

NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

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Summary of Material Modifications

December 2019

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 Trustee

This Summary of Material Modifications:

- Clarifies the Plan's initial eligibility rule;
- Describes updates and improvements to the Plan's coverage for Genetic Testing;
- Announces that the Plan: (1) has terminated Carewise Health and engaged Keystone Peer Review Organization, Inc. (KEPRO) to administer the Plan's Case Management and Utilization Review programs, and (2) has terminated the Plan's Disease Management program; and
- Clarifies the Plan's Coordination of Benefits rules with Medicare.

➤ Clarification of the Plan's Initial Eligibility Rules.

For purposes of clarification, the first two paragraphs below the heading "INITIAL ELIGIBILITY" on page 12 of the SPD are replaced with the following:

Generally, a Probationary Apprentice, as that term is defined in the collective bargaining agreement, will first be eligible for coverage under the Plan on the first day of the calendar month after the Probationary Apprentice has completed at least 100 hours of employment in each of six (6) 30-day periods as measured from the Probationary Apprentice's initial date of hire ("Industry Date"). The six (6) 30-day periods do not have to be consecutive. A Probationary Apprentice who fails to establish initial eligibility within 18 months of his or her Industry Date and who later reenters the industry as a Probationary Apprentice will have his or her initial eligibility determined based on his or her reentry Industry Date, and only those hours worked after such reentry date will be taken into account for purposes of determining whether the Probationary Apprentice has completed at least 100 hours of employment in each of six (6) 30-day periods.

If a Probationary Apprentice does not meet the hours requirement above but completes 1,000 hours within any 12 consecutive month period, he or she will be eligible for coverage on the first day of the calendar month following such 12 consecutive month period.

➤ Updates and Improvements to the Plan's Genetic Testing Benefit.

The Trustees have updated the Plan's genetic testing coverage guidelines to ensure that the Plan's guidelines are current and relevant based on the continued development and utilization of genetic testing, and effective September 17, 2019:

1. The Section "Genetic Testing" on page 39 of the SPD is amended as follows:

Genetic Testing Coverage

Coverage for the following genetic testing, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, and the associated genetic counseling, will be provided if Medically Necessary, provided that genetic testing other than state-mandated newborn screening requires precertification through the Plan's Utilization Review program (see page 41) to confirm Medical Necessity:

- state-mandated newborn screening tests for genetic disorders;
- testing for a genetic mutation in the BRCA1 and BRCA2 genes;
- covered pregnant women if the test or procedure (including fluid/tissue obtained as a result of amniocentesis, chronic villus sampling (CVS), and alphafetoprotein (AFP) analysis) is recommended by the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics;
- pre-implantation genetic diagnosis (where one or more cells are removed from an embryo and genetically analyzed to determine whether genetic abnormalities are present) in situations where the associated in vitro fertilization procedure is also covered by the Plan;
- tests to determine a Covered Individual's sensitivity to FDA-approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity, and tests to determine the effectiveness of an FDA-approved drug for treatment of a Covered Individual;
- carrier testing for certain genetic disorders (such as Cystic Fibrosis) for Covered Individuals in any of the following groups:
 - couples seeking prenatal care; or
 - couples who are planning a pregnancy; or
 - persons with a family history of the genetic disorder in question; or
 - persons with a 1st degree relative identified as a carrier; or
 - reproductive partners of persons with the genetic disorder in question;
- the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in Covered Individuals who meet all the following conditions:
 - the testing method is considered scientifically valid for identification of a genetically linked inheritable disease; and
 - the Covered Individual displays clinical features/symptoms of a genetically linked inheritable disease, or the Covered Individual is at direct risk (e.g., family history, first or second-degree relative) for the development of a genetically linked inheritable disease (pre-symptomatic); and
 - the results of the test will directly impact clinical decision-making, the clinical outcome or the treatment being delivered to the Covered Individual.

2. The 30th, 31st and 33rd bullets of the section "What's Not Covered" on page 70 of the SPD are amended as follows:

- Expenses for genetic tests, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as payable under the Genetic Testing Coverage heading under "Your Medical Benefits."
- Pre-implantation genetic diagnosis in situations where the associated in vitro fertilization procedure is not covered by the Plan. . .
- Genetic testing determined to be Experimental, investigational or not Medically Necessary.

GENETIC TESTING SERVICES

The Plan will provide Medically Necessary coverage for both pre-test and post-test genetic counseling for those Covered Individuals undergoing genetic testing if provided by a licensed Physician or a licensed or certified genetic counselor in conjunction with a genetic test that is covered by this Plan.

Genetic testing other than state-mandated newborn screening requires precertification through the Plan's Utilization Review program (see page 41).

➤ **Effective December 1, 2019: (1) Keystone Peer Review Organization, Inc. (KEPRO) will administer the Plan’s Case Management and Utilization Review programs, and (2) the Plan will terminate Carewise Health’s Disease Management program.**

The Trustees have terminated the Plan’s relationship with Carewise Health effective December 1, 2019. Effective December 1, 2019, KEPRO will administer the Plan’s Case Management and Utilization Review programs. The Plan’s Disease Management program previously administered by Carewise Health will terminate on December 1, 2019, while the Trustees continue to explore other effective solutions to disease management. To reflect these changes, the Plan’s SPD is amended as follows:

1. Effective December 1, 2019, the first table below the Section “Important Contact Information” on page 6 of the SPD is amended to indicate that KEPRO will administer the Plan’s Precertification program:

FOR INFORMATION ABOUT	CONTACT	PHONE NUMBER	WEBSITE
Precertification	KEPRO	1-800-634-4832	N/A

2. Effective December 1, 2019, The Section “Health Management Program” on page 43 of the SPD is amended as follows:

HEALTH MANAGEMENT PROGRAM

KEPRO administers the Plan’s Case Management and Utilization Review programs. The phone number for both programs is 1-800-634-4832.

- Case Management is a collaborative process structured to address catastrophic illness and complex health needs of patients. Case managers work with a patient’s medical care providers to coordinate services associated with treatment, discharge or return to home, and post care needs. In addition, case managers provide assistance with seeking specialized treatment, address the psychological needs of the patient and the patient’s family, and intervene when necessary to achieve desired medical outcomes for the patient. Complex medical cases that are addressed by case managers include end-stage renal disease, cancer, high-risk pregnancies, spinal cord injuries, stroke, and other conditions.
- Utilization Review is a process required by the Plan to review specific medical services to ensure the necessity of medical care and provide review of medical treatment pre- and post- care delivery. The process evaluates the efficiency, appropriateness, necessity, and efficacy of health care services. Utilization review is required for all inpatient hospital admissions, all surgeries, all Home Health Care services and all pain management services.

3. Effective December 1, 2019, the third paragraph below the Section heading “Nutritional Counseling” on page 40 of the SPD is amended as follows:

To be eligible for a Medically Necessary nutritional counseling benefit other than for the treatment of a behavioral health or substance use disorder condition, you must contact the Benefits Office prior to starting nutritional counseling services. The Benefits Office will ask you or your prescribing Physician to submit detailed medical records to corroborate this counseling. The Benefits Office will then submit these records to KEPRO for a Medical Necessity determination. If approved, participation in the Plan’s Case Management program is also required (see page 43).

4. Effective December 1, 2019, the Section “Precertification” on page 41 of the SPD is amended as follows:

Precertification

Precertification is required for all surgeries performed in an inpatient, outpatient or Ambulatory Surgical Center. Precertification is also required prior to all non-emergency hospital admissions and within 48 hours of an emergency hospital admission. Your provider must contact KEPRO, the Plan’s precertification administrator, at 1-800-634-4832 for approval. Surgical, hospital and related expenses, and expenses for genetic testing other than state-mandated newborn screening, submitted to the Plan without a valid precertification will not be covered. Precertification is also required for all pain management and Home Health Care services.

5. Effective December 1, 2019, the first paragraph below the Section heading “Organ Transplants” on page 51 of the SPD is amended as follows:

Benefits are payable for certain organ transplants when services are provided through a facility in the OptumHealth Complex Medical Conditions Transplant Network. Transplant facilities across the country have been screened and selected by the OptumHealth Complex Medical Conditions Transplant Network for their proficiency in performing heart, kidney, bone marrow, liver, lung, intestinal and pancreas transplants. To use the OptumHealth Complex Medical Conditions Transplant Network, you or your Physician must contact KEPRO, the Plan’s case management administrator, at 1-800-634-4832.

➤ Clarifications to the Plan's Coordination of Benefits Rules with Medicare.

When you or your eligible dependent becomes Medicare eligible, health care benefits provided by the Plan are coordinated with Medicare. The Plan's coordination rules with Medicare generally provide that whenever Medicare can be the primary coverage, you and/or your eligible dependent must enroll in Medicare Part B. Medicare's coordination rules (i.e., the rules that determine whether and when Medicare is primary or secondary) can be confusing. To help provide you with clarity regarding the Plan's coordination of benefit rules with Medicare, the Trustees have amended the SPD as follows:

1. The second bullet of "Fast Facts," below the chapter heading "Coverage for Retired Employees," on page 16 of the SPD is amended as follows:

- If you are a Retiree, once you're eligible for Medicare coverage, you are required to enroll in Medicare Part A and Part B. Under the Plan's coordination of benefits rules, Medicare becomes your Primary Plan once you are eligible to enroll in Medicare, and the Plan will pay benefits as your Secondary Plan. The amount you pay for coverage under the Plan will be reduced once you have enrolled in Medicare Part A and Part B.

2. The second paragraph below the section heading "YOUR COVERAGE" on page 16 of the SPD is replaced with the following:

As a Retiree, your coverage under this Plan will change and the monthly rate of your Retiree coverage will be reduced once you become eligible for Medicare Part A and Part B because once you become eligible for Medicare Part A and Part B, Medicare becomes your Primary Plan (i.e., Medicare pays first) and the Plan becomes your Secondary Plan, (i.e., the Plan supplements Medicare). Similarly, your eligible spouse's coverage will also change and the monthly rate of your Retiree coverage will be reduced once your eligible spouse becomes eligible for Medicare Part A and Part B because once he or she becomes eligible for Medicare Part A and Part B, Medicare becomes your spouse's Primary Plan and the Plan becomes his or her Secondary Plan. **Proof of coverage in Medicare Part A and Part B must be submitted to the Benefits Office within 90 days of the effective date of the coverage to receive the lower rate.**

3. The Section "IF YOU BECOME ELIGIBLE FOR MEDICARE" on page 31 of the SPD is amended as follows:

IF YOU BECOME ELIGIBLE FOR MEDICARE

If you, your covered Spouse, or dependents become eligible for Social Security Retirement benefits at age 65 (or earlier if due to End-Stage Renal Disease (ESRD) or disability), you, or your Spouse or dependent may also be eligible for Medicare. Medicare is the federally sponsored health care program consisting of hospital insurance (Part A) and supplementary medical insurance (Part B).

If you are a Medicare-eligible Retiree, your coverage under this Plan is designed to supplement the coverage you get through Medicare once you and/or your eligible dependents first become eligible to enroll in Medicare. Accordingly, your monthly costs for Retiree coverage will be reduced when you first become eligible to enroll in Medicare.

The Plan requires that you and/or your Spouse or other eligible dependents enroll in Medicare Part A and Part B as soon as you or they are eligible—generally three months before your 65th birthday, or in certain cases earlier (i.e., in the event of disability or ESRD)—in order to avoid a gap in coverage. If you leave employment and have not applied for Medicare Part B within three months from the date you turn 65, it may cost you more to enroll in Part B coverage and result in reduced benefits from the Plan that Medicare won't pay because you haven't enrolled on time.

For information on how your benefits are coordinated when you are eligible to enroll in Medicare Part A and Medicare Part B, see pages 16 and 71.

4. The Section "COORDINATION WITH MEDICARE" on page 71 of the SPD is amended as follows:

COORDINATION WITH MEDICARE

When you or your Spouse reach age 65, or when you or one of your eligible dependents become disabled, or when you or one of your eligible dependents suffer End-Stage Renal Disease (ESRD), you or your dependents may be eligible for Medicare. Therefore, you and/or your dependent must enroll in Medicare as soon as you are eligible for Medicare Part A and Medicare Part B. (See page 31.)

Medicare Part A covers inpatient Hospital care, and Medicare Part B covers Physician services, outpatient Hospital services and other medical supplies. While you generally do not have to pay for Medicare Part A, you do have to pay a monthly premium for Medicare Part B. Generally, to have adequate coverage, you and your spouse must sign up for both Part A and Part B when first eligible. The Plan will pay benefits as if you have both Medicare Part A and Part B, whether you are signed up for them or not.

All expenses that may be covered by this Plan should first be submitted to Medicare.

TO ENROLL IN MEDICARE

- Visit your local Social Security Office;
- Call 1-800-MEDICARE (1-800-633-4227); or
- Go to the Medicare website at www.medicare.gov.

The Plan's Medicare Coordination Rules

- Medicare is the Primary Plan (pays first) and the Plan is the Secondary Plan (pays second) for Retirees age 65 or older and their dependents age 65 and older.
- Medicare is the Primary Plan and the Plan is the Secondary Plan for Medicare-disabled former Employees or Retirees under age 65.
- Medicare is the Primary Plan and the Plan is the Secondary Plan for Medicare-disabled dependents of former Employees or Retirees.
- The Plan is the Primary Plan and Medicare is the Secondary Plan for Disabled Active Members, who are covered under the Plan other than through retiree coverage, extended benefits or COBRA.
- The Plan is the Primary Plan and Medicare is the Secondary Plan for Disabled dependents of Active Members who are covered under the Plan other than through retiree coverage, extended benefits or COBRA.
- Special Coordination Rule for ESRD: If you or your eligible dependent are eligible for Medicare because of ESRD, the Plan is the Primary Plan for the first 30 months after you become eligible to join Medicare, and Medicare is the Secondary Plan during this 30-month period. Medicare will be the Primary Plan and the Plan will be the Secondary Plan after this 30-month period.

If Medicare Part A Coverage is Not Free

If you are a Retiree (or an eligible dependent of a Retiree) who is eligible for Medicare because of your age, but you're ineligible for free Medicare Part A hospital coverage, this Plan will be your Primary Plan, provided that you are otherwise eligible for Plan benefits but are not eligible for Medicare Part A coverage because of your own work record or the work record of a Spouse or parent ("piggyback" coverage).

Social Security must send a letter to the Benefits Office indicating that free Medicare Part A coverage is not available to you before this Plan can pay otherwise covered health claims. The letter should be sent to: NEI Health Benefit Plan, c/o Director, Health Claims Administration, 19 Campus Blvd., Suite 200, Newtown Square, PA 19073.

Active Members Age 65 or Older

If you are an Active Member age 65 or older, the Plan is the Primary Plan for you and your family including a family member who qualifies for Medicare because of age or total disability. If you are an Active Member age 65 or older and your dependents are not eligible for Medicare, you will receive the same medical benefits as Active Members under age 65 and their eligible dependents. You must enroll for Medicare Part A and Part B as soon as you are eligible if you want Medicare to be the Secondary Payer. Failure to enroll in Medicare as soon as you are eligible may result in a delay in Medicare coverage at a later date.

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.

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.

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

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.