NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

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Summary of Material Modifications

March, 2024

To: All Participants in the National Elevator Industry Health Benefit Plan, IUEC Local Unions, and Regional Directors

From: Robert O. Betts, Jr.
Executive Director for the Board of Trustees

This Summary of Material Modifications describes benefit improvements and other important clarifications and changes to the National Elevator Industry Health Benefit Plan. Specifically, this Summary of Material Modifications includes the following improvements, updates, and changes to your Plan:

- **Effective for Members who commence receiving Weekly Income Benefits on and after January 1, 2024, the Plan's Weekly Income Benefit increases to $715 (Weekly Income Benefit amounts for Members who reside in NY, NJ, or Hawaii may be different.)**
- **Effective March 1, 2024, the Plan's Life Insurance and Accidental Death and Dismemberment Benefits will be provided through policies with MetLife.**
- **Reminder to all Members: (1) That a Member must notify the Benefits Office of their divorce and (2) the ramifications for a Member's failure to do so.**
- **Clarifications regarding the Plan's precertification requirement.**
- **The Plan's Extended Benefit Rates for Laid-Off and Disabled Participants and Retiree Extended Benefit Rates (Effective July 1, 2024).**
- **The Plan's provider for case management, utilization review, precertification, and Care Navigation services recently changed their name from Kepro to Acentra Health.**

Page 7, effective for Members who commence receiving Weekly Income Benefits on and after January 1, 2024, revise the table headed "Weekly Income, Life and AD&D Benefits" to indicate that the Plan's Weekly Income Benefit is now $715 (previously $500) as follows:

WEEKLY INCOME, LIFE AND AD&D BENEFITS	
Weekly Income Benefit	$715 per week for up to 26 weeks*
Life Insurance	$40,000 benefit for your designated beneficiary
Accidental Death and Dismemberment (AD&D)	▪ $40,000 benefit for your beneficiary for your accidental death (in addition to the life insurance benefit above). ▪ $40,000 benefit for you for loss of both hands, both feet, or sight in both eyes. ▪ $40,000 benefit for you for loss of any combination of one foot, one hand, or sight in one eye. ▪ $20,000 benefit for you for loss of one hand or one foot. ▪ $20,000 benefit for you for the loss of sight in one eye.

* Note: Weekly Income Benefits may be different in NY, NJ and HI.

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- **Page 19, for purposes of clarification and to emphasize a Member's obligation to notify the Benefits Office of the Member's divorce, amend the "call out box" as follows:**

NOTIFY THE BENEFITS OFFICE!

- *Divorce, Child's loss of dependent status, entitlement to Medicare, retirement, death, or ceasing to be eligible for extended benefits: You or your family member must notify the Benefits Office immediately if the COBRA Qualifying Event is divorce, legal separation, Child's loss of dependent status, entitlement to Medicare, retirement, death, or your loss of extended benefits for any reason other than failure to submit timely extended benefit payments.*
- *Termination of employment or reduction in hours: You or your family member should also notify the Benefits Office when you lose coverage on account of your termination of employment or a reduction in hours to avoid confusion over the status of your health care in case your Employer does not provide prompt or correct information.*

***Remember:** You must reimburse the Plan for any claim the Plan pays in error because the Plan was not promptly notified of your or your dependent's loss of eligibility.*

- **Page 26, for purposes of clarification and to emphasize a Member's obligation to notify the Benefits Office of the Member's divorce, amend the provisions below the heading "IF YOU DIVORCE" as follows:**

IF YOU DIVORCE

Once you divorce, your Spouse is no longer eligible for benefits under this Plan; however, your Spouse may enroll in COBRA Continuation Coverage (see page 19).

- **If you divorce, you must notify the Benefits Office immediately.**
- **Once you divorce, you should promptly submit a new Enrollment Form to the Benefits Office. As your divorce is about to become final, promptly contact the Benefits Office or visit www.neibenefits.org to obtain an Enrollment Form, and as soon as your divorce becomes final, submit your updated Enrollment Form to the Benefits Office.**
- **You must provide the Benefits Office with a copy of your divorce decree.**
- **If you fail to promptly notify the Benefits Office of your divorce, you will be responsible for reimbursing the Plan for all charges the Plan erroneously pays on behalf of your former Spouse while your former Spouse was not eligible for coverage under this Plan. If you fail to reimburse the Plan for any claim the Plan pays in error, the Trustees may decide to recover those benefits by treating such benefits as an advance to you and deducting such amounts from benefits which become due to you or your eligible dependents until the entire amount of benefits erroneously paid is recovered. The Trustees may also act in accordance with the Plan's "Right to Recovery" provision (see below) to recover the amount paid in error.**
- **Your divorce will automatically revoke your Spouse as your designated beneficiary for all Plan purposes (such as the Plan's life insurance and accidental death and dismemberment benefits); accordingly, you must designate a new beneficiary on your updated Enrollment Form.**
- **If your former Spouse wants to purchase COBRA Continuation Coverage, they must contact the Benefits Office. Your Former Spouse may purchase COBRA and receive COBRA Coverage for up to a maximum of 36 months as long as the Benefits Office is informed of your divorce within 60 days of the day your divorce becomes final. For more information regarding COBRA rights, see page 19.**

- **Page 29, effective March 1, 2024, to reflect that the Plan's group life insurance policy is now through MetLife, amend the paragraph below the heading "Converting Your Life Insurance" as follows:**

Converting Your Life Insurance

If you leave covered employment, the Benefits Office will send you notice of your right to transfer your group life insurance to a policy through MetLife. To convert your insurance, you must apply to MetLife within 31 days after your life insurance terminates or 15 days after you receive notice of your right to convert from the Benefits Office, whichever is later. You must make the applicable premium payments to keep your new coverage in force.

- **Page 41, for purposes of clarification, the paragraph below the heading "Precertification" is revised as follows:**

Precertification

Precertification is required for:

- All surgeries performed in an inpatient, outpatient, or Ambulatory Surgical Center.
- All non-emergency hospital admissions (or within 48 hours of an emergency hospital admission).
- Genetic testing (other than state-mandated newborn screening).
- Pain Management.
- Home Health Care services.

Your provider must contact Acentra Health, the Plan's precertification administrator, at 1-800-634-4842 for approval. **Please note that if you do not obtain valid precertification for expenses that require precertification, and your provider is Out-of-Network, under no circumstances will the Plan cover any portion of those Out-of-Network claims.**

- **Page 63, effective for Members who commence receiving Weekly Income Benefits on and after January 1, 2024, revise the table below the heading "YOUR WEEKLY INCOME BENEFIT AT-A-GLANCE" to indicate that the Plan's Weekly Income Benefit has increased to $715 (previously $500) as follows:**

Weekly Income Benefit	$715 (May be different in NY, NJ and HI)
Maximum Payment Period	26 weeks
Waiting Period—Injury	0 days
Waiting Period—Illness	7 days

- **Page 65, effective March 1, 2024, to reflect that the Plan's group life insurance policy is now through MetLife, amend the introductory paragraph of the section "Life Insurance" as follows:**

You want your family to be protected in case something happens to you. The Health Benefit Plan, through its insurance policy with MetLife, provides a life insurance benefit of $40,000, payable to your beneficiary, in the event of your death. Eligibility for life insurance benefits is determined in accordance with the Plan's eligibility rules.

- **Page 66, effective March 1, 2024, to reflect that the Plan's group life insurance policy is now through MetLife, amend the first paragraph below the heading "CONVERTING YOUR LIFE INSURANCE" as follows:**

If your life insurance coverage ends because you stop working in covered employment, you may convert your group life insurance without a medical examination or other evidence of insurability to any individual life insurance policy issued by MetLife (other than term insurance). To convert your life insurance coverage, apply to MetLife within 31 days after your insurance terminates or, if later, 15 days after you receive notice of your right to convert, and pay the required premiums. The amount of your individual policy may not be more than $40,000, minus any amount you become eligible for under any other group plan within 31 days if you become employed and are eligible for life insurance through MetLife.

- **Page 67, effective March 1, 2024, to reflect that the Plan's Accidental Death and Dismemberment Benefit is now through a policy with MetLife, amend the introductory paragraph of the section "Accidental Death and Dismemberment Insurance" as follows:**

If you become injured and suffer a loss due to an accident, you (or in the case of your death, your beneficiary) may be eligible to receive a lump-sum payment through the Plan's accidental death and dismemberment (AD&D) benefit. Like its life insurance benefit, the Plan's AD&D benefit is provided through the Plan's insurance policy with MetLife.

- **Page 67, effective March 1, 2024, to reflect that the Plan's Accidental Death and Dismemberment Benefit is now through a policy with MetLife, amend the last paragraph of page 67 as follows:**

The AD&D benefit is provided by MetLife. MetLife is solely responsible for determining if a loss is caused by an accident as defined in this Plan's insurance policy with MetLife. Appeals to the Trustees on issues related to whether the loss is covered by the AD&D policy will be forwarded to MetLife for final decision.

➢ **Page 73, for purposes of clarification and to emphasize a Member's obligation to notify the Benefits Office of the Member's divorce or other events that result in the Member's or their dependent's loss of coverage under the Plan, prior to the heading "OTHER PARTY LIABILITY CLAIMS" add the following provision:**

PLAN'S RIGHT TO RECOVER PAYMENTS MADE IN ERROR

Payments Made Due to Failure to Update Enrollment Status, Etc.

You must report to the Benefits Office important events such as your divorce, loss of custody, loss of eligible dependent status, and any other event that impacts the eligibility of you or your dependent(s). You must reimburse the Plan for any claim the Plan paid in error because you failed to: (1) report to the Benefits Office any of the previously described events; (2) update your enrollment status; or (3) update the status of your dependents.

Fraud and Misrepresentation

If a fraudulent claim is submitted on a Member's behalf or a Member's dependent's behalf, benefits will be denied, and the Member will be required to reimburse the Plan for any fraudulent claim paid by the Plan in error. For purposes of this provision, a claim submitted by or on behalf of a former Member, a Member's former Spouse, or a former eligible dependent of a Member is a fraudulent claim if the Member, former Spouse, or former eligible dependent was not eligible for benefits at the time claims were incurred.

Recovery of Improper Payments

If the Plan pays a claim in error as described above or makes any payment in excess of the amount necessary at that time to satisfy the intent and provisions of the Plan, the improper amount paid by the Plan (overpayment) may be deducted from any benefits due to the Member and/or the Member's eligible dependents until the Plan is reimbursed for the full amount of the overpayment.

The Plan may take any other action it deems appropriate to recover any improperly paid amount against one or more of the following parties: (1) the recipient of the payment; (2) the Participant or former Participant with respect to whom the payment was made; and (3) any other person, organization, or entity. The Member will be liable to the Plan for all of its expenses, including attorneys' fees, related to the cost of collecting any improperly paid amount.

Failure to Provide Information to the Plan upon Request and Misrepresentations to the Plan in Response to Information Requests

In order for the Trustees to ensure that the Plan is paying claims in accordance with the Plan's governing documents, the Benefits Office may from time to time request that you provide information that verifies your and your dependents' ongoing eligibility for any benefits under the Plan. Your failure to timely respond to the Benefits Office's requests for such information may result in the Plan suspending the payment of claims on your or your dependents' behalf. Providing inaccurate or misleading information to the Benefits Office in response to the Benefits Office's request for information is an intentional misrepresentation, and in the event the Plan makes any erroneous payment in reliance on such misleading information, the Plan will exercise its right to recovery of such overpayment in accordance with the provisions of this section.

➢ **Page 85, effective March 1, 2024, to reflect that the Plan's Life Insurance and Accidental Death and Dismemberment benefits are now through a policy with MetLife, replace the chart "Organizations through which Plan Benefits are Provided" with the following:**

Organizations through which Plan Benefits Are Provided

- **Medical Care:** Blue Cross Blue Shield BlueCard PPO Program
- **Mental Health and Substance Use Disorder:** Blue Cross Blue Shield BlueCard PPO Program
- **Prescription Drugs:** Express Scripts
- **Vision Care:** EyeMed Vision Care
- **Dental Care:** The Guardian Insurance Company (Optional PPO)
- **Hearing Care:** Audio*NET*America
- **Life Insurance and Accidental Death and Dismemberment Benefit:** MetLife

➢ **Please note that recently, the Plan's provider of case management, utilization review, precertification, and Care Navigation services changed their name from Kepro to Acentra Health.**

- **For purposes of clarification, Page 6 of the July 2022 Summary of Material Modification is amended by revising the text beneath the heading "Prior Authorization" as follows:**

Prior Authorization

Prior Authorization (or precertification) is required for all medical/surgical and mental health or substance use disorder inpatient admissions and for certain inpatient treatments to ensure the care you receive is consistent with quality-of-care standards. For more information regarding the types of Behavioral Health services that need prior authorization, see the table on page 3 of this SMM (MENTAL HEALTH TREATMENT BENEFITS) and the table on page 4 of this SMM (SUBSTANCE USE DISORDER TREATMENT BENEFITS).

Acentra Health's precertification phone number is 800-634-4832. If you or a family member is admitted to a treatment facility or hospital, let your provider know that the Acentra Health precertification information is on your Blue Cross Blue Shield medical ID card. They can work with Acentra Health to make sure your inpatient treatment is certified. **Please note that if you do not obtain Prior Authorization for a medical/surgical or mental health or substance use disorder inpatient admission or any inpatient treatment that requires Prior Authorization and any such inpatient admission or inpatient treatment is Out-of-Network, the Plan will not cover any portion of those Out-of-Networks claims.**

Regarding the Plan's Notice of Privacy Practices

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require health plans, such as the NEI Health Benefit Plan, to protect the confidentiality of your protected health information (PHI). PHI is defined under HIPAA and generally includes individually identifiable health information created or received by the Plan.

The NEI Health Benefit Plan will not use or disclose your PHI except as is necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law, or as otherwise authorized by you. In addition, the Plan requires business associates that create or receive PHI on behalf of the Plan to observe the privacy rules with respect to such PHI.

You have certain rights under the privacy rules with respect to your PHI, including the right to see and copy the information, to receive an accounting of certain disclosures of the information and to amend the information in certain circumstances. You also have the right to file a complaint with the Plan or with the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Your rights with respect to your PHI are explained in greater detail in the NEI Health Benefit Plan's Notice of Privacy Practices. The Notice also describes how the Plan uses and discloses PHI.

If you would like to see (or obtain a copy of) the Plan's Notice of Privacy Practices, please contact Member Services at the Benefits Office or visit our website www.neibenefits.org.

Women's Health and Cancer Rights Act of 1998

If a participant receiving benefits under the NEI Health Benefit Plan elects breast reconstruction, in connection with a mastectomy, coverage will be provided under the Plan in a manner determined in consultation with the attending physician and the patient for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions regarding this Notice of Rights, please contact Member Services at the Benefits Office or the Plan Administrator.

ACA Nondiscrimination Notice

The National Elevator Industry Health Benefit Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The National Elevator Industry Health Benefit Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Medical Benefits provided under this Plan are afforded without regard to an individual's sex assigned at birth, gender identity, or gender.

When necessary, the National Elevator Industry Health Benefit Plan will provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The National Elevator Industry Health Benefit Plan also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages upon request. If you need these services, contact Robert Betts.

If you believe that the National Elevator Industry Health Benefit Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Robert Betts, Executive Director, National Elevator Industry Health Benefit Plan, 19 Campus Blvd., Suite 200, Newtown Square, PA 19073, 610-325-9100 extension 2200, 610-325-9028 (fax) or civilrightscoordinator@neibenefits.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Robert Betts, Executive Director, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-610-325-9100 ext. 2200.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-610-325-9100 ext. 2200.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-610-325-9100 ext. 2200.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-610-325-9100 ext. 2200.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-610-325-9100 ext. 2200.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-610-325-9100 ext. 2200. 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-610-325-9100 ext. 2200.

9100-325-610-1 اتصل برقم. بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا :ملحوظة ext. 2200.- هاتف الصم والبكم:.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-610-325-9100 ext. 2200.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-610-325-9100 ext. 2200..

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-610-325-9100 ext. 2200.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-610-325-9100 ext. 2200.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-610-325-9100 ext. 2200 पर कॉल करें।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń