

NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

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Summary of Material Modifications

March 2018

To: All Participants in the National Elevator Industry Health Benefit Plan, I.U.E.C. Locals and Regional Directors

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

This Summary of Material Modification describes:

- Improvements the Trustees have made to the Plan's Dental Benefits,
- Significant modifications and improvements to the Plan's Wellness and Preventive Services Benefits (formerly "Wellness Benefits"),
- Modifications to the Plan's Prescription Drug Benefits including a new opioid management program to address growing concerns relating to the use of prescription opioid pain medications for acute and chronic pain, and
- A new Paid Family Leave Benefit that complies with New York State's new Paid Family Leave Law (NYPFLL) (only applicable to Active Members who are eligible for paid family leave under the NYPFLL).

I. Dental Benefit Improvements - Effective January 1, 2018

- **Revise the provisions of the SPD under the heading "Dental Benefits" of the Schedule of Health Benefits section (page 9 of the SPD) as follows:**

DENTAL BENEFITS

You and your eligible dependents are eligible for dental benefits. The Plan's network dental provider is Guardian. The chart below shows the Plan's annual deductible for dental benefits, the Plan's applicable annual and Lifetime Maximums, and the amount of your coinsurance after you've met the annual deductible. If you visit an in-network (Guardian DentalGuard Preferred Select PPO) provider, you are only responsible for amounts applied to your deductible and coinsurance. You cannot be balance billed for amounts above the contracted rate.

If you visit an out-of-network provider for dental care, benefits are paid at the UCR Rate. You must pay any amount your out-of-network provider charges that exceeds the UCR Rate, in addition to any annual deductible and your coinsurance.

Summary of Material Modifications (continued)

DENTAL BENEFITS		
Annual Deductible (Does not apply to preventive and diagnostic services)	\$50 per person or \$100 per family	
Annual Maximum Amounts the Plan Will Pay	\$2,000 per Covered Individual for Type II and Type III services	
	\$2,000 per Covered Individual for dental implant procedures	
	No Annual Maximum for Covered Individuals ages 18 and under	
Lifetime Maximum Amount the Plan Will Pay for Orthodontia	Up to \$2,500 per Covered Individual. Lifetime Maximum does not apply to pediatric Medically Necessary Orthodontia.	
Lifetime Temporomandibular Joint Dysfunction Benefit	\$1,500 per Covered Individual	
	You Pay In-Network	You Pay Out-Of-Network
Exams *	\$0	100% of amount over UCR Rate
Cleanings *	\$0	100% of amount over UCR Rate
X-Rays *	\$0	100% of amount over UCR Rate
Fluoride *	\$0	100% of amount over UCR Rate
Sealants *	\$0	100% of amount over UCR Rate
Fillings	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Oral Surgery	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Periodontics	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Denture Repairs	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Crowns & Inlays	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Full or Partial Dentures or Bridges	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Implants	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Braces (Orthodontics)	Up to \$2,500 paid in installment payments every 90 days for up to two years while receiving active treatment (\$2,500 Lifetime Maximum does not apply to pediatric Medically Necessary Orthodontia)	

* Services do not apply to Annual Dental Maximum

Summary of Material Modifications (continued)

- Revise the provisions of the SPD under the heading “YOUR DENTAL BENEFITS AT-A-GLANCE” in the Dental Care section (page 50 of the SPD) as follows:

YOUR DENTAL BENEFITS AT-A-GLANCE

Annual Deductible	Per person—\$50; Per family—\$100			
Annual Maximums (excluding Orthodontia)	\$2,000 per Covered Individual for Type II and Type III services			
	\$2,000 per Covered Individual for dental implant procedures			
	No Annual Maximum for Covered Individuals ages 18 and under			
Lifetime Maximum Orthodontia Benefit	\$2,500			
Preventive and Diagnostic Services	No deductible applies			
Lifetime Temporomandibular Joint Dysfunction (TMJ) Benefit	\$1,500			
	THE PLAN PAYS (PPO DENTIST)	YOU PAY (PPO DENTIST)	THE PLAN PAYS (OUT-OF-NETWORK PROVIDER)	YOU PAY (OUT- OF NETWORK PROVIDER)
Type I Services (diagnostic and preventive)	100% of contracted rate	\$0	100% of the UCR Rate	The difference between the UCR Rate and the amount your provider charges
Type II Services (minor restorative)	80% of contracted rate	20% of the contracted rate; deductible applies	80% of the UCR Rate	20% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Type III Services (major restorative)	70% of contracted rate	30% of the contracted rate; deductible applies	70% of the UCR Rate	30% after deductible, plus the difference between the UCR Rate and the amount your provider charge
Dental Implant Procedures	70% of contracted rate	30% of the contracted rate; deductible applies	70% of the UCR Rate	30% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Orthodontia	Benefits are paid, up to the \$2,500 Lifetime Maximum benefit, in equal installments while in active treatment every 90 days for up to two years. Medically Necessary services for Covered Individuals age 18 and under are not subject to the Lifetime Maximum.			

- Revise the provisions of the SPD under the heading “COVERED DENTAL EXPENSES” in the Dental Care section (pages 52 and 53 of the SPD) as follows:

COVERED DENTAL EXPENSES

Covered dental expenses are the services or supplies listed on the following pages that are covered by the Plan. The service or supply must be necessary and given by a Dentist or Physician for the treatment of a Covered Expense.

The maximum amount payable by the Plan for Covered Expenses for Type II and Type III services (see below) is \$2,000 per Covered Individual per calendar year. The Plan applies a separate annual maximum of \$2,000 per Covered Individual per calendar year for Dental Implant Procedures. These annual maximums do not apply to Covered Individuals ages 18 and under. The Plan also applies a separate Lifetime Maximum of \$2,500 per Covered Individual for Orthodontia. The Orthodontia Lifetime Maximum does not apply to Medically Necessary Orthodontia for Covered Individuals who are age 18 and under. Precertification is required for Medically Necessary Orthodontia. See “Orthodontia” on page 53.

When options are available for a particular dental procedure, the Plan will cover the expense of the least costly professionally adequate procedure even if a more costly one is used.

Summary of Material Modifications (continued)

Expenses (excluding Orthodontia) are considered incurred as of the date the service is rendered or the supply is furnished, except:

- with respect to fixed bridgework, crowns, inlays, onlays or gold restorations, the service is considered incurred on the first date of preparation of the tooth or teeth involved;
- with respect to full or partial dentures, the service is considered incurred on the date the impression was taken; and
- with respect to endodontics, the service is considered incurred on the date the tooth was opened for root canal therapy.

Preventive and Diagnostic Services (Type I)

- Cleaning and scaling of teeth (prophylaxis) twice a calendar year.
- Periodontal cleaning of teeth twice a calendar year.
- Emergency treatment (palliative) for dental pain when no other treatment except x-rays are provided.
- Fluoride treatment or application to a dependent Child's teeth once in a calendar year.
- Oral exams twice a calendar year.
- Space maintainers and their fittings.
- X-rays needed to diagnose a dental problem or to check the progress of treatment. Examples of Type I x-rays are:
 - Bitewing x-rays twice a calendar year.
 - Full-Mouth x-rays and panoramic x-rays once every three years to the day.
 - Single tooth (periapical) x-rays.
- Dental sealants are covered once every five years for permanent molars only.

Restorative Services (Type II)

- Cutting procedures in the mouth.
- Extractions or oral surgery.
- Fillings consisting of composite, plastic, porcelain, silicate, or silver (amalgam).
- General anesthesia for oral surgery or treatment of fractures and dislocations.
- Relining or rebasing dentures that are performed at least six months after the denture was originally installed. (Charges for relining or rebasing performed less than six months after the denture was originally installed are usually covered in the cost of the denture.)
- Repairs to bridges, crowns, dentures and inlays that are performed at least six months after the item was originally installed. (Charges for repairs less than six months after the item was originally installed are usually covered in the cost of the item.)
- Root canal work (endodontia).
- Treatment of the gums (periodontia).

Major Services (Type III)

- Adding teeth to fixed bridgework or partial dentures to replace missing natural teeth.
- Crowns to repair a tooth that is damaged by decay, injury, or to replace a crown that was installed at least five years before and cannot be repaired.
- Full or partial dentures to replace missing or natural teeth, or when the prior denture was installed at least five years before and cannot be repaired. The maximum covered expense for a permanent denture when replacing a temporary denture is limited to the charge for the permanent denture.
- Inlays to repair a tooth that is damaged by decay, injury, or when the prior inlay was installed at least five years before and cannot be repaired.

Dental Implant Procedures

- Dental implants, when necessary, but not more often than once every five years.

The SPD continues with "Temporomandibular Joint Dysfunction (TMJ)" on page 53 of the SPD booklet.

II. Wellness and Preventive Services Benefits – Effective January 1, 2018

Since the passage of the Affordable Care Act (ACA) in 2010, significant attention has been given to the study of preventive and wellness services. The ACA requires that new group health plans and non-grandfathered group health plans provide coverage of certain specified preventive services without cost sharing. As a grandfathered plan, the National Elevator Industry Health Benefit Plan is not required to provide these preventive services without cost sharing; nevertheless, for many years the Plan has covered a number of adult and child wellness and preventive services at 100% of a PPO provider's contracted rate.

The Trustees are pleased to announce that, similar to non-grandfathered group health plans, the Plan will now follow current guidelines issued by the United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), Bright Futures and the Centers for Disease Control and Prevention (CDC). Accordingly, the SPD is amended as follows:

Summary of Material Modifications (continued)

- Replace the section “Wellness Benefits” (pages 39 and 40 of the SPD) with the following:

Preventative Services

The Plan covers a comprehensive list of wellness and preventative services to keep you and your family health.

FAST FACTS:

- Covered wellness and preventive services are payable at 100% of the contracted rate when you visit a PPO provider. If you visit an out-of-network provider, benefits are payable at 75% of the UCR Rate or 100% of the UCR Rate if you are considered out-of-area.
- Covered wellness and preventive services for you and your eligible dependents are not subject to the Plan’s annual deductible if you use a BlueCross BlueShield BlueCard PPO Provider or if you are considered out-of-area.

PREVENTIVE / WELLNESS PROGRAM

Changes to the Plan’s Preventive / Wellness Program are designed so that the lineup of preventive and wellness services provided by the Plan closely follows current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), Bright Futures, and the Centers for Disease Control and Prevention (CDC). The following websites list the types of preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal) covered by the Plan:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>, with more details at:
<http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> and
<http://www.hrsa.gov/womensguidelines/>.

- In addition to wellness services listed on the websites above, the Plan will pay for these wellness services:
 - an annual wellness/physical exam for adults,
 - annual prostatic specific antigen (PSA) lab test for men age 40 and older,
 - glaucoma screening,
 - thyroid test,
 - complete blood count,
 - urinalysis, and
 - EKG.
- Certain additional preventive care expenses are payable for all covered females as listed on the government websites at <http://www.hrsa.gov/womensguidelines/> or <https://www.healthcare.gov/what-are-my-preventive-care-benefits> including but not limited to:
 - well woman office visits,
 - screening for gestational diabetes,
 - BRCA breast cancer gene test,
 - HPV testing at least every 3 years starting at age 30,
 - counseling on sexually transmitted infections,
 - annual HIV screening and counseling,
 - rental of breastfeeding equipment and necessary supplies after delivery with lactation support following delivery.
- Covered wellness and preventive services are payable at 100% of the contracted rate when you visit a PPO provider. If you visit an out-of-network provider, benefits are payable at 75% of the UCR Rate or 100% of the UCR Rate if you are considered out-of-area.
- Covered wellness and preventive services for you and your eligible dependents are not subject to the Plan’s annual deductible if you use a BlueCross BlueShield BlueCard PPO Provider or if you are considered out-of-area.
- When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. Preventive services are those services performed for screening purposes when the Covered Individual does not have active signs or symptoms of a condition. Preventive services do not include diagnostic tests performed because the Covered Individual has a condition or an active symptom of a condition. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive.
- If a USPSTF/HRSA/AAP/Bright Futures/CDC preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.
- Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the claims administrator with a diagnosis code other than “wellness,” claims will be processed under the Plan’s usual deductible/copyay/coinsurance.

Summary of Material Modifications (continued)

- Services not covered under the Plan's Wellness / Preventive Program may be covered only as provided under another section of the SPD. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles, Coinsurance or Copayments, and all other Plan provisions.
- If there is no network provider who can provide the wellness service, then the Plan will cover the service when performed by an out-of-network provider without cost-sharing.
- Certain over-the-counter (OTC) drugs are payable without cost-sharing in compliance with USPSTF/HRSA/AAP/Bright Futures/CDC preventive service recommendations. See "What's Covered" in the Prescription Drug section of the SPD for more information.

The SPD continues with "DIABETES SELF-MANAGEMENT TRAINING PROGRAM" on page 40 of the booklet.

- Revise "YOUR PRESCRIPTION DRUG BENEFITS AT-A-GLANCE" in the Prescription Drugs section (page 46 of the SPD) as follows:

YOUR PRESCRIPTION DRUG BENEFITS AT-A-GLANCE

	PREVENTATIVE CARE	GENERIC	PREFERRED BRAND-NAME	NON PREFERRED BRAND-NAME	SUPPLY	REFILLS
Retail Pharmacy	\$0 Copayment	20% of cost, minimum \$5 Copayment	20% of cost, minimum \$15 Copayment*	20% of cost, minimum \$30 Copayment*	up to 30-day supply	up to two refills
Home Delivery	\$0 Copayment	\$10 Copayment	\$30 Copayment*	\$50 Copayment*	up to 90-day supply	Up to three refills

*Subject to the Plan's Generic Drug Incentive Program (see below).

NOTE: Retirees whose pensions became effective on or before January 1, 1984 are eligible for Prescription Drug benefits as follows, subject to the Plan's Generic Drug Incentive Program (see below): \$5 Copayment for generic drugs or \$10 Copayment for brand-name drugs for a 30-day supply from a retail pharmacy; or \$10 Copayment for generic drugs or \$20 Copayment for brand name drugs for a 90-day supply through the mail order program.

- Revise "WHAT'S COVERED" in the Prescription Drugs section (page 47 of the SPD) as follows:

WHAT'S COVERED

- Most Prescription Drugs that are prescribed by a Physician and are Medically Necessary for the care or treatment of an injury, illness or pregnancy.
- Erectile dysfunction drugs, for not more than eight pills per 30-day period at a retail pharmacy or 24 pills per 90-day period through home delivery for those Covered Individuals age 18 and older.
- Oral contraceptives, under both retail and home delivery programs.
- Depo-Provera and Lunelle injections, if purchased through retail or home delivery programs and then taken to a Physician for administration.
- Subject to certain limitations, the following Preventative Care OTC and Prescription Drugs are covered at no cost in their generic forms:
 - Low dose aspirin
 - Preventative breast cancer drugs
 - Fluoride for children up to the age of five years
 - Vitamin D
 - Folic Acid
 - Statins

III. Advanced Opioid Management Program – Effective March 1, 2018

Summary of Material Modifications (continued)

Opioid Crisis in America

According to the Centers for Disease Control and Prevention, overdose deaths involving prescription opioids were five times higher in 2016 than 1999, while sales of prescription opioids have quadrupled. From 1999 to 2016, more than 200,000 people died in the U.S. from overdoses related to prescription opioids, and in 2016, more than 46 people died every day from overdoses involving prescription opioids. Overdose is not the only risk related to prescription opioids; every day, over 1,000 people are treated in emergency rooms across the country for misusing prescription opioids, and as many as 1 in 4 people who receive prescription opioids long-term for non-cancer pain in primary care settings struggles with addiction.¹

The Board of Trustees is aware of the growing problem and hardship that prescription opioids can pose to Participants and their families. The Trustees previously implemented a "Fraud, Waste, and Abuse" program that identified people who obtained opioid prescriptions from multiple doctors and used multiple pharmacies to fill such prescriptions. Some who acted this way are now limited to one pharmacy for their prescription fills. Unfortunately, this type of program only affects people *after* they have developed a serious problem. The Trustees are now taking further action to help others from becoming addicted.

The Trustees have approved Express Scripts' Advanced Opioid Management Program. The program focuses on appropriate prescribing by doctors and ensuring that those patients who do benefit from opioids are able to obtain therapy that is safe and effective.²

- **Revise the SPD by adding a new section "ADVANCED OPIOID MANAGEMENT PROGRAM" following "FRAUD WASTE AND ABUSE PROGRAM" in the Prescription Drugs section (page 48 of the SPD) as follows:**

ADVANCED OPIOID MANAGEMENT PROGRAM

The Plan is enrolled in Express Scripts' Advanced Opioid Management Program. This program is designed to minimize early exposure, improve Participant education, and help prevent overuse, abuse and addiction. The program features:

- Morphine Equivalent Dose (MED) based quantity limit.

This quantity limit tracks MED for each opioid dispensed. Since not all opioids have the same potency, MED standardizes the value of opioid dosing so that different opioids can be compared on the same basis. A prescription opioid user will be subject to a Prior Authorization if he or she takes a cumulative dose of opioids greater than 200 MED per day over a rolling 30 day period.

- 7-day supply limit for first fills of short-acting opioids.

Covered Individuals without a history of filling an opioid prescription in the prior 130 days will be limited to a 7-day supply of opioids for the first prescription. While this 7-day supply opioid prescription will not require Prior Authorization, the Covered Individual will be limited to a 7-day supply limit (to the extent a state law has a more restrictive limit, the limit under state law will be followed). The 7-day supply limit applies to new opioid users and does not impact those Covered Individuals with a recent history of taking short-acting opioids.

- Prior Authorization requirement on all new long-acting opioids.

To ensure that patients are appropriately started on long-acting opioids, prescriptions for long-term opioids will be subject to Express Scripts' Prior Authorization if the Covered Individual has not had a prior fill for a long-acting opioid. This Prior Authorization program will not apply to Covered Individuals with a recent history of taking long-acting opioids.

In addition to the MED-based quantity limit, 7-day supply limit and Prior Authorization requirements described above, the Advanced Opioid Management Program also features:

- Proactive education for Covered Individuals new to opioid therapy through educational letters.
- Specific utilization trends of a Covered Individual will trigger an Express Scripts specialist Pharmacist to contact that Covered Individual. The Pharmacist will provide live clinical consultation education for the Covered Individual on potential risks and directions for safe use, proper storage, and proper disposal of opioid Prescription Drugs.

¹ Centers for Disease Control and Prevention (<http://www.cdc.gov>). National Center for Injury Prevention and Control (<http://www.cdc.gov/injury>), Division of Unintentional Injury Prevention.

² The Trustees are committed to ensuring that people who need long-term pain management connected with their existing medical condition (such as is sometimes the case with cancer patients) will continue to receive their Medically Necessary opioid containing drugs. It is expected that this new program will not interfere with such appropriate long-term use of opioids.

Summary of Material Modifications (continued)

- Safe opioid disposal initiative whereby Express Scripts ships opioid disposal bags directly to the homes of Covered Individuals who may have excess opioid medications following their initial fills.
- Daily prescriber interventions (Opioid Physician Care Alerts) provided through electronic medical record (EMR), fax or letter.

Express Scripts will not target oncology, hospice, or palliative care patients with the Advanced Opioid Management Program.

IV. Paid Family Leave Benefit (New York State ONLY) - Effective January 1, 2018

- **Revise the SPD by adding a new section “PAID FAMILY LEAVE BENEFIT (ACTIVE MEMBERS IN NEW YORK STATE ONLY)” at the end of the Weekly Income Benefit section (page 62 of the SPD) as follows:**

PAID FAMILY LEAVE BENEFIT (ACTIVE MEMBERS IN NEW YORK STATE ONLY)

In General

The Plan provides a paid family leave benefit that complies with New York State’s Paid Family Leave Law (NYPFL). This paid family leave benefit is only available to Active Members who are eligible for paid family leave under the NYPFL. This benefit is generally payable to Active Members who may need to take time off to:

- bond with a newly born, adopted or fostered child;
- care for a close relative with a serious health condition; or
- assist loved ones when a family member is deployed abroad on active military service.

The paid family leave benefit is 50% of your average weekly wage, capped at 50% of the New York State Average Weekly Wage, which for 2018 is \$652.96 per week.

Your paid family leave benefit will stop when any of the following occurs:

- You return to covered employment in the position you were in when you took your leave;
- The maximum payment period has been paid;
- You begin receiving a monthly Disability Retirement Pension Benefit or other pension benefit under the NEI Pension Plan, IUEC Officers and Employees Pension Plan or NEI Fund Office Employees Defined Benefit Pension Plan. All New York Paid Family Leave benefits you receive that cover periods in which you receive a pension benefit under these pension plans must be refunded in full to the Plan.
- You no longer qualify for benefits; or
- You die.

The New York State Paid Family Leave benefit provided by the Plan is scheduled to expire with respect to leaves beginning after December 31, 2018, unless it is renewed by the Board of Trustees. Contact your employer for information about New York Paid Family Leave benefits beginning after 2018.

For more information visit: <https://www.ny.gov/new-york-state-paid-family-leave/paid-family-leave-information-employees>

Requesting Paid Family Leave

Foreseeable Leave

- To request Paid Family Leave in the case of *foreseeable* leave (an expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of a family member, the planned medical treatment for a serious injury or illness of a covered service member, or other known military exigency), you must provide 30-days advance notice to your Employer prior to the first day of leave taken for the foreseeable event. If 30-days advance notice is not practicable, you must give notice as soon as practicable.
- The advance notice must include the anticipated timing and duration of the leave for continuous leave or intermittent leave. You should consult your Employer on whether your Employer requires that you provide notice as soon as practicable before each day of intermittent leave. You must advise your Employer and the Plan’s Paid Family Leave Benefit insurance provider of your schedule of intermittent leave (the insurer may withhold payment pending submission of a request for payment together with the dates of intermittent leave).
- You must advise your Employer of any change in the timing and/or duration of the leave.

Summary of Material Modifications (continued)

- If you fail to give your Employer 30-days advance notice of foreseeable leave, your Employer may request that the insurer delay the payment of benefits to you (known as partial denial) for a period of up to 30 days from when the notice was given.

Summary of Material Modifications (continued)

Unforeseeable Leave

- When your need for continuous leave is unforeseeable, you must provide notice to your Employer as soon as practicable.
- When your need for intermittent leave is unforeseeable, your Employer may require you to provide notice as soon as practicable before each day of intermittent leave. You must advise your Employer and the insurer of your schedule of intermittent leave. The insurer may withhold payment of benefits pending submission of your request for payment together with the dates of your intermittent leave.

Filing a Claim for Paid Family Leave Benefits.

If you are an Active Member covered by NYPFLL you may receive Paid Family Leave Benefits through Ullico by following these procedures:

- Complete a Request for Paid Family Leave, (the Form PFL-1 available on the New York State Paid Family Leave website <https://www.ny.gov/new-york-state-paid-family-leave/paid-family-leave-forms-employees>). A claim is considered complete when you submit to Ullico your completed PFL-1 *and* the supporting documentation for the type of leave you need to take.
- Before you submit your PFL-1 to Ullico, you must provide your Employer with the PFL-1 so your Employer can complete the employer information section of your PFL-1. Your Employer must complete this section and return the completed PFL-1 to you within 3 business days.
- You must complete the appropriate certifications or proof of claim documentation as instructed on the New York State Paid Family Leave website <https://www.ny.gov/new-york-state-paid-family-leave/paid-family-leave-forms-employees>. No benefits are required to be paid until your completed PFL-1 together with the necessary certifications or proof of claim documentation have been submitted to Ullico:

Ullico Claims Service Center
PO Box 49
Bloomfield, CT 06002
Phone: (888) 855-4261
Forms can also be faxed to: (860)769-6986

- You must submit the PFL-1 together with the necessary certifications or proof of claim documentation to Ullico before, or within 30 days after, your first day of leave. If you cannot get documentation to support your leave request within this timeframe, Ullico can deny your request, but you may reapply once you have received the supporting documentation for submitting your completed Paid Family Leave Request.
- If Ullico denies your Paid Family Leave Request for reasons other than your claim is incomplete or the certification or proof of claim documentation you submitted is insufficient, Ullico will provide you with a written Paid Family Leave denial that will state the reason for the denial, repeat any relevant information filed in your request and include any other information considered by Ullico in making its decision.
- If Ullico denies your Paid Family Leave Request and you disagree with Ullico's denial, you and Ullico should make every effort to informally resolve the denial of your Paid Family Leave Request. In the event an informal resolution is unsuccessful, you may seek formal resolution through arbitration. Any claim related dispute, including eligibility, benefit rate, and duration of family leave, is subject to arbitration pursuant to procedures established by the Chair of the New York State Workers' Compensation Board.

Payment of Paid Family Leave Benefits

The first payment of benefits shall be paid within 18 days of Ullico's receipt of your completed Paid Family Leave Request with the necessary certification or proof of claim documentation. Thereafter, Paid Family Leave benefits shall be paid biweekly. If you submit a completed Paid Family Leave Request more than 18 days before the occurrence of a qualifying event, Ullico will send payment to you within 5 days following the qualifying event.

For more information, visit: <https://www.ny.gov/new-york-state-paid-family-leave/paid-family-leave-frequently-asked-questions>.

- **Revise the SPD's Claims and Appeals Procedures to reference Paid Family Leave Benefit Claims. The following revisions are made to the Plan's recently updated Claims and Appeals Procedures, which were included in the Plan's February 2018**

Summary of Material Modifications (continued)

Summary of Material Modifications (2/2018 SMM) at pages 3 through 19.)

- Revise the chart on page 3 of the 2/2018 SMM as follows:

BCBS Medical (except Medicare Primary claims)	Your Local BCBS Plan
Medicare Secondary Claims	National Elevator Industry Health Benefit Plan P.O. Box 910 Newtown Square, PA 19073-0910
Non-BCBS Medical Claims	National Elevator Industry Health Benefit Plan P.O. Box 477 Newtown Square, PA 19073-0477
Dental Claims	National Elevator Industry Health Benefit Plan P.O. Box 475 Newtown Square, PA 19073-0475
Weekly Income Benefit and Non-EyeMed Vision Claims	National Elevator Industry Health Benefit Plan Claims P.O. Box 476 Newtown Square, PA 19073-0476
Life Insurance Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn: Life Insurance Claims Department
Accidental Death and Dismemberment Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn: AD&D Claims Department
Paid Family Leave Benefit Claims (New York State only)	Ullico Claims Service Center PO Box 49 Bloomfield, CT 06002 Forms can also be faxed to: (860) 769-6986

- After a new Section immediately preceding the Section Plan Policies, Determinations or Actions (2/2018 SMM at page 19) as follows:

CLAIMS AND APPEALS FOR PAID FAMILY LEAVE BENEFIT CLAIMS

To file a claim for Paid Family Leave Benefits you must follow the procedures set forth on pages 9 and 10 of this Summary of Material Modification. In accordance with rules established by the New York State Workers' Compensation Board, in the event Ullico denies your claim, you have the right to challenge that denial through neutral arbitration (See page 10 of this Summary of Material Modification).

Disclosure of Grandfather Status

The Board of Trustees of the National Elevator Industry Health Benefit Plan believes the Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the ACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the ACA, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at National Elevator Industry Health Benefit Plan Board of Trustees, c/o Robert O. Betts, Jr., 19 Campus Blvd, Suite 200, Newtown Square, PA 19073-3288, (800) 523-4702, Options 3, 5 then 2. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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.

1-610-325-9100 ext. 2200. - مقرب لصرتا. ن اجم اب لك رفاوتت ةيوغلل ا ءدع اسمل تامدخ نإف، ةغلل ركذا شحتت تنك اذا: ةظوح لم مكبل او مصلا فتاه.

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 pod numer 1-610-325-9100 ext. 2200.

National Elevator Industry Health Benefit Plan | Notices