NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN
19 Campus Boulevard • Suite 200 • Newtown Square, PA 19073-3288
800-523-4702 • www.neibenefits.org

Summary of Material Modifications

May 2020

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

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

Re: (1) Extension and Clarification of Special 14-Day Weekly Income Benefit: Quarantine on Account of Coronavirus Disease 2019 (COVID-19); (2) Clarification of Scope of Plan's COVID-19 Diagnostic Testing Benefit; (3) Expansion of Plan's Telemedicine / Virtual Visit Benefits: Virtual Visits Powered by MDLIVE; and (4) Extended Benefit Rates for Laid-Off and Disabled Participants and Retiree Extended Benefit Rates (Effective July 1, 2020).

Dear Participant:

This Summary of Material Modifications describes:

- The extension of and clarifications to the Plan's Special 14-Day Weekly Income Benefit: Quarantine on Account of Coronavirus Diseases 2019 (COVID-19).
- Clarifications of the scope of the Plans COVID-19 Diagnostic Testing Benefit.
- Expansion of the Plan's Lineup of Telemedicine / Virtual Medicine Benefits to include Virtual Visits through MDLIVE.
- Extended Benefit Rates for Laid-Off and Disabled Participants and Retiree Extended Benefit Rates (Effective July 1, 2020).

Special 14-Day Weekly Income Benefit Coronavirus Disease 2019 (COVID-19) Quarantines and Isolations (NEW! Expanded through September 30, 2020 and Clarified)

Effective immediately and through September 30, 2020, in the event:

- An Active Member is directed to **Quarantine** (as defined below) on account of COVID-19, or
- An Employer directs an Active Member to **Self-Quarantine** (as defined below) on account of COVID-19, or
- An Active Member reasonably believes he or she should **Self-Quarantine** because he or she has been exposed to COVID-19, or
- An Active Member, either voluntarily or as compelled by federal, state, or local public health order, enters into **Isolation** (as defined below) because there is a reasonable belief the Active Member has been infected by COVID-19 (e.g., shows certain symptoms of COVID-19 such as subjective or measured fever, cough, or difficulty breathing),

such Active Member may receive Weekly Income Benefits for the period the Active Member is unable to work due to **Quarantine, Self-Quarantine, or Isolation** (not to exceed 14-days). This Special Weekly Income Benefit will not be subject to any waiting period.

- Only **Quarantines**, **Self-Quarantines** or **Isolations** beginning by September 30, 2020 are covered by these rules.

- You are not eligible to receive this Special Weekly Income Benefits if your Quarantine, Self-Quarantine or Isolation commences after the date of your termination from covered employment.

Completing the Special 14-Day Weekly Income Benefit Form (COVID-19 Quarantine).

- An Active Member who Quarantines, Self-Quarantines or enters into Isolation on account of COVID-19 may apply for Weekly Income Benefits by submitting a Special 14-Day Weekly Income Benefit Form (COVID-19 Quarantine) (a fillable pdf). You do not need medical certification from your attending physician. The form is now available online at: www.neibenefits.org/members/health-plan/. Please note that while this form references only "Self-Quarantine;" it applies to Quarantines, Self-Quarantines and Isolations on account of COVID-19.
- After completing the "Plan Member" section of this form, you should submit the form to the National Elevator Industry Health Benefit Plan. To expedite the processing of your application, it is recommended that you submit your completed form and email it to the Benefits Office; the Benefits Office has set up a special email address, weeklyincome@neibenefits.org, to receive these applications. You may also fax your application (1-610-557-4556) or mail it to the National Elevator Industry Health Benefit Plan, P.O. Box 476, Newtown Square, PA 19073-0476. The Benefits Office will follow up with your employer to confirm that you have self-quarantined on account of COVID-19.

If you are diagnosed with COVID-19.

This Special 14-Day Weekly Income Benefit applies solely to Active Members who begin Quarantines, Self-Quarantines or enter into Isolation on account of COVID-19 by September 30, 2020. If you are diagnosed with COVID-19, you may still apply for the Plan's established Weekly Income Benefits. (See pages 63-64 of the National Elevator Industry Health Benefit Plan Summary Plan Description.) Your attending physician would provide the Health Benefit Plan with such diagnosis by completing the Attending Physician's section of the applicable Weekly Income Benefit Form (Weekly Income Claim Forms are available online at: www.neibenefits.org/members/health-plan/.)

Glossary of Terms.

As explained above, only Active Members who *Quarantine* or *Self-Quarantine* due to exposure to COVID-19 or enter into *Isolation* because they are known to be or are reasonably believed to be infected with COVID-19 are eligible for this Special 14-Day Weekly Income Benefit.

Quarantine means the separation of a person or group of people reasonably believed to have been exposed to COVID-19 but not yet symptomatic, from others who have not been so exposed, to prevent the possible spread of COVID-19. Self-Quarantine occurs when a person or group of people choose to Quarantine, though not directed to do so, because they reasonably believe they have been exposed to COVID-19.

Isolation means the separation of a person or group of people known or reasonably believed to be infected with COVID-19 and potentially infectious from those who are not infected to prevent spread of COVID-19. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order.

100% Coverage for COVID-19 Diagnostic Testing (NEW! Clarification of Scope of Testing).

The Plan will completely cover the testing necessary to diagnose COVID-19, regardless of the setting in which such testing occurs. This means that such testing will be covered without any out-of-pocket cost to you, irrespective of whether the testing occurs in your physician's office, an urgent care facility, an emergency room, hospital, or via telehealth. 100% coverage will apply for testing incurred on both an in-network and out-of-network basis, subject to all applicable Plan rules. With respect to testing incurred by an out-of-network provider, the Plan's reimbursement will not exceed the cash price for such testing listed by the provider on a public internet website.

For purposes of this provision, "COVID-19 Diagnostic Testing" also includes:

- Seriological tests used to detect antibodies against COVID-19, and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-CoV-2, the virus which causes COVID-19, and
- Items and services furnished a Covered Individual to the extent such items and services relate to the furnishing or administration of COVID-19 Diagnostic Testing or the evaluation of an individual for purposes of determining the need for COVID-19 Diagnostic Testing.

NEW! Virtual Visits powered by MDLIVE

Earlier this year, a Summary of Material Modifications was mailed to all Participants describing the Plan's Telehealth/Virtual Medicine benefits. As a reminder, the Plan covers a Covered Individual's in-network telehealth/virtual visits for clinically appropriate, Medically Necessary covered health services with an in-network provider. In addition, the Plan covers a Covered Individual's in-network telehealth/virtual visits for Mental Health and Substance Abuse Outpatient Therapies through Beacon Health Options. *During the COVID-19 emergency, there will be no cost sharing (deductibles, coinsurance or copayments) with respect to these services; at the conclusion of this emergency period, as determined by the Board of Trustees, routine office visit cost sharing will apply to all telehealth/virtual visits.*

To make it even easier to access medical care, earlier this month, the Trustees added a special Telemedicine/Virtual Medicine service: MDLIVE. MDLIVE gives you access to a Physician licensed in your state, any time of day or night; even on weekends and holidays. MDLIVE is appropriate for non-emergency issues like mild asthma, minor headaches, coughs, sore throats, fevers or colds, bumps, cuts, scrapes, *etc*. The Plan covers 100% of the cost of this service. While the Plan covers your virtual visit through MDLIVE in full, you will be responsible for costs arising from your virtual visit (*e.g.*, the Plan's established Copayment for a prescription drug that may be prescribed as a result of your virtual visit). You may schedule a virtual visit through MDLIVE by visiting MDLIVE.com/bcbsil, by telephone at 888-676-4204 or through the MDLIVE® mobile app.

All Telehealth/Virtual Medicine Benefits are limited to in-network providers only.

Glossary of Terms.

Telehealth refers specifically to the treatment of various health conditions without seeing the patient in person. Providers may use telehealth platforms like live video, audio, or instant messaging to address a patient's concerns and diagnose their condition remotely. This may include giving medical advice, walking them through at-home exercises, or recommending them to a local provider or facility.

Virtual Medicine encompasses all the ways providers may remotely interact with their patients. In addition to treating patients via Telehealth, providers may use live video, audio, and instant messaging to communicate with their patients remotely. This may include checking in after an in-person visit, monitoring vitals after surgery, or responding to any questions about their diagnosis, condition or treatment plan. Virtual Medicine encompasses all the ways patients and providers can use digital tools to communicate in real-time. While telemedicine refers to long-distance patient care, virtual care is a much broader term that refers to a variety of digital healthcare services.

Notices

Disclosure of Grandfather Status

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

Regarding the Plan's Notice of Privacy Practices

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

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

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

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

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

Women's Health and Cancer Rights Act of 1998

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

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

Newborns' and Mothers' Health Protection Act

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

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

ACA Nondiscrimination Notice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Extended Benefit Rates (Effective July 1, 2020)

EXTENDED BENEFIT RATES IF YOU'VE BEEN LAID-OFF

STAGE	PERIOD	MEDICAL ONLY	MEDICAL DENTAL/VISION
Stage I	Month(s) after layoff	Apply Eligibility Rule*	Apply Eligibility Rule*
Stage II	After earned eligibility a member is eligible for 2 free months once in a twelve-month period	Free	Free
Stage III	Months 1 through 2 of paid coverage	Member Only $142 Family $429	Member Only $187 Family $579
Stage IV	Months 3 through 10 of paid coverage	Member Only $213 Family $644	Member Only $258 Family $794
Stage V	Months 11 through 22 of paid coverage	Member Only $355 Family $1,074	Member Only $400 Family $1,224
Stage VI	Months 23 and beyond of paid coverage (COBRA rates)	Member Only $710 Family $2,149	Member Only $755 Family $2,299

*Note: Those with insufficient hours and not on layoff status will not be entitled to purchase this coverage but will be offered the self-pay, unsubsidized coverage under COBRA. * Verify eligibility with the Benefits Office*

EXTENDED BENEFIT RATES IF YOU ARE DISABLED AND HAVE BEEN GRANTED A SOCIAL SECURITY DISABILITY AWARD

STAGE	PERIOD	MEDICAL ONLY	MEDICAL DENTAL/VISION
Stage I	Month(s) after disability	Apply Eligibility Rule*	Apply Eligibility Rule*
Stage II	Next 6 months	Free	Free
Stage III	Months 1 through 6 of paid coverage	Member Only $200 Family $638	Member Only $299 Family $737
Stage IV	Months 7 and beyond of paid coverage	Member Only $200 Family $638	Member Only $299 Family $737

** Verify eligibility with the Benefits Office*

EXTENDED BENEFIT RATES IF YOU ARE DISABLED AND HAVE NOT BEEN GRANTED A SOCIAL SECURITY DISABILITY AWARD

STAGE	PERIOD	MEDICAL ONLY	MEDICAL DENTAL/VISION
Stage I	Month(s) after disability	Apply Eligibility Rule*	Apply Eligibility Rule*
Stage II	Next 6 months	Free	Free
Stage III	Months 1 through 6 of paid coverage	Member Only $248 Family $752	Member Only $293 Family $902
Stage IV	Months 7 and beyond of paid coverage	Member Only $355 Family $1,074	Member Only $400 Family $1,224

COBRA RATES (Effective July 1, 2020)

	Individual	Family
COBRA Core Coverage (Medical Only)	$710	$2,149
COBRA Core Plus Non-Core Coverage (Medical, Dental & Vision)	$755	$2,299

** Verify eligibility with Benefits Office*

Retiree Extended Benefit Rates (Effective July 1, 2020)

EXTENDED BENEFIT RATES FOR RETIRED EMPLOYEES WHO ARE ELIGIBLE FOR THE STANDARD RATE

Monthly Rates Effective 7/1/2020

										Age 58 or older at Retirement					
PENSION EFFECTIVE DATE -->	Prior to 2/88	2/88 to 1/90	2/90 to 1/91	2/91 to 1/94	2/94 to 1/96	2/96 to 1/98	2/98 to 1/00	2/00 to 1/01	2/01 to 7/03	8/03 to 1/06	2/06 to 1/07	2/07 to 6/08	7/08 to 12/10	1/11 to 12/11	1/12 or later
DISABLED RETIREE (w/SSDA)															
Single	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200
Married, Both under 65	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638	$638
Married, Spouse over 65	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311	$311
EARLY RETIREE															
Single under 65	$444	$458	$472	$485	$513	$527	$534	$541	$555	$569	$583	$596	$638	$652	$666
Married, Spouse under 65	$929	$958	$987	$1,016	$1,074	$1,103	$1,117	$1,132	$1,161	$1,190	$1,219	$1,248	$1,335	$1,364	$1,393
Married, Spouse over 65	$600	$618	$637	$656	$693	$712	$721	$731	$750	$768	$787	$806	$862	$881	$900
MEDICARE ELIGIBLE RETIREE															
Single	$161	$166	$171	$176	$186	$191	$193	$196	$201	$206	$211	$216	$231	$236	$241
Married, Both over 65	$322	$332	$342	$352	$373	$383	$388	$393	$403	$413	$423	$433	$463	$473	$483
Married, One over 65	$651	$672	$692	$712	$753	$773	$783	$794	$814	$834	$855	$875	$936	$956	$977
SURVIVING SPOUSE															
Single, under age 65	$491	$507	$522	$537	$568	$583	$591	$599	$614	$629	$645	$660	$706	$721	$737
Single, over age 65	$162	$167	$172	$177	$188	$193	$195	$198	$203	$208	$213	$218	$233	$238	$243
DENTAL AND VISION (ADDITIONAL COST)															
All Retirees	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99	$99

The Trustees determine the projected cost annually after consultation with the Plan's Consultant.

Retiree Extended Benefit Rates (Effective July 1, 2020)

EXTENDED BENEFIT RATES FOR RETIREES WHO RETIRED PRIOR TO THE AGE OF 58

Monthly Rates Effective 7/1/2020

PENSION EFFECTIVE DATE	Early Retiree 8/03 through 12/10 who Retires prior to Age 58		Early Retiree 1/11 through 12/11 who Retires prior to Age 58		Early Retiree 1/12 or later who Retires prior to Age 58	
AGE / RETIRE CATEGORY	Age 55,56 & 57	Upon attaining age 58	Age 55,56 & 57	Upon attaining age 58	Age 55,56 & 57	Upon attaining age 58
EARLY RETIREE						
Single under 65	$791	$694	$804	$707	$804	$735
Married, Spouse under 65	$1,654	$1,451	$1,683	$1,480	$1,683	$1,538
Married, Spouse over 65	$1,068	$937	$1,087	$956	$1,087	$993
MEDICARE ELIGIBLE RETIREE						
Single	n/a	$251	n/a	$256	n/a	$266
Married, Both over 65	n/a	$504	n/a	$514	n/a	$534
Married, One over 65	n/a	$1,018	n/a	$1,038	n/a	$1,079
SURVIVING SPOUSE						
Single, under age 65	$875	$768	$890	$783	$890	$814
Single, over age 65	$289	$254	$294	$259	$294	$269
DENTAL AND VISION (ADDITIONAL COST)						
All Retirees	$99	$99	$99	$99	$99	$99

EXTENDED BENEFIT RATES FOR RETIRED EMPLOYEES WITH A 5 YEAR BREAK

Monthly Rates Effective 7/1/2020

PENSION EFFECTIVE DATE / RETIREE CATEGORY	8/03 to 12/10	1/11 to 12/11	1/12 or After
EARLY RETIREE			
Single under 65	$832	$902	$971
Married, Spouse under 65	$1,741	$1,886	$2,031
Married, Spouse over 65	$1,124	$1,218	$1,312
MEDICARE ELIGIBLE RETIREE			
Single	$301	$326	$351
Married, Both over 65	$604	$655	$705
Married, One over 65	$1,221	$1,323	$1,425
SURVIVING SPOUSE			
Single, under age 65	$921	$998	$1,075
Single, over age 65	$304	$330	$355
DENTAL AND VISION (ADDITIONAL COST)			
All Retirees	$99	$99	$99

Any former non-retired (from the NEI Pension Fund) participant who returns to covered employment at which time he or she has not been covered by the Health Benefit Plan for at least five consecutive years after 12/31/92, who retires after June 30, 2003 and is eligible to purchase retiree coverage under the Plan, shall pay a retiree rate of not less than 60% of the projected cost of healthcare for his/her respective group– i.e., Early Retiree, Normal Retiree or surviving spouse, during the full period he or she is covered by the Plan. The Trustees shall determine the projected cost annually after consultation with the Plan's Consultant. However, this rule will not apply to a Participant with at least 51,000 hours during his or her lifetime and 3,400 hours in the 60 months prior to retirement.