC, MinuteClinic, ATI or Advocate Health System.

Services Offered	Operators' Health Center		Plan A		Platinum	
	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 $1,500 Under 19 no maximum		Age 19 and older $1,500 Under 19 no maximum		Age 19 and older $1,500 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	$40,000		$40,000		$40,000	
Dependent	$2,000		$2,000		$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	$400 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks					
PRESCRIPTION DRUG BENEFIT****						
OptumRx Network Retail Pharmacy***** (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	
OptumRx Mail Service Pharmacy (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	$12,000	$4,500	$6,500	$5,500	$11,000
Family	$10,000	$24,000	$10,000	$14,000	$11,000	$22,000

**** Specialty drugs require prior authorization.
***** Maximum of up to two 30-day fills (excluding specialty drugs) before the member is required to obtain a 90-day supply.

	Gold		Silver		Bronze		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
	$0		$0		No benefit		$0
	Age 19 and older $1,500 Under 19 no maximum		Age 19 and older $1,500 Under 19 no maximum		No benefit		Age 19 and older $1,500 Under 19 no maximum
	100%		100%		No benefit		100%
	70%		70%		No benefit		70%
	50% $2,000 lifetime maximum		50% $2,000 lifetime maximum		No benefit		50% $2,000 lifetime maximum
	$40,000		$40,000		No benefit		$40,000
	$2,000		$2,000		No benefit		$2,000
	$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident				No benefit		$1,000 OR $5,000 Based on loss $10,000 limit for 1 accident
	$400 per week up to 52 weeks Eligibility is credited with 40 hours/week for up to 17 weeks				No benefit		$400 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 $5 Preferred Brand $10 Non-Preferred Brand $25 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 $15 Preferred Brand $30 Non-Preferred Brand $45 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.

MONTHLY CREDIT COST DEDUCTIONS FOR THE 2019/2020 PLAN YEAR			
	Member Only	Member + 1	Family
Operators' Health Center Plan	1,107	1,284	1,461
Plan A PPO	1,302	1,510	1,719
Platinum PPO	1,241	1,441	1,640
EPO (Modified HMO)	1,224	1,420	1,617
Gold PPO	1,141	1,322	1,505
Silver PPO	1,073	1,244	1,416
Bronze PPO	626	1,028	1,170

Enrollment

When to Enroll

The MOE Health Plan Marketplace Plan Year starts April 1 and goes through March 31. Open enrollment for the April 1, 2019 through March 31, 2020 Plan Year will be held from January 14 through February 28, 2019.

Please note: For members who were automatically enrolled in the Bronze PPO Plan, open enrollment is extremely important since you now have the opportunity to select from seven different health plan options with varying monthly credit cost deductions. Please take the time to use the ***Health Plan Wizard*** and ***Affordability Calculator*** to determine which health plan option best meets your family's needs based on your current and projected work hours and including your Credit Bank reserve.

For those members who are first eligible February 1/March 1, 2019, you will be automatically placed in the Bronze PPO Plan for the remainder of the 2018/2019 Plan Year. If you need to update your coverage tier from Member to Member + 1/Family coverage for the remainder of the 2018/2019 Plan Year, please submit the required documents listed on the Open Enrollment Checklist so that the Fund Office can validate these dependents as soon as possible. Once the Fund Office validates your dependents, you can change your coverage tier to Member + 1 or Family coverage for the remainder of the 2018/2019 Plan Year. You will also be required to choose a health plan option/coverage tier for the upcoming Plan Year: April 1, 2019 through March 31, 2020. Please follow the steps below to get started. If you have any questions, call the Fund Office at **(708) 579-6675**.

How to Enroll

Just like last year, you'll enroll for coverage through the My150 community website. Whether you use a laptop, tablet or mobile phone, you can access many of My150's features and enroll—anytime, from anywhere.

Here are the steps for Marketplace enrollment:

- Log in to your My150 account and review the My Health Plan tile on your home page. If you're not registered, click "Start Registration" and follow the prompts to create your account.
- You'll have two options to assist you through the enrollment process:

1. To explore your health plan options, click the **"Start New Plan"** button and follow the same steps as last year. The ***Health Plan Wizard*** can help you compare up to three plans, and you can model your anticipated work hours using the ***Affordability Calculator***.
2. If you're happy with your current plan and are planning to keep it, click the **"Keep Current Plan"** button on your My Health Plan tile to start the re-enrollment process. This will allow you to review your plan coverage details and your coverage tier, then confirm your choice for the upcoming Plan Year.

In both cases, 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.

Before open enrollment, be sure you can log in to your My150 account. You may need to reset your password.

Getting Help With Your Decision

In addition to this enrollment packet and the online decision tools described on page 14, you also have the following resources:

- **Health Fair Presentation Materials** available at **www.moefunds.com**, including health plan comparison chart, important contact information, Health Fair presentation slides and FAQs.
- **District Office Meetings** during open enrollment. Fund Office staff will be available to meet with you and your spouse individually to help you enroll and transfer credits to your RMSP account, if applicable.
- **MOE Health Plan Marketplace Call Center,** staffed with experienced BlueCross BlueShield of Illinois navigators who can help you enroll and transfer credits to your RMSP account, if applicable. Call **(844) 693-1467** toll-free during open enrollment, from 8:00 a.m. to 7:00 p.m. CST, Monday through Friday and 8:00 a.m. to 12:00 p.m. CST, Saturday (including holidays). Translators will be available upon request.
- **Fund Office Marketplace Call-In Number** for answers to your Marketplace questions. Call **(708) 579-6675** for help on the phone or to schedule an appointment. If you are interested in the OHC Plan, you can speak to a specialized OHC Member Services Representative at **(708) 579-6668**.
- **Computer Kiosks** are available at each District Office and the Fund Office to help you register for My150 and/or enroll in the Marketplace.
- **Reminder Postcard** mailed to your home in mid-February.

Please read all of your mail and 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.**

How to Enroll if You Don't Have Computer Access

District Office meetings will be held during open enrollment (January 14 through February 28, 2019). Computers will be available at these meetings for members to use. Fund Office staff will be available to assist you with the enrollment process. If you need a paper enrollment form, please contact the Fund Office at (708) 579-6675.

Don't Forget

Your enrollment packet will include an Electronic Disclosure Consent Form. If you haven't already done so, 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.

MOE Health Plan Marketplace Open Enrollment: January 14 – February 28, 2019

Information: www.moefunds.com

Enrollment: www.My150.com

Call Center: (844) 693-1467

Fund Office Staff: (708) 579-6675

Specialized OHC Member Services Representative: (708) 579-6668

What Happens if You Do Not Enroll

We strongly encourage you to enroll by February 28, 2019. If you do not enroll by this deadline, you and your currently enrolled family members will be enrolled automatically in the health plan option and coverage tier you have now. If you are a new member and have not yet enrolled in the Marketplace, you will be enrolled in the Bronze PPO Plan based on the appropriate coverage tier.

But automatic enrollment may not be the right choice for you. Remember: If you don't make a change during this open enrollment, your coverage will stay in effect until March 31, 2020 (if you have enough credits in your Credit Bank), unless you have a life changing event or use the one-time option to downgrade to a lower credit cost plan (the downgrade option is not available to Bronze PPO Plan members). Don't miss your chance to make sure you have the best, most affordable health plan option for you and your family!

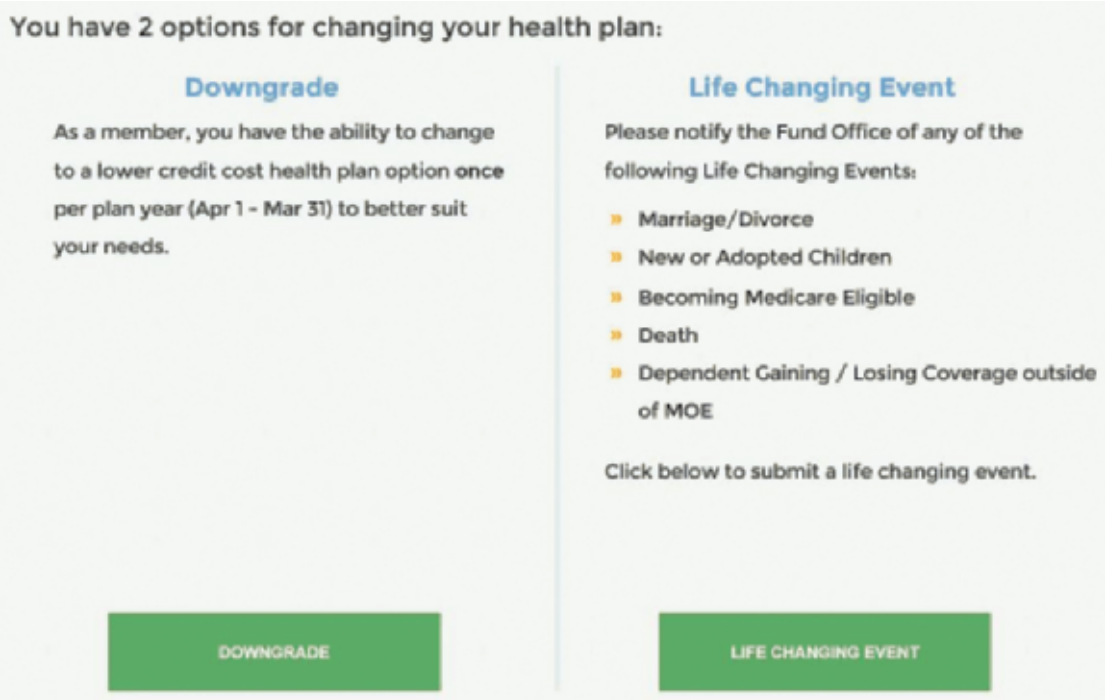
Changing Your Health Plan Option

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

- Once each Plan Year, you can downgrade your plan 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). The downgrade option is not available to Bronze PPO Plan members.
- 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 + 1 to Family coverage to cover both your spouse and newborn child).

If you change your coverage during the Plan Year, any amounts you've paid toward your annual deductibles, 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:



Getting Close to Retirement?

Option to Transfer Credits to Your RMSP Account

If you are retiring during the 2019/2020 Plan Year or will turn age 55 by March 31, 2020, you'll have the option to transfer credits from your Credit Bank to your Retiree Medical Savings Plan (RMSP) account only during open enrollment. This transfer will take place on March 31, 2019 and be reflected in your Credit Bank on April 1, 2019. Once you retire, you can use your RMSP account toward your Retiree Welfare Plan premiums, if you meet the eligibility requirements of the Retiree Welfare Plan, or other qualified medical expenses. And remember, your RMSP account will earn interest annually.

This is an important decision, so be sure to call the MOE Health Plan Marketplace Call Center at **(844) 693-1467** if you need help. Or you can schedule an appointment to attend one of the open enrollment events at select District Offices to meet with a navigator or a Retirement Services Representative to discuss your transfer options.

How Much You Can Transfer

My150 will automatically calculate the amount of credits available to transfer. You will be allowed to transfer any or all of the credits available in your Credit Bank, less credits necessary to continue coverage for your current health plan option and coverage tier through April 30, 2019.

Think Carefully about this Option

If you're eligible for this option, you need to think carefully about how many credits you will need to keep in your Credit Bank to ensure you can maintain your active coverage until you retire. If you're not retiring by the end of the 2020 Plan Year, be sure to think about how many credits you might need in future years. **Once you transfer credits to your RMSP account, these credits cannot be moved back to your Credit Bank in the future.** You'll receive a letter with more details before open enrollment. To learn more, schedule an individual meeting with Fund Office staff when they visit select District Offices during open enrollment.

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.

MIDWEST OPERATING ENGINEERS

HEALTH PLAN MARKETPLACE

January 2019