NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN
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Summary of Material Modifications

February 2018

- **New Option for Purchasing Maintenance Prescription Drugs.**

You now have the option to fill up to a 90-day supply of your maintenance Prescription Drugs at Walgreens retail pharmacies. The same Copayments as maintenance Prescription Drugs filled through Express Scripts' home delivery program will apply. Accordingly, the National Elevator Industry Health Benefit Plan Summary Plan Description (SPD) will be amended as follows:

1. The "Fast Facts" and "Your Prescription Drug Benefit" on page 46 of the SPD will now read as follows:

The Trustees contract with Express Scripts to serve as the Plan's Prescription Benefit Manager. You may purchase your Prescription Drugs at a retail pharmacy, or through the Plan's home delivery program.

FAST FACTS:

- You may purchase up to a 30-day supply of Prescription Drugs for a 20% Copayment at participating retail pharmacies. Minimum and maximum Copayments apply.
- The maximum Prescription Drug Copayment is $40 for retail and $50 for home delivery.
- You may purchase up to a 90-day supply of maintenance Prescription drugs for a $10 Copayment on most generic medications through Express Scripts' home delivery program or at Walgreens retail pharmacies.

YOUR PRESCRIPTION DRUG BENEFITS AT-A-GLANCE

	GENERIC	PREFERRED BRAND-NAME	NON-PREFERRED BRAND-NAME	SUPPLY	REFILS
Participating Retail Pharmacy	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*	$10 Copayment	$30 Copayment	$50 Copayment	Up to 90-day supply	Up to three refills
*You may also purchase up to a 90-day supply of maintenance Prescription drugs at Walgreens retail pharmacies and pay the same Copayment that you would pay through the home delivery program.					

NOTE: Retirees whose pensions became effective on or before January 1, 1984 are eligible for Prescription Drug benefits as follows: $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 or at Walgreens retail pharmacy.

2. On page 47, a new section, Maintenance Drug Program, will be added at the top of the page. The current section, Home Delivery Program is revised and will now be a subsection of the new Maintenance Drug Program section, followed by a new subsection, Maintenance Drugs through Walgreens Retail Pharmacy:

MAINTENANCE DRUGS

Maintenance drugs are those medications that you take on a regular basis, such as medicine for diabetes, high blood pressure or heart conditions. For your convenience, the Plan offers two options for purchasing maintenance Prescription Drugs: You can purchase maintenance Prescription Drugs through Express Scripts' home delivery program or at Walgreens retail pharmacies.

Home Delivery Program

Your Copayment for prescriptions through the mail is $10 for generic drugs, or $30 for preferred brand-name drugs and $50 for non-preferred brand-name drugs for up to a 90-day supply. Most Prescription Drugs can be ordered and sent directly to your home within 48 hours of receipt of your order. You can order refills 24 hours a day, seven days a week by visiting www.express-scripts.com.

What You Need To Do:

Home Delivery Program

- You may request a mail order form and envelopes by calling Express Scripts at 1-866-830-3890 or through the Express Scripts website www.express-scripts.com.
- Obtain a prescription from your doctor for up to a 90-day supply of the Prescription Drug plus up to three refills if necessary. The prescription must include:
- the patient's full name;
- the doctor's name, phone number and address;
- exact strength, quantity and dosage; and
- diagnosis, if required for that drug.
- Complete the form and mail it in with your prescription and required Copayment

Maintenance Drugs through Walgreens Retail Pharmacy

For your convenience, you may also fill your maintenance Prescription Drug at Walgreens retail pharmacies. Your Copayment for your 90-day supply will be the same as the Copayment you would pay if you filled your prescription through the home delivery program ($10 for generic drugs or $30 for preferred brand-name drugs and $50 for non-preferred brand-name drugs for up to a 90-day supply).

- **Updated Claims and Appeals Procedures.**

Due to modifications to how certain claims are processed and how appeals are adjudicated and due to recent federal regulations that govern how employee benefit plans process disability benefit claims, FILING YOUR CLAIMS (pages 73 – 82 of the SPD) will be replaced in its entirety with the following:

FILING YOUR CLAIMS

In general, when you use an in-network provider, the provider will file your claims for you. In all other cases, you must submit your claims either to your local Blue Cross Blue Shield Plan, the Benefits Office, Express Scripts or Beacon Health Options as applicable. Refer to chart below for the appropriate address.

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 19073-0901
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-Eye Med Vision Claims	National Elevator Industry Health Benefit Plan P.O. Box 476 Newtown Square, PA 19073-0476
Life Insurance and Accidental Death and Dismemberment Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn: Eligibility Unit
Prescription Drug Claims	Express Scripts Attn: Benefit Coverage Review Department, PO Box 66587 St Louis, MO 63166-6587
Mental Health and Substance Abuse Claims	Beacon Health Options Attn: Appeals / Grievances Coordinator PO Box 1850 Hicksville, NY 11802-1850

Claim forms and documentation that must be submitted to the National Elevator Industry Health Benefit Plan (the Benefits Office) should be submitted no later than 90 days after you have received medical service. Not furnishing proof within this period will not invalidate or reduce your claim if you can show that, although late, proof was furnished as soon as was reasonably possible.

Remember to keep a copy for your records

A claim will be deemed incomplete if you do not provide enough information for the Benefits Office to determine whether and to what extent your claim is covered by the Plan.

When a claim is pending, the Benefits Office may request additional medical opinions relating to you or your eligible dependents to ensure that the claim is processed in accordance with the terms of the Plan.

When processing your claim, the Benefits Office may require your provider's statement of the treatment and may request from your provider models, pre- and post-operative x-rays, and any such additional information the Benefits Office deems necessary to ensure that your claim is processed in accordance with the terms of the Plan.

Generally, all benefits will be processed and paid after receipt of the claim form and documentation, except that:

- Upon your request and subject to documentation of your eligibility for such benefits, Weekly Income Benefits will be paid each week during any period for which benefits are provided as described on page 7 of the SPD and any balance remaining unpaid at the termination of such period will be paid after receipt of documentation.
- Generally, any benefits payable on behalf of your dependents after your death, other than Life Insurance and Accidental Death and Disability Benefits, which will be paid as provided on pages 63 through 65 of the SPD) will be paid to your surviving Spouse, or at the option of the Trustees, directly to any hospital or person having a claim for services rendered to any legal guardian of your dependents.

WORKERS' COMPENSATION CLAIMS

The Plan does not pay benefits for work-related Illness or injury. Those claims are covered under workers' compensation laws. If your injury or Illness is work related, you should file a claim with your Employer and/or the appropriate workers' compensation carrier. However, during the period your workers' compensation claim is under review or your claim has been denied by the workers' compensation carrier, the Plan may provide temporary benefits. In order for such benefits to be considered, the Plan must receive a copy of your workers' compensation claim determination stating whether your claim is under review or has been denied as non-work related, and a fully executed Reimbursement Agreement (supplied by the Plan) from you stipulating that all benefits paid by the Plan for the work-related condition will be refunded, in full, to the Plan by the workers' compensation carrier and/or yourself. Submission of the Reimbursement Agreement and supporting documentation is subject to review and is not a guarantee that related benefits will be issued. The Plan's reimbursement rights for benefits it advances while your workers' compensation claim is under review are set forth on pages 71 – 72 of the SPD.

You must keep the Plan informed of the status of your workers' compensation claim and you must immediately notify the Plan regarding the outcome of the claim. If you do not notify the Plan of the outcome, the Plan will contact the workers' compensation carrier or other third party to learn the outcome.

The Plan will provide documentation of the amount of benefits paid on your behalf by the Plan to the workers' compensation carrier for reimbursement upon request of the carrier or the Employee.

If you received weekly income benefits from this Plan for the work-related condition, you are responsible for reimbursing those benefits to the Plan, as well as any health benefits you received, from any monies received from any source in connection with your claim or your own funds.

If the workers' compensation carrier denies liability, or your claim is determined by the workers' compensation agency not to be work related, and no settlement is reached otherwise, sufficient supporting documentation is needed so that the Plan may continue to pay benefits relating to the condition, if any are payable.

The Plan will directly contact the workers' compensation carrier, or other third party, to verify the denial and to verify that an appeal has or has not been filed. If an appeal has been filed, you must keep the Plan informed of the status and the outcome of the appeal. A periodic follow-up will be done by the Plan to obtain the outcome of this appeal.

If no workers' compensation claim is filed, and it appears to the Plan that the condition is work related, no benefits will be paid for the work-related injury or Illness.

MEDICARE CLAIMS

If you are eligible for Medicare, you should submit your medical claims to Medicare first and then submit a copy of the claim and the Explanation of Medicare Benefits (EOMB) to the Benefits Office for payment in the event Medicare has not paid the entire expense.

- Under Medicare Part A, a patient is eligible for 90 days of hospital care in a benefit period and may be eligible for as many as 150 days of hospital care in a benefit period if he/she draws on his/her lifetime reserve days.

- Under Medicare Part B, after satisfaction of an annual deductible, Medicare will pay participating providers 80% of the allowed charge for covered services.
- This Plan will not pay for charges for a private hospital room when Medicare coverage only provides for a semi-private room.

If a medical expense you incur is covered but Medicare does not pay the entire expense, you should submit your medical claim form and the Explanation of Medicare Benefits (EOMB) for payment to:

National Elevator Industry Health Benefit Plan
P.O. Box 910
Newtown Square, PA 19073-0910

CLAIMS AND APPEALS PROCEDURES FOR MOST HEALTH BENEFIT CLAIMS.

Overview

This section describes how the Plan makes an initial determination as to whether certain health benefits are covered by the Plan, how you and/or your authorized representative will be notified of such determinations, and how you may appeal the Plan's decision to deny your claim in whole or in part (called an "adverse benefit determination.") This section relates to:

- Most medical claims, wellness, extended care, organ transplant, dental care, vision care and hearing care claims.
- Any claim for *any* benefit under the Plan to the extent the claim involves a determination of whether an individual is a Covered Individual eligible for benefits under the Plan unless the eligibility determination relates to a disability.

Separate sections found on pages 11-16 of this Summary of Material Modification (SMM) describe claims and appeals procedures for:

- Prescription Drug claims.
- Mental Health and Substance Abuse claims.
- Claims involving disability determinations, *i.e.*, Weekly Income Benefit claims; eligibility for extended benefits due to disability and eligibility determinations for disabled adult Children.
- Life Insurance and Accidental Death and Dismemberment Benefit claims.
- Disagreements you have with a Plan policy, determination or action that is *not* an "adverse benefit determination" as defined below.

Applicable Definitions

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves **urgent care** or is a **pre-service claim**, **post-service claim** or **concurrent care claim**. These terms are defined as follows:

Urgent Care Claim.

This is a claim that (1) involves emergency medical care needed immediately in order to avoid serious jeopardy to your life, health, or ability to regain maximum function; or (2) in the opinion of a Physician with knowledge of your medical condition would subject you to severe pain if your claim were not dealt within the "urgent care" time frame described below. Whether your claim is one involving urgent care will be determined by an individual acting on behalf of the Plan, applying an average layperson's knowledge of health and medicine. If a Physician with knowledge of your medical condition determines that your claim is one involving urgent care, the Plan will treat your claim as an urgent care claim.

Pre-Service Claim.

This is any claim with respect to which the terms of the Plan condition receipt of a benefit, in whole or part, on approval of the benefit in advance of obtaining medical care.

Post-Service Claim.

This is any claim for a benefit that is not a pre-service claim. In this type of claim, you request reimbursement after medical care has already been rendered.

Concurrent Care Claim.

This is any claim to extend a course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be an urgent care claim, a pre-service claim or a post-service claim.

Adverse Benefit Determination.

- Any of the following: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of your or your dependents' eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or investigational or not Medically Necessary or appropriate; and
- Any rescission of disability coverage with respect to you or your dependent (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Notification of Initial Benefit Determinations

Urgent Care Claims

The Benefits Office will notify you whether your claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim, unless your claim is incomplete. The Benefits Office will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Benefits Office may notify you orally, unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Benefits Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

Pre-Service Claims

The Benefits Office will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Benefits Office require that additional time is needed to process your claim. If an extension is needed, the Benefits Office will notify you prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Benefits Office expects to reach a decision. If the Benefits Office needs an extension because you have submitted an incomplete claim, it will notify you of this within 5 days of receipt of your claim. The notice will describe the information needed to make a decision. The Benefits Office may notify you orally, unless you request written notification. You will have 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Benefits Office to decide a claim, the period for making the benefit determination is tolled from the date on which the Benefits Office sent the notification of the extension until the date you respond to the request for additional information.

- **Post-Service Claim**

The Benefits Office will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period, if circumstances beyond the control of the Benefits Office require that additional time is needed to process your claim. If an extension is needed, the Benefits Office will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which it expects to reach a decision. If the Benefits Office needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If you fail to submit information necessary for the Benefits Office to decide a claim, the period for making the benefit determination is tolled from the date on which the Benefits Office sends you the notification of the extension until the date you respond to the request for additional information.

- **Concurrent Care**

If the Benefits Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Benefits Office will notify you of its determination within 24 hours after receiving your claim, provided that it receives your claim at least 24 hours prior to the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

If Your Claim for Benefits Is Denied

If any claim for benefits described above is denied, in whole or in part, the Benefits Office (or an individual or entity acting on its behalf) will provide you with a written or electronic Explanation of Benefits notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination is based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the Explanation of Benefits will include either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free of charge upon request.

In the case of an adverse benefit determination concerning an urgent care claim, the Explanation of Benefits will also describe the shortened time frames for reviewing urgent care claims. In addition, in the case of an urgent care claim, the notice may be provided to you orally, within the time frames described above. You will be provided with a written notice within 3 days of oral notification.

Appeal Procedures

If any claim for benefits described above is denied, in whole or in part, you may request the Board of Trustees to review the benefit denial. Your written appeal must be submitted within 180 days of receiving the denial notice. If the Benefits Office has approved an ongoing course of treatment to be provided over a period of time or number of treatments, it will notify you at a time sufficiently in advance of the reduction or termination of treatment, which may be a period that is less than 180 days, to allow you to appeal and obtain review before the benefit is reduced or terminated. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Benefits Office will be final and binding.

Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Benefits Office did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

Your appeal will be reviewed by the Trustees or a designated committee of the Trustees, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. The Trustees or the designated committee of the Trustees deciding the appeal will give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

If the Trustees, or a designated committee of the Trustees, in the process of considering an appeal determine, based upon the medical information available that an otherwise non-covered service, procedure, treatment or equipment with respect to you is likely to achieve the same results as a more costly covered service, procedure, treatment or equipment, then the Trustees or committee of the Trustees, in their sole discretion, may elect to provide coverage for the less costly but otherwise non-covered expense in lieu of the more costly covered expense. In addition, the availability of coverage for alternative treatment in accordance with this provision will be limited to those circumstances in which the likelihood of a cost saving to the Plan can be clearly identified. The Trustees may establish limits and review requirements with respect to each individual coverage determination.

Also, in the case of an urgent care claim, you may request review orally or in writing, and communications between you and the Plan may be made by telephone, facsimile, or other similar means.

Notification of Decision on Appeal

- **Timing of Notification for an Urgent Care Claim**

The Trustees will notify you of their decision of an urgent care claim as soon as possible, but not later than 72 hours after receiving your request for review.

- **Timing of Notification for an Pre-Service Claim**

The Trustees will notify you of their determination of a pre-service claim within a reasonable period of time, but not later than 30 days after receiving your request for review.

- **Timing of Notification for a Post-Service Claim**

In the case of a post-service claim, the Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal was received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

- **Content of Notifications**

The Plan will provide you with written or electronic notice of its determination on review. The notice will set forth the specific reason(s) for the adverse determination, the specific Plan provisions on which the benefit determination

is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under Section 502(a) of ERISA. In addition, if an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, either you will be provided with the specific rule, guideline, protocol or similar criterion, or you will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to you free of charge upon request. If the adverse determination was based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, the denial notice will include either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Trustees' Decision on Appeal is Final and Binding

The decision of the Trustees on review is final and binding upon all parties including any person claiming a benefit on your behalf. The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

SPECIAL RULES FOR DISABILITY DETERMINATIONS

Overview

Recent amendments to Department of Labor's Claims Procedure Regulations establish special procedural requirements for claims and appeals that involve disability determinations. For this Plan, these amendments may impact how the Benefits Office and the Trustees review claims or appeals involving Weekly Income Benefits (see pages 61-62 of the SPD); eligibility for extended benefits due to disability (see pages 29-30 of the SPD), and eligibility determinations for disabled adult Children (see page 14 of the SPD).

In general, the Claims and Appeals procedures described above in the section Claims and Appeals Procedures for Most Health Benefit Claims also apply to disability claims except as follows:

Timing of Notification for a Claim Involving a Disability Determination

The Benefits Office will notify you whether your claim involving a disability determination is approved or denied in writing within a reasonable period of time, but not later than 45 days after the claim has been received by the Benefits Office. If the Benefits Office needs more time to review the claim for reasons beyond its control, it may take up to an additional 30 days. Should additional time be required, you will be sent a notice of the extension before the initial 45-day period expires specifically explaining the circumstances requiring the extension, the date by which the Plan expects to make a decision, the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information necessary to resolve those issues. If, prior to the end of the first 30-day extension period, the Plan determines that another extension of up to 30 days is needed, it will send a second extension notice in accordance with the preceding sentence before the expiration of the initial 30 day extension. If a notice of extension requests additional information from you that is needed to resolve an issue, you will be given at least 45 days to provide the requested information. If an extension is necessary due to your failure to submit information needed by the Plan to decide your claim, the period for deciding the claim will be tolled from the date you are sent the notice of extension until the date on which you respond to the request for additional information.

Content of Notification of an adverse benefit determination relating to disability

The notification of an adverse benefit determination relating to disability will include the information specified above in the "If Your Claim for Benefits is Denied" section, along with a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination; and

- If applicable, a disability determination made by the Social Security Administration regarding you.

If the adverse benefit determination is based on Medical Necessity or Experimental treatment or similar exclusion or limit, notification will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The notification will also include:

- Either the specific rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, as statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Such notification shall be provided in a culturally and linguistically appropriate manner.

Special Appeal Procedures for Disability Determinations

In addition to the Appeal Procedures set forth above (see pages 3 through 10 of this SMM), in the case of an appeal involving a disability determination, the Plan will, before issuing an adverse benefit determination on appeal, provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with your claim. You will be provided with such evidence as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to you (see "Notification of Disability Decision on Appeal" below) to give you a reasonable opportunity to respond prior to that date.

In addition, before the Plan can issue an adverse benefit determination on appeal based on a new or additional rationale, the Plan will provide you, free of charge, with the rationale. You will be provided with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to you (see "Notification of Disability Decision on Appeal" below) to give you a reasonable opportunity to respond prior to that date.

Notification of Disability Decision on Appeal

- **Timing of Notification for a Disability Claim**

  The Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal was received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring the extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

- **Content of Notifications for a Disability Claim**

  The Plan will provide you with written or electronic notice of its determination on review. The notice will include the information specified above in the "Content of Notifications" section, as well as a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

  - The views you presented to the Trustees of health care professionals treating you and vocational professionals who evaluated you;

- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- If applicable, a disability determination regarding the claimant that you presented to the Plan made by the Social Security Administration;

If the adverse benefit determination is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, the Plan will provide you with either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request;

The Plan's notice will also include:

- Either the specific rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, as statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist, and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Such notice will be provided in a culturally and linguistically appropriate manner.

CLAIMS AND APPEALS PROCEDURES FOR PRESCRIPTION DRUG CLAIMS

Overview

As the Plan's Prescription Benefit Manager, Express Scripts has agreed to be responsible for reviewing initial Prescription Drug claims filed by Covered Individuals. In addition, the Trustees have delegated to Express Scripts the authority to review appeals of adverse benefit determinations of Prescription Drug claims. Express Scripts has agreed that it will process all claims and appeals in accordance with the Department of Labor's Claims Procedure Regulations and will be the appropriate named fiduciary of the Plan in accordance with the provisions of the Claims Procedure Regulations that govern appeals of adverse benefit determinations.

> As noted above, the initial determination of any claim, *including a Prescription Drug claim*, that involves a determination of whether an individual is a Covered Individual eligible for benefits under the Plan shall be determined by the Benefits Office in accordance with the procedures described above, and the appeal of any adverse determination of any such claim shall be reviewed by the Trustees, or designated committee of the Trustees.

The definitions of pre-service claim, post-service claim, urgent care claim, concurrent care claim and adverse benefit determination on pages 6 and 7 of this SMM apply to this section.

You have the right to request that a medication be covered or be covered at a higher benefit (*e.g.* lower Copayment, higher quantity, etc.). The first request for coverage is called an initial coverage review. Express Scripts reviews both **clinical coverage review requests** and **administrative coverage review requests**. These terms are defined as follows:

Clinical Coverage Review Request.

A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, a request for medications that require a prior authorization, and reviews involving plan exclusions and quantity limits would be considered clinical coverage review requests.

Administrative Coverage Review Request.

A request for coverage of a medication that is based on the Plan's benefit design. For example, a review involving copayments, deductibles, and coordination of benefits would be considered administrative coverage review requests.

Requesting an initial coverage review

To request an initial clinical coverage review, also called prior authorization, the prescriber submits the request electronically. Information about electronic options can be found at express-scripts.com/PA. Home Delivery coverage review requests are automatically initiated by the Express Scripts Home Delivery pharmacy as part of filling the prescription.

To request an initial administrative coverage review, you or your authorized representative must submit the request in writing to: Express Scripts Attn: Benefit Coverage Review Department, PO Box 66587 St Louis, MO 63166-6587.

If you have an urgent claim, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of the request. In general, an urgent situation is one which, in the opinion of the attending provider, your health may be in serious jeopardy or you may experience pain that cannot be adequately controlled while awaiting the decision on review. If you or your provider believes your situation is urgent, expedited review must be requested by phone at 1-800-753-2851.

Processing of Initial Coverage Reviews

Express Scripts will notify you and your provider of its decision regarding a pre-service claim within 15 days after receipt of a retail Prescription Drug claim or 5 days after receipt of a home delivery Prescription Drug claim. Express Scripts will notify you and your provider of its decision regarding a post-service claim within 30 days after receipt of the claim. You and your provider will be notified of Express Scripts' decision by phone and/or letter.

If Express Scripts does not receive the necessary information needed to make a determination within the decision timeframe, a letter will be sent to you and your provider stating that the information must be received within 45 days or the claim will be denied.

Processing of Initial Coverage Reviews of Urgent Claims

Express Scripts will notify you and your provider whether your urgent claim is approved or denied as soon as possible from its receipt of your request, but not later than 72 hours after receipt. If Express Scripts does not receive information necessary to process the claim from you or your provider within 24 hours of receipt, a 48 hour extension will be granted. You and your provider will be notified of Express Scripts' decision by phone and/or letter.

Appeals (other than Urgent Appeals)

When an initial coverage review has been denied (*i.e.*, adverse benefit determination), you, your authorized representative, or your provider may submit a request for an appeal to Express Scripts within 180 days from receipt of the notice of the initial adverse benefits determination. To initiate the appeal, the following information must be submitted by fax or mail to the appropriate department for clinical or administrative appeals: (1) patient's name; (2) patient's ID number; (3) patient's phone number; (4) the Prescription Drug name for which benefit coverage has been denied; (5) a brief description of why you disagree with the initial adverse benefit determination; and (6) any additional information that may be relevant to the appeal, including provider statements/letters, bills, or any other documents.

Send clinical appeal requests to:

Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588

Or fax: 1-877-852-4070.

Send administrative appeal requests to:

Express Scripts Attn: Administrative Appeals Department
PO Box 66587
St. Louis MO 63166-6587

Or fax: 1-877-328-9660.

Urgent appeals

Urgent appeals must be submitted by phone: 1-800-753-2851 or fax 1-877-852-4070. Appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeals as urgent.

An urgent appeal may be submitted if in the opinion of your provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or would subject the patient to sever pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Processing of Appeals

Depending on the type of appeal, appeal decisions are made by an Express Scripts Pharmacist, Physician, panel of clinicians, trained prior authorization staff member, or independent third party utilization management company.

- **Pre-Service Appeals**

Pre-service appeals are subject to two levels of review. Express Scripts will notify you and your provider of its decision regarding your first-level appeal within 15 days after it receives your appeal. You will be notified of Express Scripts' decision by phone and/or letter. For clinical appeals, your provider will also be notified by letter.

If your pre-service appeal is denied, you will receive a denial notice with instructions on how to request a second level of review. You will have 90 days from receiving a first-level denial notice to request a second level of review. Express Scripts will make a decision regarding your second-level appeal within 15 days after receiving your appeal. You will be notified of Express Scripts' decision by phone and/or letter. For clinical appeals, your provider will also be notified by letter.

- **Post-Service Appeals**

Post-service appeals are subject to two levels of review. Express Scripts will notify you and your provider of its decision regarding your first-level appeal within 30 days after it receives your appeal. You will be notified of Express Scripts' decision by phone and/or letter. For clinical reviews, your provider will also be notified by letter.

If the first-level review of your pre-service appeal is denied, you will receive a denial notice with instructions on how to request a second-level review. You will have 90 days to request a second level of review. Express Scripts will make a decision regarding your second-level appeal within 30 days after receiving your appeal. You will be notified of Express Scripts' decision by phone and/or letter. For clinical reviews, your provider will also be notified by letter.

- **Urgent Appeals**

Express Scripts will only perform one level of review for urgent appeals. Express Scripts will notify you and your provider whether your urgent appeal is approved or denied as soon as possible from its receipt of your request, but not later than 72 hours after receipt of the urgent appeal. If new information is received and considered or relied upon in deciding the appeal, such information will be provided to you and/or your provider, together with an opportunity to respond prior to the issuance of any final determination. Notice of Express Scripts' decision regarding your urgent care appeal will be provided by phone and letter.

Required Exhaustion of Claims Procedures

You may not commence a judicial proceeding against any person, including the Plan, any of its Trustees, or any fiduciary of the Plan with respect to a claim for Prescription Drug benefits without first exhausting the procedures set forth above.

Voluntary Appeal to the Board of Trustees

If Express Scripts denies your appeal, you may submit a voluntary appeal to the Board of Trustees. See page 17 of this SMM for a description of this voluntary appeals process.

CLAIMS AND APPEALS PROCEDURES FOR MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS

Overview

As the network provider for mental health and substance abuse treatment, Beacon Health Options has agreed to be responsible for making initial Medical Necessity determinations and administrative decisions and handling appeals relating to mental health and substance abuse services.

> As noted above, the initial determination of any claim, *including a mental health or substance abuse claim*, that involves a determination of whether an individual is a Covered Individual eligible for benefits under the Plan shall be determined by the Benefits Office in accordance with the procedures described above, and the appeal of any adverse determination of any such claim shall be reviewed by the Trustees, or designated committee of the Trustees.

The definitions of a pre-service claim, post-service claim, urgent care claim, concurrent care claim and adverse benefit determination on page 6 of this SMM also apply to this section.

Initial Claim Determination

You, your authorized representative, or your provider may initiate a request for services.

Beacon Health may deny your claim based on an administrative or clinical reason. This denial is considered an adverse benefit determination that will trigger appeal rights.

An *administrative* adverse benefit determination is a denial based on reasons other than lack of Medical Necessity, such as: benefit exhaustion, provider not in network, eligibility, *etc*. A *clinical* adverse benefit determination is a denial based on a determination of Medical Necessity.

Beacon Health will make initial claims determinations in the time periods described below.

- **Pre-Service Claims**

Beacon Health will notify you and your provider of its decision regarding a pre-service or non-urgent concurrent care claim within 15 days. If you do not follow Beacon Health's filing procedures when you file your pre-service claim, Beacon Health will notify you of the proper procedures within 5 calendar days. If additional information is needed to decide your claim, Beacon Health will notify you within 15 days, and provide you with at least 45 days to provide such information. If additional information is not provided within that timeframe, Beacon Health may deny your claim.

- **Post-Service Claims**

Beacon Health will notify you and your provider of its decision regarding a post-service claim within 30 days. If additional information is needed to decide your claim, Beacon Health will notify you within 15 days, and provide you with at least 45 days to provide such information. If additional information is not provided within that timeframe, Beacon Health may deny your claim.

- **Urgent Care Claims**

With respect to urgent care claims, Beacon Health will notify you and your provider of its decision within 72 hours. If you do not follow Beacon Health's filing procedures when filing your urgent claim, Beacon Health will notify you of the proper procedures within 24 hours. If additional information is needed to decide your claim, Beacon Health will notify you within 24 hours, provide you with at least two days to provide such information, and provide you with its decision within two days.

- **Concurrent Urgent Care Claims**

If Beacon Health has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and the claim involves urgent care, Beacon Health will notify you and your provider of its determination within 24 hours after receiving your claim, provided that it receives your claim at least 24 hours prior to the expiration of the course of treatment. If Beacon Health receives your claim within 24 hours prior to the

expiration of the course of treatment, it will notify you and your provider of its decision within 72 hours. If you do not follow Beacon Health's filing procedures when filing your claim, Beacon Health will notify you of the proper procedures within 24 hours. If additional information is needed to decide your claim, Beacon Health will notify you within 24 hours and provide you with at least two days to provide such information, and provide you with its decision within two days.

- **Concurrent Care Claims (not urgent)**

If a concurrent care claim does not involve urgent care, the request will be decided in the appropriate time frame as if it were a **pre-service claim**.

As permitted by the Department of Labor's Claims Procedure Regulations, Beacon Health may request an extension of time to decide your claim if it does not have sufficient information to make a determination on a request for services, or for reasons beyond Beacon's control, such as disruptions due to a natural disaster.

Peer-to-Peer Review

During an initial clinical claims review (*i.e.*, review of a claim involving Medical Necessity), Beacon Health may contact your provider in order to obtain additional clinical information. This is called "peer-to-peer review." Peer-to-peer reviews are conducted within the standard review timeframes described above. If Beacon Health does not request a peer-to-peer review and your claim is denied, your provider will be notified of his/her right to request a peer-to-peer review within three business days. This conversation may result in a decision to approve all or part of the requested care or to uphold the original denial. If the original denial is upheld, you will not receive additional notification. This "reconsideration" process is not considered an appeal and does not in any way affect your right to appeal any denial of authorization for care.

Appeals- In General

Following its review of your initial claim, Beacon Health will provide you with notice of how to appeal an adverse benefit determination. You may appeal an adverse benefit determination to Beacon Health within 180 days of the date of the adverse benefit determination. To initiate an appeal, you, your provider, the facility rendering service, or your authorized representative must provide Beacon Health with your name or identification number and the dates of service of the denied claim.

Send your appeal request to:

Beacon Health Options
12369-C Sunrise Valley Drive
Reston, VA 20191

Or phone: 800-331-4824

Or fax: 877-826-8584.

If you authorize a third party to file an appeal on your behalf (such as a provider), you must provide such authorization in writing to Beacon Health. No written authorization is needed if your provider is acting as your representative for an urgent appeal, or if your provider is requesting an appeal of inpatient acute services and you are confined when receiving such services.

Every appeal will receive fair consideration. A qualified professional will review clinical appeals by completing a full investigation of the substance of the appeal. All aspects of clinical care involved, actions taken, and all documents, records, or other relevant information will be taken into account regardless of whether such information was previously submitted or considered in the initial determination. All Medical Necessity appeals are conducted by a Physician/psychologist advisor who was not involved in the original adverse benefit determination, nor is the subordinate of that Physician/psychologist. Administrative appeals are conducted by an appropriate subject matter expert or committee based on the nature of the appeal.

Upon receipt of the appeal request, Beacon Health will acknowledge its receipt either verbally or in writing. The letter will include clear documentation explaining the substance of the appeal, actions taken, and the timeframe to process

the request. You will be informed of what information, if any, is required to conduct the appeal, and the timeframes for submission. If the requested information is not received within the decision timeframe, the appeal is conducted based on whatever information is available and a decision is rendered within appropriate timeframes as described below.

You or your representative will be notified of your right submit any additional information you would like Beacon to consider in deciding your appeal. This includes the opportunity to submit, verbally or in writing, evidence and allegations of fact or law, and to submit written comments and documents, records and other information concerning the appeal. In addition, you may request copies of documents relevant to the appeal, free of charge.

You, your authorized representative or your provider may request an expedited pre-service or concurrent appeal review for urgent care conditions. An urgent care condition is a condition that threatens life, or is of such severity that not conducting an expedited appeal would threaten the member's safety. An expedited appeal will also be granted if you have received emergency services but have not been discharged from a facility. All requests for expedited appeals submitted by a provider will be processed as expedited appeals unless Beacon Health determines that the provider's request is unrelated to your current health condition. In the event that a request for an expedited appeal is not granted, you will be notified verbally within 48 hours and in writing within 2 business days that the expedited appeal request has been denied, and the request will be processed as a standard appeal. This notification will include the appeal determination date.

Notification of Decision of Appeal – First-Level Appeal

Expedited appeals and appeals involving inpatient care will be decided within 72 hours. For pre-service and concurrent care appeal requests, appeal decisions are made within 15 days of receipt of the request for appeal. For post-service appeals, appeal decisions are made within 30 days of receipt of the request. You may also request to extend the timeframe by an additional fourteen days. Unless there is agreement between you and Beacon Health to extend timeframes, an appeal not properly acted on by Beacon Health within the established time limits shall be deemed resolved in your favor.

You will be notified of Beacon Health's decision of your appeal in writing. The notification will include: 1) the specific reason for the decision; 2) a reference to the benefit provision, guideline, protocol or criteria on which the decision was based; 3) notification that you may obtain, at no cost, a copy of said criteria and a copy of all documents relevant to the appeal; 4) the credentials of the qualified professional(s) who participated in the appeal; and 5) a description of the next level of appeal available to you. All notifications will be in an easily understood language and accessible to non-English speaking and visually impaired members. Oral interpretation, alternate formats of written material, and TTY access will also be made available.

Second-Level Appeal

If your first-level appeal is denied, Beacon Health will provide you with information regarding how to file a second-level appeal. You may submit a second-level appeal to Beacon Health within 90 days after receipt of the first-level appeal notification.

File your second-level appeal request to:

Beacon Health Options
12369-C Sunrise Valley Drive
Reston, VA 20191

Or phone: 800-331-4824

Or fax: 877-826-8584.

If you request a second-level appeal, you or your representative may submit any additional information you would like Beacon to consider in deciding your appeal. Appeal decisions are made within 15 days of the receipt of the request for ongoing care, or within 30 days of the request if services have ended at the time of the request. The second-level appeal will be conducted by a Physician/psychologist advisor who was not involved in the original adverse determination or first level appeal nor is the subordinate of those physician/psychologist. You will be notified of Beacon Health's decision in writing.

Voluntary Appeal to the Board of Trustees

If Beacon Health denies your appeal, you may submit a voluntary appeal to the Board of Trustees. See page 17 of this SMM for a description of this voluntary appeals process.

TRUSTEE REVIEW OF PRESCRIPTION DRUG AND MENTAL HEALTH/SUBSTANCE ABUSE CLAIMS (VOLUNTARY APPEALS)

Overview

If you exhaust your appeal rights with Express Scripts or Beacon Health, and if Express Scripts or Beacon Health denied your appeal for Prescription Drugs or mental health/substance abuse services, you may submit a voluntary appeal to the Board of Trustees. Your appeal will be considered by the Trustees or a designated committee of Trustees during the Board of Trustees' next regularly scheduled meeting, except in the case of an expedited appeal, which will be considered by the Trustees as soon as possible. The Board of Trustees encourages all participants to take advantage of this voluntary level of review to ensure that all issues relating to your Prescription Drug and mental health/substance abuse benefits are resolved appropriately.

Your written appeal should state your name and address, the date of the denial by Express Scripts or Beacon Health, the fact that you are appealing the denial, and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

As required by regulation, the Plan: (1) waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit your claim to the Board of Trustees after you exhausted your appeal rights with Express Scripts or Beacon Health; (2) agrees that any statute of limitations or other defense based on timeliness is tolled during the time that such voluntary appeal is pending; and (3) will not require you to pay any fees or costs associated with the voluntary review. In addition, you may submit your claim for voluntary review only after exhausting all prior available levels of review, and the decision of whether to submit your claim for a voluntary review will have no effect on your rights to any other benefits under the Plan.

The Plan will provide you, upon request, sufficient information regarding the voluntary appeals process to enable you to make an informed judgment about whether to submit a voluntary appeal.

The decision of the Trustees on voluntary review is final and binding upon all parties including any person claiming a benefit on your behalf. The Board of Trustees has full discretion and authority to determine all matters relating to the benefits provided under the Plan, including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

CLAIMS AND APPEALS FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

To file a claim for life insurance or accidental death and dismemberment benefits, you must follow all of the procedures explained on page 73. In addition, the following procedures apply. Life Insurance and accidental death and dismemberment benefits will be paid in accordance with the terms of the provisions of the insurance contract by the insurance company that provides the coverage for these benefits.

Denial of Claim for Benefits

If your claim for benefits is denied, in whole or in part, the Benefits Office will provide you with a written or electronic notice that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, explains why that information is necessary, and describes the Plan's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA.

This notice will be given to you within a reasonable time but not more than 90 days after your claim is received by the Benefits Office. This 90-day period may be extended for up to an additional 90 days if special circumstances require that additional time is needed to process your claim. If an extension is needed for the Benefits Office to process your claim, you will be given written notice of the delay prior to the expiration of the 90-day period stating the reason(s) why the extension is necessary and the date by which the Benefits Office expects to make a decision. Once you receive the decision, you may consider the claim approved or denied. If the claim is denied, you may take steps to appeal the denial.

Appeals

If your claim is denied, you may request the Board of Trustees to review the benefit denial by submitting a written appeal to the Trustees. Your written appeal must be submitted within 180 days of receiving the denial notice. Failure to file a timely appeal will result in a complete waiver of your right to appeal and the decision of the Benefits Office will be final and binding. Upon receipt of an adverse benefit determination, you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, relevant information regarding the claim determination.

Your written appeal should state your name and address, the date of the denial, the fact that you are appealing the denial, and the reasons for your appeal. You should include documents that support your claim. The review of your claim will take into account all comments and documents that support your position, even if the Benefits Office did not have this information in making the initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

Timing of Notification of Decision on Appeal

The Trustees or a designated committee of the Trustees will review your appeal at their quarterly meeting immediately following receipt of your appeal unless your appeal was received by the Benefits Office within 30 days of the date of the meeting. If your appeal is received by the Benefits Office within 30 days of the date of the meeting, the Trustees may not be able to review your appeal until the second quarterly meeting following the Benefits Office's receipt of the appeal. You may wish to contact the Benefits Office concerning the date of the next meeting so that you may submit your appeal in time to be heard at that meeting. If special circumstances require a further extension of time for review for the Trustees, a benefit determination will be rendered not later than the third Trustees' meeting following receipt of your appeal. You will be notified in writing prior to the extension of the circumstances requiring an extension and the date by which the Trustees expect to reach a decision. You will receive written or electronic notice of the decision of the Trustees after review by the Trustees, within 5 days of their decision.

Content of Notification

This notice will set forth the specific reason(s) for the adverse determination, the specific Plan provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, relevant information regarding a claim determination, and a statement of your right to bring a civil action under Section 502(a) of ERISA. The decision of the Trustees is final and binding upon all parties including the claimant and any person claiming a benefit on behalf of the claimant.

Trustees' Decision on Appeal is Final and Binding

The Trustees have full discretion or authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. However, regarding Accidental Death and Dismemberment (AD&D) benefits, loss eligibility is determined by the insurance carrier providing the AD&D benefit under the terms of the policy with the Plan.[1] If the Trustees deny your appeal of a claim, and you decide to seek judicial review, the Trustees' decision is subject to limited judicial review to determine only whether the decision was arbitrary and capricious.

[1] See the section entitled "Your AD&D Benefits At-A-Glance" on page 65 of the SPD which explains that the insurance carrier providing the AD&D coverage is the sole decision-maker on loss eligibility claims.

PLAN POLICIES, DETERMINATIONS OR ACTIONS

If you disagree with a policy, determination or action of the Plan, you may request the Trustees to review the Plan policy, determination or action with which you disagree by submitting a written appeal to the Trustees. Your written appeal must be submitted within 60 days after you learn of a Plan policy, determination or action with which you disagree and which is not an "adverse benefit determination" as defined on page 5 of this SMM.

Your written appeal should state the reasons for your appeal. This does not mean that you are required to cite all applicable Plan provisions or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim or why you disagree with a policy, determination, or action. The Trustees can best consider your position if they understand your claims, reasons and/or objections.

Disclosure of Grandfather Status

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.

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