Open Enrollment: January 14 – February 28, 2019

YOUR MOE HEALTH PLAN FOR MUNICIPALITIES ENROLLMENT GUIDE

Great Benefits, Great Coverage—More Choice!

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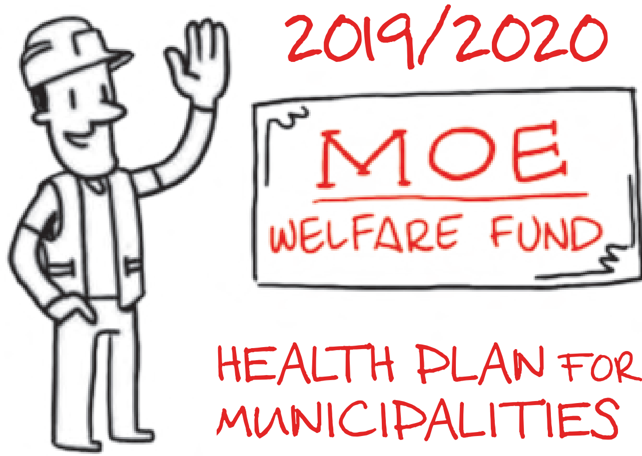
This guide provides a summary of benefits available to monthly eligible members of the Midwest Operating Engineers (MOE) Local 150 and their eligible dependents under the Midwest Operating Engineers Welfare Fund Health Plan, effective April 1, 2019. The information provided in this guide is of a general 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.

Welcome to Open Enrollment for the MOE Health Plan for Municipalities!



MOE Health Plan for Municipalities
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

Welcome to open enrollment for the MOE Health Plan for Municipalities, 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), you will have two health plan options to choose from. Both options provide excellent benefits and the coverage that you deserve and expect from MOE. You will also have a choice of three coverage tiers (Member Only, Member + 1, Family). It's important to think through your choices carefully to determine what coverage your family really needs.

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 Welfare Fund enhancements. For more information about the changes noted below, see the 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 health care coverage.

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

If you have not had the opportunity to experience the convenience of My150, enroll today! To register, visit www.My150.com and follow the instructions. For assistance, you can click on the ***Welcome Kit*** or you can call Technical Support at (888) 220-3599. Through My150, you will be able to enroll for benefits and update your family and contact information. 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.

Need to Reset Your My150 Password?

For security purposes, if you are registered on My150 but you have not logged in 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 easily!

Eligibility

Who Is Eligible

Initial Eligibility

You are eligible for coverage on the first day of the month in which your employment with your contributing employer begins, and for which your employer makes the required monthly contribution to the Fund on your behalf.

Continuing Eligibility

Continuing eligibility will be determined on a month-to-month basis as long as your employer makes the required monthly contribution to the Fund on your behalf.

Who Can Be Covered Under Your Health Plan Option

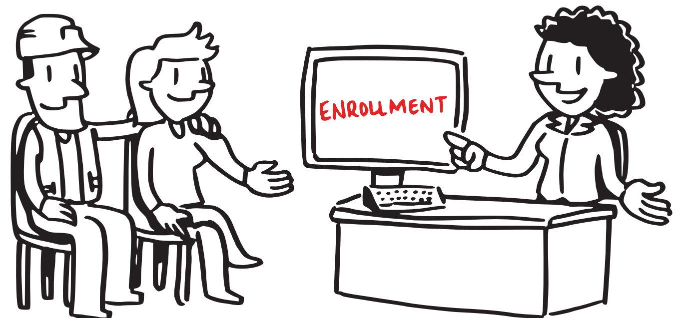
If you are eligible for coverage, and depending on the coverage tier you select, you can also enroll your eligible dependents. Eligible dependents include your spouse and children, as defined below:

- 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.

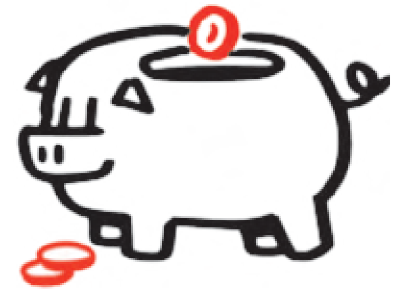
Continuing Medical Coverage After Termination of Employment

If you terminate employment with your employer and lose coverage under the MOE Health Plan for Municipalities, you have the following options:

- **Elect COBRA coverage.** You can elect COBRA coverage immediately after you lose eligibility. You can elect to continue coverage in the plan you enrolled in and select a lower coverage tier, if desired.
- **Elect coverage under another group health plan.** If you do not 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 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.



How the MOE Health Plan for Municipalities Works



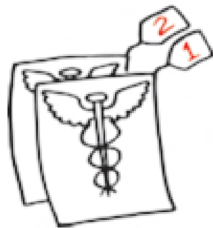
For each month you work, your employer contributes to the Welfare Fund.

- **Before you enroll,** you should compare your health plan options and determine which option will best meet your family's needs.

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

You have two health plan options to choose between, as shown in the overview chart below. At a minimum, as required under the Affordable Care Act, you must choose "Member Only" coverage under one of the offered health plan options.

	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
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	Included

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

Understanding Your Health Plan Options

Here's a brief overview of the differences between your health plan options, followed by a detailed comparison chart showing the coverage 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 personalized assistance, described on pages 9 and 10.

- **Plan A is a Preferred Provider Organization (PPO).** It uses the BlueCross BlueShield network of providers. 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. **If you are thinking about choosing the Plan A PPO, follow the instructions in the box below to make sure your current health care providers are in the network**.
- **The EPO is an Exclusive Provider Organization.** It has the same BlueCross BlueShield network as Plan A, but it works like a Health Maintenance Organization (HMO). You must use in-network providers; otherwise, the plan **will not** pay benefits, except for life threatening emergencies. There is no deductible 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 below to make sure your current health care providers are in the network.**

For both 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.**

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

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.**

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

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.

Reminder: To stretch your FSB dollars, be sure to use a provider in the EyeMed Advantage Network. To locate an EyeMed Advantage Network provider near you, log in to **www.eyemed.com** or call **(866) 393-3401**. EyeMed also offers hearing discounts through Amplifon: **(844) 526-5432**.

A Note about Preventive Care Coverage

The Affordable Care Act (ACA) requires that certain preventive care services are covered at 100% by both plans when you see an in-network provider.

Under Plan A, 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. Under the EPO, ACA-mandated preventive care services are not covered if you see an out-of-network provider.

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

Benefits Effective April 1, 2019 through March 31, 2020

Services Offered	Plan A PPO		EPO (modified HMO)
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%
MEDICAL BENEFIT			
	In-Network	**Out-of-Network**	**In-Network ONLY**
Medical Annual Deductible (applies to all services unless noted otherwise)			
Person	$300	$300	None
Family	$700	$700	None
Medical Out-of-Pocket Maximum (applies to all services unless noted otherwise)			
Person	$2,500	$2,500	$2,500
Family	$6,000	$6,000	$6,000
Hospital Services	90%	80%	Inpatient: $250 copay per admission Outpatient: $20 copay per visit
Emergency Room (if life-threatening emergency; if not a true emergency, Hospital Services coinsurance and copays apply)	90%		$100 copay per visit
Preventive Services (Not subject to deductible. See page 6 for details.)	100%	100%*	100%
Physician Visits	90%	80%	Primary: $20 copay per visit Specialist: $40 copay per visit
Chiropractic Services (limited to maximum of $60 per visit and 24 spinal manipulations per Plan Year)	90%	80%	$20 copay per visit
Acupuncture (limited to maximum of $125 per visit and 12 treatments per Plan Year; **MD referral required)**	90%	80%	$20 copay per visit
Outpatient Restorative Speech Therapy	90%	80%	$20 copay per visit
Outpatient Speech Therapy (25-visit limit)	90%	80%	$20 copay per visit
Outpatient Speech Therapy for Developmental Condition, including Congenital Neurological for Dependent Children age 2 through age 18 (25-visit limit)	90%	80%	$20 copay per visit
Outpatient Physical and Occupational Therapy**	90%	80%	$20 copay per visit
Outpatient Physical and Occupational Therapy for Congenital Neurological for Dependent Children age 2 through age 18**	90%	80%	$20 copay per visit
Lab and X-ray	90%	80%	100%
Family Supplemental Benefit— per family per Plan Year	$1,500		$1,500

* 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.

** Outpatient physical and occupational therapy is covered at 100% for both health plan options if medically necessary and received at an ATI Physical Therapy facility; not subject to the deductible.

Services Offered	Plan A PPO		EPO (modified HMO)
	In-Network	Out-of-Network	In-Network ONLY
PRESCRIPTION DRUG BENEFIT***			
OptumRx Network Retail Pharmacy**** (30-day supply)	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		
PRESCRIPTION OUT-OF-POCKET MAXIMUM			
Person	$2,000	$4,000	$2,000
Family	$4,000	$8,000	$3,200
COMBINED OUT-OF-POCKET MAXIMUM (INCLUDES BOTH MEDICAL AND PRESCRIPTIONS)			
Person	$4,500	$6,500	$4,500
Family	$10,000	$14,000	$9,200
DENTAL BENEFIT			
Deductible	$0		
Calendar Year Maximum	Age 19 and older $1,500; Under 19 no maximum		
Preventive	100%		
Basic & Restorative	70%		
Orthodontia	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	$400 per week for up to 30 days		

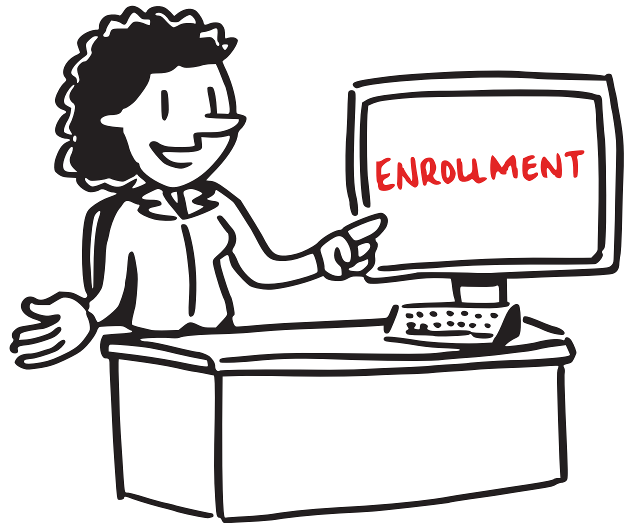
*** Specialty drugs require prior authorization.
**** Maximum of up to two 30-day fills (excluding specialty drugs) before the member is required to obtain a 90-day supply.

Optimizing Your Benefits Under BOTH Plans

Regardless of whether you choose Plan A or the EPO Plan, eligible members and dependents are entitled to receive the following benefits:

- 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. The OHC is now accepting appointments for DOT Physicals. You must make an appointment for DOT physicals. Please call **(708) 485-2273**.
- MinuteClinics, located in either CVS or Target retail stores, cover several services for free. Additionally, there are some cash pay services. Visit **http://moefunds.com/minuteclinic-partnership** for a list of MinuteClinic services. This list is updated annually.
- ATI Physical Therapy covers physical and occupational therapy services for free, if medically necessary.
- EyeMed Advantage Network providers offer discounts on vision services.
- The Member Assistance Program, through Employee Resource Systems, Inc. (ERS), offers up to five free counseling sessions, with master-level clinicians, per episode.

Enrollment



When to Enroll

The MOE Health Plan for Municipalities 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.

How to Enroll

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 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.
- To explore your health plan options, click the **"Start New Plan"** button and follow the steps.
- To add dependents, select the ***My Profile*** tab. Select the blue button: ***My Family***, then click the green button to "ADD NEW DEPENDENT". Once all dependents are added, submit your required documents **as soon as possible** so the Fund Office can validate your dependents as "eligible." Once your dependents are validated, you will receive an email through My150 verifying that they have been added to your plan and that your coverage tier has changed. **Please note:** you have until February 28, 2019 to modify your coverage tier after the update, if needed. If documents are received after this date, you will not be able to add your dependents until next year's open enrollment period, unless you have a life changing event, as described on page 11.
- It is imperative that the Fund Office receives copies of the following documentation in order to validate you dependents.
  - **Spouse:** County Marriage Certificate, 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/Step-Child:** County Birth Certificate, Social Security Card
  - **Adopted Child:** Adoption letter or record showing date of adoption signed and dated by a court official, County Birth Certificate, Social Security Card

  By validating your dependents, you will be able to change your coverage tier.

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, you also have the following resources:

- **Municipalities Health Fair Presentation Materials** available at www.moefunds.com, including a 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.
- **MOE Health Plan Marketplace Call Center,** staffed with experienced BlueCross BlueShield of Illinois navigators who can help you enroll. 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 Call-In Number** for answers to your questions. Call **(708) 579-6675** for help on the phone or to schedule an appointment.
- **Computer Kiosks** are available at each District Office and the Fund Office to help you register for My150 and/or enroll.
- **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 for Municipalities Open Enrollment: January 14 – February 28, 2019

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Call Center: (844) 693-1467

Fund Office Staff: (708) 579-6675

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 Plan A PPO with the coverage tier on record with the Fund Office.

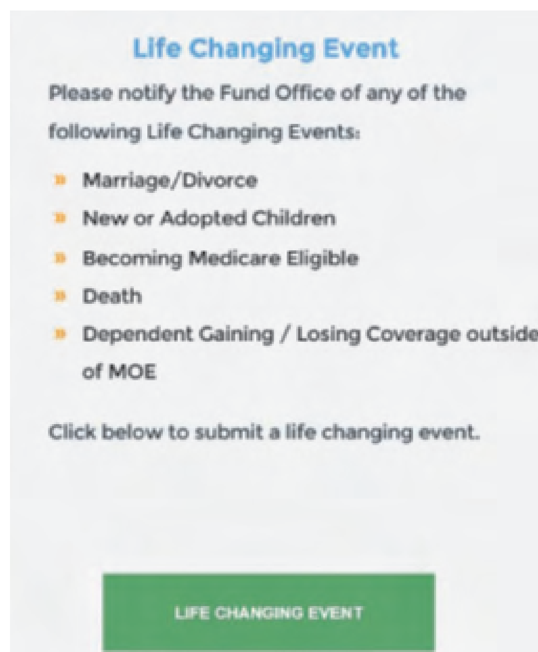
But automatic enrollment may not be the right choice for you. Remember: If you don't make a change during this open enrollment, your coverage will stay in effect until March 31, 2020, unless you have a life changing event. Don't miss your chance to make sure you have the best health plan option for you and your family!

Changing Your Health Plan Option

Outside of open enrollment, you can change your health plan option 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 out-of-pocket maximums and other Plan Year benefit limits will be transferred to the new plan, where applicable. Please note: Plan A PPO has a deductible and both plans have different 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 the below image. Or you can always call the Fund Office at **(708) 579-6675** for assistance.



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.

January 2019