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

October 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 of the Special 14-Day Weekly Income Benefit: Quarantine on Account of Coronavirus Disease 2019 (COVID-19); (2) Amendments to the 5-year break in coverage rule that impacts the cost of Retiree coverage; (3) Amendment expanding the eligibility rules for a Retiree's surviving Spouse upon the Retiree's death, and (4) Amendment to the Plan's Genetic Testing guidelines.

Dear Participant:

This Summary of Material Modifications describes:

- The extension of the Plan's Special 14-Day Weekly Income Benefit: Quarantine on Account of Coronavirus Diseases 2019 (COVID-19).
- Amendments to the Plan's "5-year break in coverage rule." Under this rule, a Participant who incurs a break in coverage of 5 consecutive years of more may be required to pay a higher monthly rate for Retiree coverage than the standard monthly rate.
- Amendment to the Plan's eligibility rules for a Retiree's surviving Spouse upon the Retiree's death that allows a surviving Spouse who has been covered by the Plan for a minimum of 10 years to elect to continue coverage even though the Participant did not elect a surviving Spouse pension benefit.
- Amendment to update the Plan's Genetic Testing benefit to reflect continued development and growth in the area of genetic testing.

Special 14-Day Weekly Income Benefit Coronavirus Disease 2019 (COVID-19) Quarantines and Isolations (NEW! Expanded through December 31, 2020)

Effective immediately and through December 31, 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 December 31, 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. 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 December 31, 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 ("SPD").) 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: https://www.neibenefits.org/resources/forms/.)

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.

Amendments to the Plan's 5-Year Break in Coverage Rule (Cost of Retiree Coverage)

A primary factor governing the cost of and eligibility for Retiree coverage is the number of hours of work a Participant has accumulated over his or her career. In general, the cost of a Participant's Retiree coverage will be the "standard rate" or "standard monthly rate" if he or she meets the following requirements:

- The Participant has a total of at least 25,500 hours of work in covered employment throughout the Participant's career including at least 5,100 hours of work in covered employment in the 60 months immediately before retirement; or

- The Participant has a total of at least 42,500 hours of work in covered employment throughout the Participant's career including at least 3,400 hours of work in covered employment in the 60 months immediately before retirement.[1]

However, rates higher than the standard rate for Retiree coverage may apply if a Participant incurred a break in coverage of 5 or more consecutive years. The Trustees have amended this "5-Year Break in Coverage Rule" to limit the rule's impact on Participants with significant post-break hours of work and to reduce the total number of hours a Participant with a 5-year break in coverage needs in order to pay the standard monthly rate instead of the higher rate that would otherwise apply to a Participant with a 5-year break in coverage. Specifically:

- Effective July 1, 2020, a Retiree with a break in coverage of 5 or more consecutive years will pay for Retiree coverage is the *lesser* of: (a) the Extended Benefit Rate applicable to Retired Employees with a 5 Year Break posted on the Plan's website (see https://www.neibenefits.org/resources/plan-documents/), or (b) the rate the Retiree would otherwise pay for Retiree coverage based ***solely*** on the hours the Participant worked ***after*** a break in coverage of 5 or more consecutive years (see page 17 of the SPD), and
- Effective October 1, 2020, current Retirees covered by the Plan and Retirees with Effective Dates on or after October 1, 2020 will pay the applicable Retiree Extended Benefit Rate the Retiree would otherwise pay instead of the higher "Extended Benefit Rate for Retired Employees with a 5 Year Break" if they have a total of at least 42,500 hours reported to the Plan over their career and 3,400 hours in the 60 months prior to retirement.

Accordingly, effective July 1, 2020, the text box below the "EXTENDED BENEFIT RATES FOR RETIRED EMPLOYEES WITH A 5 YEAR BREAK" set forth in the Retiree Extended Benefit Rates as posted on the Plan's website is amended as follows:

> 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 (5) consecutive years after December 31, 1992, who retires after June 30, 2003 and is eligible to purchase Retiree coverage under the Plan, shall pay a Retiree rate of the lesser of:
>
> (a) the applicable extended benefit rate for Retired Employees with a 5 Year Break as set forth in the table above, or
>
> (b) the applicable Retiree Extended Benefit Rate the Participant would otherwise pay for Retiree coverage based solely on the hours the Participant worked after such break in coverage. .
>
> However, this rule will not apply to a Participant with at least 42,500 hours of work reported (or, with respect to monthly Retiree extended benefits payable prior to October 1, 2020, at least 51,000 hours of work reported) during his or her lifetime and 3,400 hours of work reported in the 60 months prior to retirement.

▪ Amendment to the Plan's Eligibility Rules for Surviving Spouses of Deceased Retirees (effective for Retiree deaths on or after June 1, 2019).

Prior to June 1, 2019, to be eligible to elect to continue medical, dental and vision coverage under the Plan after a Retiree's death, a Retiree's surviving Spouse had to be eligible to receive a surviving Spouse benefit under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan. Effective for Retiree deaths on or after June 1, 2019, a surviving Spouse of a Retiree may elect to continue medical, dental and vision coverage under the Plan even though the surviving Spouse will not receive a surviving Spouse benefit from one of these pension plans if the surviving Spouse had been covered by the Plan throughout the 10 year period immediately prior to the Retiree's death. Accordingly, effective for Retiree deaths that occur on or after June 1, 2019, the section of the Plan captioned "Surviving Spouse: Extended Benefits after Retiree's Death" (page 32 of the SPD) is amended as follows:

[1] For more information regarding the cost of Retiree coverage, see pages 17 and 18 of the SPD.

Surviving Spouse: Extended Benefits after Retiree's Death

If you are married and you die while you're covered by the Plan as a Retiree, your surviving Spouse may elect to continue medical, dental and vision coverage if he or she:

- Is eligible for a surviving Spouse benefit under the National Elevator Industry Pension Plan, IUEC Officers and Employees Pension Plan or the NEI Fund Office Employees Defined Benefit Pension Plan, or
- Has been covered by the Plan throughout the 10 year period immediately prior to your death.

If your surviving Spouse elects to continue coverage under the Plan, your Children who were eligible dependents covered by the Plan at the time of your death will also be covered. Your surviving Spouse must file a written agreement to pay the required amount for this coverage within 60 days of the date he or she receives from the Benefits Office the election form and information regarding extended benefits. If your Spouse remarries, he or she will no longer be eligible for this coverage under the Plan but may extend eligibility for as many as 36 months by electing COBRA Continuation Coverage.

Amendment to the Plan's Genetic Testing Coverage.

To account for the continued development and growth in the area of genetic testing, the section of the Plan previously captioned "Genetic Testing" (page 39 of the SPD) is amended as follows:

Genetic Testing Coverage

Coverage for genetic testing, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, and the associated genetic counseling, will be provided as Medically Necessary, subject to Medically Necessary peer review, as described below. The Plan covers genetic testing for:

- state-mandated newborn screening tests for genetic disorders;
- testing for a genetic mutation in the BRCA1 and BRCA2 genes;
- covered pregnant women if the test or procedure (including fluid/tissue obtained as a result of amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis) is recommended by the American College of Obstetricians and Gynecologists and/or the American Academy of Pediatrics, and if the test or procedure is Medically Necessary as determined by the Plan or its designee;
- pre-implantation genetic diagnosis (where one or more cells are removed from an embryo and genetically analyzed to determine whether genetic abnormalities are present) in situations where the associated in vitro fertilization procedure is also covered by the Plan;
- tests to determine a Covered Individual's sensitivity to FDA-approved drugs, such as the genetic test for warfarin (blood thinning medication) sensitivity, and tests to determine the effectiveness of an FDA-approved drug for the treatment of a Covered Individual, if the test is Medically Necessary as determined by the Plan or its designee;
- carrier testing for certain genetic disorders (such as Cystic Fibrosis) for Covered Individuals in any of the following groups, if the testing is Medically Necessary as determined by the Plan or its designee:
  - couples seeking prenatal care; or
  - couples who are planning a pregnancy; or
  - persons with a family history of the genetic disorder in question; or

GENETIC TESTING SERVICES
The Plan will provide Medically Necessary coverage for both pre-test and post-test genetic counseling for those Covered Individuals undergoing genetic testing if provided by a licensed Physician or a licensed or certified genetic counselor and provided in conjunction with a genetic test that is payable by this Plan. *Genetic testing other than state-mandated newborn screening requires precertification by contacting the Utilization Manager program (see page 41).*

  - persons with a 1st degree relative identified as a carrier; or
  - reproductive partners of persons with the genetic order in question;
- the detection and evaluation of chromosomal abnormalities or genetically transmitted characteristics in Covered Individuals who meet all of the following conditions:
  - the testing method is considered scientifically valid for identification of a genetically linked inheritable disease; and
  - the Covered Individual displays clinical features/symptoms of a genetically inheritable disease, or the Covered Individual is at direct risk (*e.g.*, family history, first or second-degree relative) for the development of a genetically linked inheritable disease (pre-symptomatic); and
  - the results of the test will directly impact clinical decision-making, the clinical outcome or the treatment being delivered to the Covered Individual.

What's Not Covered under the Plan's Genetic Testing Coverage

- Expenses for genetic tests, including obtaining a specimen or laboratory analysis, to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics, except as listed as listed above.
- Pre-implantation genetic diagnosis in situations where the associated in vitro fertilization procedure is not covered by the Plan.
- Genetic testing performed primarily for the medical management of individuals who are not covered under the Plan. Genetic testing costs may be covered for a non-covered individual only if such testing would directly impact the treatment of a Covered Individual.
- Home genetic testing kits and services.
- Genetic testing determined to be experimental or investigational or not Medically Necessary.

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. ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان 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