NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

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Summary of Material Modifications

December, 2023

To: All Participants in the National Elevator Industry Health Benefit Plan, IUEC Local Unions, and Regional Directors

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

This Summary of Material Modifications describes important changes to the National Elevator Industry Health Benefit Plan. Specifically, this Summary of Material Modifications:

- Adds a number of improvements and features, along with certain terminology, to bring the Plan into full compliance as a "non-grandfathered" health plan under the Patient Protection and Affordable Care Act (ACA). Currently, the Plan is administered as a "grandfathered health plan" under the ACA. The Trustees, in consultation with Plan's consultants and actuaries, have concluded that it is no longer in the best interest of the Plan and its participants and beneficiaries for the Plan to maintain its status as a grandfathered health plan. Accordingly, **effective January 1, 2024**, the Plan has been amended to add a number of features, protections, and improvements to bring the Plan into full compliance with ACA requirements that apply to "non-grandfathered health plans."
- Fully integrates protections and related benefit improvements required under the No Surprises Act into the Plan.
- Includes valuable improvements to your Vision Benefits effective **January 1, 2024**.
- Implements the Plan's new **Specialty Pharmacy Copay Assistance Program** effective **January 1, 2024**.
- Updates the list of the Plan's Trustees and professionals.

H1506-18-202312

- **Page 1, effective January 1, 2024, for purposes of Affordable Care Act ("ACA") compliance, Letter to Members is updated and revised as follows:**

Dear Member,

The Board of Trustees of the National Elevator Industry Health Benefit Plan is pleased to issue this revised National Elevator Industry Health Benefit Plan Summary Plan Description. This is the official Plan of Benefits adopted by the Trustees in accordance with their authority under the Restated Agreement and Declaration of Trust of the National Elevator Industry Health Benefit Plan. It has been written to reflect the changes in the written Plan of Benefits since the last version of the Plan of Benefits was issued.

Your Plan of Benefits includes:

- Comprehensive medical care;
- Preventive services;
- Behavioral health benefits including substance use disorder treatment benefits;
- Prescription drug benefits, including a mail order program;
- Vision care benefits, including a benefit toward LASIK vision correction surgery;
- Hearing care benefits, and a benefit toward the purchase of a hearing aid;
- Dental care benefits, including Orthodontia for all covered Participants;
- Weekly income benefits; and
- Life insurance and accidental death and dismemberment insurance.

We encourage you and your family to read this Summary Plan Description carefully to make the best use of the benefits the National Elevator Industry Health Benefit Plan offers.

This Summary Plan Description (or Plan of Benefits) provides the required information about your rights and protection under the law in order to comply with the Employee Retirement Income Security Act of 1974 (ERISA), the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA) and other federal laws.

If you have any questions concerning the benefits or your eligibility, please feel free to contact the Benefits Office of the National Elevator Industry Benefit Plans at 1-800-523-4702.

Sincerely Yours,

The Board of Trustees

NOTE: Over time, it may be necessary to change the eligibility rules and benefits provided by the Plan. In accordance with the Restated Agreement and Declaration of Trust of the National Elevator Industry Health Benefit Plan, the Trustees, in their sole discretion, have the authority to change, modify, or discontinue all or part of the eligibility rules or benefits at any time. Whenever the Plan provides that certain policies (such as self- payment rates, benefits provided, etc.) are set by the Trustees, these policies will be on file at the Benefits Office. If you have any questions, contact the Benefits Office.

- **Page 2, Board of Trustees, is updated and revised as follows:**

The Board of Trustees is made up of an equal number of Employer Trustees and Union Trustees. The Trustees serve without compensation. The Trustees have complete discretion and authority to control and manage the operation and administration of the National Elevator Industry Health Benefit Plan. They also have exclusive authority to interpret the terms of this Plan of Benefits.

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- **Page 7, effective January 1, 2024, revise the "Medical Benefits" table to: (1) comply with "Essential Health Benefits" provisions of the Affordable Care Act ("ACA"), and (2) clearly indicate compliance with the ACA's Preventive Services provisions for Non-Grandfathered Plans as follows:**

MEDICAL BENEFITS	
Annual Medical Deductible	$300 per person; $600 per family
Annual Out-of-Pocket Medical Maximum*	$1,500 per person; $3,000 per family (includes Behavioral Health Benefits including Substance Use Disorder Treatment Benefits)
Preventive Services Benefits	Preventive Services are not subject to any annual deductible if In-Network or Out-of-Area.
****Your Annual Medical Deductible, coinsurance amounts you pay (see page 35), and any emergency room visit Copays you pay (see page 38) are applied towards your Annual Out-of-Pocket Maximum. Amounts you are balance billed by an out-of-network provider because the charge exceeds the UCR Rate, and coinsurance that is applied to Chiropractic services are not applied towards your Out-of-Pocket Maximum (see page 36).*	

- **Page 8, effective January 1, 2024, for purposes of clarification, revise the table as follows:**

	You Pay In-Network Paid at the Contracted Rate	You Pay Out-of-Network Paid at the UCR Rate*
Acupuncture Services	$0 (after deductible) when performed by an M.D. LaC or D.O. only	25% of UCR Rate (after deductible) when performed by an M.D. LaC or D.O., R.N., N.P., R.N.P. or provider certified by the National Certification Commission for Acupuncture and Oriental Medicine
Ambulance Service	$0 (after deductible)	100% of amount over UCR (after deductible)
Chiropractic Care (visits per calendar year)	Visit 1-12: $0 (after deductible) Visit 13-24: 25% of Allowed Amount (after deductible) Visit 25-36: 50% of Allowed Amount (after deductible) Visit 37+: 75% of Allowed Amount (after deductible)	Visit 1-12: 25% of UCR Rate (after deductible) Visit 13-24: 50% of UCR Rate (after deductible) Visit 25-36: 75% of UCR Rate (after deductible) Visit 37+: No coverage
Diagnostic: Laboratory or X-Ray	$0 (after deductible)	25% of UCR Rate (after deductible)
Durable Medical Equipment	$0 (after deductible)	25% of UCR Rate (after deductible)
Emergency Room	$50 Copay; $0 (after deductible)	$50 Copay ; 100% of amount over UCR Rate (after deductible)
Hearing Aids (benefit limits apply)	$0	N/A
Hospice Care	$0 (after deductible)	25% of UCR Rate (after deductible)
Home Health Care	$0 (after deductible) Up to 80 visits per calendar year	25% of UCR Rate (after deductible) Up to 80 visits per calendar year
Infertility Treatment	$0 (after deductible)	25% of UCR Rate (after deductible)
Inpatient Rehabilitation Facility	$0 (after deductible)	25% of UCR Rate (after deductible)
Skilled Nursing Facility	$0 (after deductible)	25% of UCR Rate (after deductible)
Office Visits (Primary Care Physician)	$0 (after deductible)	25% of UCR Rate (after deductible)
Office Visits (Specialist)	$0 (after deductible)	25% of UCR Rate (after deductible)
Organ Transplants	$0 (after deductible)	25% of UCR Rate (after deductible)
Physical and Occupational Therapy (Outpatient)	$0 (after deductible)	25% of UCR Rate (after deductible)
Preventive Services (see pages 7 through 9 below)	$0 (not subject to Plan's deductible)	25% of UCR Rate (after deductible)
Speech Therapy (benefit limits apply)	$0 (after deductible)	25% of UCR Rate (after deductible)
Surgical Expenses	$0 (after deductible)	25% of UCR Rate (after deductible)

- **Page 9, effective January 1, 2024, to comply with "Essential Health Benefits" provisions of the ACA, amend the first paragraph below the Section heading "Dental Benefits" as follows:**

Please note that your and your eligible dependents' participation in the Plan automatically includes coverage for Dental Benefits. However, a Participant may choose to waive Dental Benefits coverage by notifying the Plan in writing. A Participant who waives Dental Benefits Coverage may later reinstate Dental Benefits coverage by submitting a written request to the Plan. Coverage for Dental Benefits will resume only after the Benefits Office receives this written request.

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

- **Page 11, effective January 1, 2024, to: (1) comply with Essential Health Benefits provisions of the ACA and (2) clearly indicate compliance with the ACA's Preventive Services provisions for Non-Grandfathered Plans, revise the "Prescription Drug Benefits" table as follows:**

PRESCRIPTION DRUG BENEFITS	
Drug Type	**You Pay In-Network**
Generic Drugs (Retail Pharmacy)	20% of amount charged: Minimum Copay of $5 and Maximum Copay of $40! (30-day supply)
Preventive Care (Retail Pharmacy or Home Delivery)	You pay $0
Preferred Brand Name Drugs (Retail Pharmacy)	20% of amount charged: Minimum Copay of $15 and Maximum Copay of $40*! (30-day supply)
Non Preferred Brand Name Drugs (Retail Pharmacy)	20% of amount charged: Minimum Copay of $30 and Maximum Copay of $40*! (30-day supply)
Generic Drugs (Home Delivery)	$10 Copay! (31 to 90-day supply)
Preferred Brand Name Drugs (Home Delivery)	$30 Copay*! (31 to 90-day supply)
Non Preferred Brand Name Drugs (Home Deliver)	$50 Copay*! (31 to 90-day supply)
Your Annual Out-of-Pocket Prescription Drug Benefits Maximum	$7,950 per person; $15,900 per family

*Subject to the Plan's Generic Drug Incentive Program.
!Subject to the Plan's Specialty Pharmacy Copay Assistance Program.

OUT-OF-POCKET PRESCRIPTION DRUG BENEFITS MAXIMUM	
Your Annual Out-of-Pocket Prescription Drug Benefits Maximum*	$7,950 per person; $15,900 per family
**All Copayments are applied towards your Annual Out-of-Pocket Prescription Drug Benefits Maximum. Once you or your family has met the Annual Out-of-Pocket Prescription Drug Benefits Maximum, you will no longer be required to pay Prescription Drug Benefit Copays. Charges, if any, associated with specialty pharmacy drugs covered under the Pharmacy Copay Assistance Program (see below), are not applied to your Annual Out-of-Pocket Prescription Drug Benefits Maximum.*	

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

- **Page 25: The last sentence below the heading "IF YOU HAVE A BABY" is revised as follows:**

The Plan covers expenses related to Women's and Children's Preventive Services (see pages 7 through 9 below).

- **Page 35: In accordance with the No-Surprises Act, the text below the PPO Provider vs. Out-of-Network Provider Table is revised as follows:**

If you use an out-of-network provider, you may incur significantly higher out-of-pocket expenses. In addition, in certain cases, the out-of-network provider also may charge the participant for the remainder (or "balance") of the provider's bill after applying payment (if any) from the Plan. This practice, known as *balance billing*, can occur regardless of whether you use an out-of-network provider by choice, for level of expertise, for convenience, for location, because of the nature of the services, or based on the recommendation of a provider.

However, you should be aware that certain states prohibit balance billing, in which case you should not be responsible for amounts balance billed. In addition, when you receive Emergency Services for an Emergency Medical Condition, you are protected from balance billing by a federal law known as the **No Surprises Act**. This protection may extend to services you receive after you are in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

You are also protected from balance billing by the No Surprises Act if you are treated by an out-of-network provider at an in-network facility, unless you give written consent and give up your protection from being balance billed for such treatment. However, in certain cases, such a provider cannot balance bill you under any circumstances. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, intensivist services, and other items or services rendered by an out-of-network provider if there was no PPO provider at the facility who could provide the item or service.

Finally, you are also protected from balance billing if you receive air ambulance services and while you are considered a Continuing Care Patient as defined below.

Out-of-Network Services Treated as In-Network

1. Services Covered by the No Surprises Act

Out-of-network services covered by the **No Surprises Act** will be treated as if rendered in-network. These services include **Emergency Services** for an **Emergency Medical Condition**, services rendered by an out-of-network provider at an in-network facility (unless, if permitted, you waive your protection from being balance billed), and air ambulance services.

In general, the term "Emergency Medical Condition" means an Illness, injury, symptom, or condition severe enough that you reasonably believe it will risk serious danger to your health if you do not get medical attention right away. Officially, the term "Emergency Medical Condition" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

In general, the term "Emergency Services" means services received in an emergency room or appropriately licensed urgent care facility to check for an Emergency Medical Condition and treat you to keep such a condition from getting worse. Officially, the term "Emergency Services" means, with respect to an Emergency Medical Condition: an appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department appropriately licensed under state law (including ancillary services routinely available to the emergency department or independent freestanding emergency department) to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the emergency department or independent freestanding emergency department, as are required under the Social Security Act (or would be required if the Social Security Act applied to the freestanding emergency department) to stabilize the patient. Emergency Services also include services you may receive after you are in a stable condition, unless you give written consent and give up your protection from being balance billed for these post-stabilization services in a manner that complies with federal law.

2. Continuity of Care

Federal law requires extended in-network treatment for qualifying "Continuing Care Patients" when such a patient's in-network provider suddenly becomes an out-of-network provider. If you are a Continuing Care Patient, you may not be balance billed for services provided by the specified out-of-network provider or facility during a transitional care period. The transitional care period begins on the date of the notice that an individual qualifies as a Continuing Care Patient and ends after 90 days or until the individual no longer qualifies as a Continuing Care Patient, whichever is sooner.

A "Continuing Care Patient" is an individual who:

- Is undergoing a course of treatment for a serious and complex condition;
- Is undergoing a course of institutional or inpatient care;

- Is scheduled to undergo nonelective surgery, including receipt of postoperative care;
- Is pregnant and undergoing a course of treatment for the pregnancy; or
- Is or was determined to be terminally ill and is receiving treatment for such illness.

A "serious and complex condition" means a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or a chronic illness or condition that is life threating, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time. If you may qualify as a Continuing Care Patient, as determined by the Plan, you will be notified of this possible status.

3. Provider Directory Issues

The Plan maintains a provider directory and other protocols for verifying a provider's in-network or out-of-network status. If the directory or other protocol incorrectly advises you that a provider is in-network, the services you receive from that provider will be treated as if rendered in-network. (Incorrect advice furnished by the provider directory or other protocol must be verified through supporting documentation for this provision to apply.)

Out-of-Area Services

If you are considered "out-of-area" and you visit a non-PPO provider and services provided are not services covered by the No Surprises Act, your expenses are paid at 100% of the UCR Rate, but if your non-PPO provider charges you an amount in excess of the UCR Rate, you will be responsible for paying the amount of the charge that exceeds the UCR Rate in addition to any coinsurance that applies. Services provided out-of-area but covered by the No Surprises Act will be treated as if rendered in-network as described above.

➢ **Page 36, Replace the section "Your Out-of-Pocket Maximum" in its entirety and replace with the following:**

YOUR ANNUAL OUT-OF-POCKET MEDICAL MAXIMUM

The Annual Out-of-Pocket Medical Maximum is the most you'll pay in the calendar year for covered medical and Behavioral Health Benefits including Substance Use Disorder Treatment Benefits. These out-of-pocket costs include your Annual Medical Deductible, coinsurance amounts, and any emergency room visit Copays you pay. There are charges that are not taken into account for determining whether you have reached your Annual Out-of-Pocket Medical Maximum. These charges include:

- Amounts you are balance billed by an out-of-network provider because the charge exceeds the UCR Rate,
- Coinsurance that is applied to Chiropractic services,
- Amounts for charges for services not covered under the Plan, and
- Amounts that are applied to your Annual Out-of-Pocket Prescription Drug Benefits Maximum.

If you reach your Annual Out-of-Pocket Medical Maximum, the Plan will pay 100% of your covered medical and Behavioral Health Benefits including Substance Use Disorder Treatment Benefits for the remainder of the calendar year. You should keep in mind, however, that if you reach your Annual Out-of-Pocket Medical Maximum and you visit an out-of-network provider, the Plan will not cover amounts in excess of the UCR Rate; moreover, you will be responsible for any coinsurance applied to Chiropractic services.

ANNUAL OUT-OF-POCKET MEDICAL MAXIMUM	
Annual Out-of-Pocket Medical Maximum	$1,500 per person; $3,000 per family (includes Behavioral Health Benefits including Substance Use Disorder Treatment Benefits)

➢ **Page 42: Replace "Wellness Benefits" in its entirety and replace with new "Preventive Services Benefits" as follows:**

Preventive Services Benefits

To promote the health of you and your family, the Plan's In-Network Preventive Services benefits are covered without application of the Plan's deductibles at 100% coverage.

FAST FACTS:

- **The Plan covers Preventive Services and supplies in the form of periodic exams, routine screening tests, immunizations, and other preventive services to the extent required by applicable law.**
- **Preventive Services are not subject to the Plan's deductible and are paid in full by the Plan when provided In-Network.**

- **Preventive Services provided by an Out-of-Network provider are subject to the Out-of-Network deductible and coinsurance without regard to whether the service would otherwise be considered a Preventive Service.**

OVERVIEW OF PREVENTIVE SERVICES:

PREVENTIVE SERVICES

"Preventive Services" means routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

At a minimum, the Plan will adhere to certain federal guidelines, *i.e.*, United States Preventive Services Task Force (USPSTF), Health Resources and Services Administration (HRSA), American Academy of Pediatrics (AAP), Bright Futures, and the Centers for Disease Control and Prevention (CDC), in determining the Preventive Services and treatments it will cover without application of the Plan's deductibles at 100% coverage when provided In-Network. To the extent not already set forth in these federal guidelines, the Plan may impose reasonable, recognized rules or other limits with respect to the number of visits or treatments it will cover in a given period of time for any one particular Preventive Service. To the extent any such limits or other rules are inconsistent with applicable law or federal guidelines, applicable law or the guidelines will control.

The scope of Preventive Services the Plan covers is described as follows:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the HRSA.
- With respect to women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the USPSTF), which will be commonly known as HRSA's Women's Preventive Services: Required Health Care Plan Coverage Guidelines.
- Preventive Services incurred for non-medical reasons (*e.g.*, to maintain a license or employment, as part of judicial or administrative proceedings, a prerequisite for traveling or education purposes) are not covered under the Plan.
- A service that is provided to monitor or treat an existing condition and not as a Preventive Service will be covered to the extent otherwise covered by the Plan and will be subject to the Plan's applicable cost-sharing provisions.

A comprehensive list of available Preventive Services covered by the Plan as part of the Plan's Preventive Services Benefit may be found at the following website:

www.healthcare.gov/preventive-care-benefits/

The types of Preventive Services required by law may be updated from time to time and will be deemed to have been incorporated in the Plan by reference. Any change or update to the types of preventive services required by law will take effect with respect to the benefits provided under the Plan on the first day of the Plan Year beginning on or after one year following the date the change or update occurs.

To the extent the comprehensive list referenced above is inconsistent with applicable law or the preventive service guidelines, such applicable law or guidelines will control. In addition, this Section will supersede any inconsistent or conflicting Plan provision regarding the coverage of services that are considered preventive under applicable law or the guidelines.

CERTAIN SERVICES TREATED AS PREVENTIVE SERVICES

Adults

Preventive Services are payable for all adult Covered Individuals as listed in the government website at www.healthcare.gov/preventive-care-adults/. To the extent the following Preventive Services are not listed at www.healthcare.gov/preventive-care-adults/, the Plan will pay for these Preventive Services:

- One routine physical examination per Covered Individual per calendar year for male and female adults will be treated as a Preventive Service regardless of whether such examination otherwise qualifies as a Preventive Service,
- Annual prostatic specific antigen (PSA) lab test for men age 40 or older,

- Glaucoma screening,
- Thyroid test,
- Complete blood count,
- Urinalysis, and
- EKG.

Women's Preventive Services

Certain additional Preventive Services are payable for all female Covered Individuals as listed in the government websites at www.hrsa.gov/womensguidelines/ or www.healthcare.gov/what-are-my-preventive-care-benefits. To the extent the following Preventive Services are not listed at www.hrsa.gov/womens-guidelines/ or www.healthcare.gov/what-are-my-preventive-care-benefits, the Plan will pay for these Preventive Services:

- Well-woman preventive visits,
- Screening for diabetes in pregnancy,
- BRCA breast cancer gene test,
- HPV testing at least every 3 years starting at age 30,
- Counseling for sexually transmitted infections,
- Annual HIV screening and counseling, and
- Rental of breastfeeding equipment and necessary supplies after delivery with lactation support following delivery.

Children's Preventive Services

Preventive Services are payable for all Children who are Covered Individuals as listed in the government website at www.healthcare.gov/preventive-care-children/.

PREVENTIVE SERVICES CLAIMS ADMINISTRATION RULES

- Covered Preventive Services are payable at 100% of the contracted rate when you visit an In-Network provider. If you visit an Out-of-Network provider, benefits are payable at 75% of the UCR Rate or 100% of the UCR Rate if you are considered Out-of-Area.
- Covered Preventive Services for you and your eligible dependents are not subject to the Plan's annual deductible if you use an In-Network Provider or if you are considered Out-of-Area.
- When both Preventive Services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the Preventive Services. For purposes of this rule, Preventive Services are those services performed for screening purposes when the Covered Individual does not have active signs or symptoms of a condition. Preventive Services do not include diagnostic tests performed because the Covered Individual has a condition or an active symptom of a condition. When a Preventive Services visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered a Preventive Service.
- If a USPSTF/HRSA/AAP/Bright Futures/CDC Preventive Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that Preventive Service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.
- Preventive Services are considered for payment when billed under the appropriate Preventive Service code (benefit adjudication depends on accurate claim coding by the providers). If the billing for a Preventive Service is submitted to the claims administrator with a diagnosis code other than Preventive Service, claims will be processed under the Plan's usual deductible/copay/coinsurance.
- Services not covered under the Plan's Preventive Services Benefit provision may be covered only as provided under another section of the SPD. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's deductibles, copay, or coinsurance, and all other Plan provisions.
- If there is no In-Network provider who can provide the Preventive Services, then the Plan will cover the Preventive Service when performed by an Out-of-Network provider without cost sharing, *i.e.*, at 100% of the UCR Rate and not subject to Plan's annual deductible. Certain
- Certain over-the-counter (OTC) drugs are payable without cost-sharing in compliance with USPSTF/HRSA/AAP/Bright Futures/CDC Preventive Services recommendations. See "What's Covered" in the Prescription Drug section of the SPD for more information.

➢ **Page 48, effective January 1, 2024, to: (1) comply with Essential Health Benefits provisions of the ACA, and (2) reference the Plan's new Specialty Pharmacy Copay Assistance Program, revise "Your Prescription Drug Benefits At-A-Glance" as follows:**

YOUR PRESCRIPTION DRUG BENEFITS AT-A-GLANCE

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

*Subject to the Plan's Generic Drug Incentive Program (see below).
!Subject to the Plan's Specialty Pharmacy Copay Assistance Program (see below).

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

Your Annual Out-of-Pocket Prescription Drug Benefits Maximum

The Annual Out-of-Pocket Prescription Drug Benefits Maximum is the most you'll pay in the calendar year for covered prescription drugs. These out-of-pocket costs include your prescription drug Copays listed above. There are charges that are not taken into account for determining whether you have reached your Annual Out-of-Pocket Prescription Drug Benefits Maximum. These charges include:

- Amounts for charges for services not covered under the Plan,
- Charges, if any, associated with specialty pharmacy drugs covered under the Pharmacy Copay Assistance Program (see below), and
- Amounts that are applied to your Annual Out-of-Pocket Medical Maximum.

If you reach your Annual Out-of-Pocket Prescription Drug Benefits Maximum, you will no longer be required to pay Prescription Drug Copayments listed in the table above.

OUT-OF-POCKET PRESCRIPTION DRUG BENEFITS MAXIMUM	
Your Annual Out-of-Pocket Prescription Drug Benefits Maximum*	$7,950 per person; $15,900 per family
**All Copayments are applied towards your Annual Out-of-Pocket Prescription Drug Benefits Maximum. Once you or your family has met the Annual Out-of-Pocket Prescription Drug Benefits Maximum, you will no longer be required to pay Prescription Drug Benefit Copays listed above. Charges, if any, associated with specialty pharmacy drugs covered under the Pharmacy Copay Assistance Program (see below), are not applied to your Annual Out-of-Pocket Prescription Drug Benefits Maximum.*	

➢ **Page 50, following "Generic Drug Incentive Program" add new section ("Specialty Pharmacy Copay Assistance Program") as follows:**

SPECIALTY PHARMACY COPAY ASSISTANCE PROGRAM

The Plan has implemented a Specialty Pharmacy Copay Assistance Program. Certain specialty pharmacy drugs are not considered "Essential Health Benefits" under the Plan, and thus the cost of such drugs will not be applied toward satisfying your Annual Out-of-Pocket Prescription Drug Benefits Maximum. Although the cost of the specialty pharmacy drugs subject to this program will not be applied towards satisfying your Annual Out-of-Pocket Prescription Drug Benefits Maximum, the cost of specialty pharmacy drugs within this program will be reimbursed by the manufacturer at little or no cost to you. Copayments for medications that are included in the program will be higher than the Copayments otherwise set forth above; typically, those Copayments will be set to the maximum level of available manufacturer-funded

copayment assistance. However, you will not pay more for these drugs; rather, due to the manufacturer copay assistance, you may pay less or even nothing at all. To find out whether a particular drug is part of the Plan's Specialty Pharmacy Copay Assistance Program, contact SaveOnSP at 800-683-1074 visit https://www.saveonsp.com/neihbp/].

To qualify for copay assistance through this program, your specialty medication must be filled through the specialty pharmacy designated by the Plan. If a drug you are prescribed is included in the program, the specialty pharmacy will work with you to secure the maximum amount of copayment assistance available.

- **Page 50 (Prescription Drugs): Replace the bullet-points below "What's Not Covered" with the following:**

  - Over-the-counter drugs, vitamins, and dietary supplements except where such over-the-counter drug, vitamin, or dietary supplement meets the Plan's definition of Preventive Services, in which case, coverage of such over-the-counter drug, vitamin, or dietary supplement shall be determined under the Plan's Preventive Services Benefit.
  - Drugs removed from the Express Scripts formulary and not covered by the Plan (see above).
  - Prescriptions that require prior authorization (see above) if you did not obtain such prior authorization.
  - Contraceptives that fall outside current Women's Preventive Services Guidelines as set forth in www.hrsa.gov/womens-guidelines/ (See also, Preventive Services).
  - Drugs labeled "Caution—limited by Federal Law to investigational use."
  - Drugs with the sole purpose of promoting or stimulating hair growth or promote hair removal.
  - Experimental drugs.
  - Legend vitamins except where such legend vitamins meet the Plan's definition of Preventive Services, in which case, covered of such legend vitamins shall be determined under the Plan's Preventive Services Benefit.
  - Liquid protein supplements.
  - Medication that is to be taken by, or administered to, you or an eligible dependent while a patient in a Hospital, Skilled Nursing Facility, nursing home, or similar facility.
  - Therapeutic devices or appliances.
  - Compounded medications which contain ingredients that are excluded under Express Scripts' Compound Management Program (see above).

- **Page 57 (Vision Care): effective January 1, 2024, to comply with "Essential Health Benefits" provisions of the ACA, replace the first paragraph below the chapter heading "Vision Care" as follows:**

Your and your eligible dependents' participation in the Plan automatically includes coverage for Vision Benefits. However, you may choose to waive Vision Benefit coverage by notifying the Plan in writing. A Participant who waives Vision Benefit coverage may later reinstate Vision Benefits coverage by submitting a written request to the Plan. Coverage for Vision Benefits will resume only after the Benefits Office receives this written request.

Vision care benefits include routine eye exams are an important part of your overall health. That's why the Plan has a contract with EyeMed, a nationwide provider network of Optometrists, ophthalmologists, and opticians.

- **Page 58: Vision Care Benefit Improvements (Effective January 1, 2024): The Trustees have made improvements to the Plan's *In-Network* Vision Benefit. The provision of the SPD under the heading "YOUR IN-NETWORK VISION CARE BENEFITS AT-A-GLANCE" is revised as follows:**

VISON BENEFIT	THE MAXIMUM THE PLAN WILL PAY PER CALENDAR YEAR USING THE EYEMED NETWORK
Routine eye exam ▪ At PLUS Providers* ▪ At non-PLUS Providers	 Paid in full; no Copayment Paid in full; no Copayment
Dilation	Paid in full; no Copayment
Standard Lenses** (pair)	Paid in full; no Copayment
Standard progressive lenses	Paid in full; $60 Copayment
Premium progressive lenses ▪ Tier I	 Paid in full; $65 Copayment

▪ Tier II ▪ Tier III ▪ Tier IV	Paid in full; $85 Copayment Paid in full; $110 Copayment Paid in full; $175 Copayment
Standard Anti Reflective Coating	Paid in full; $45 Copayment
Premium Anti Reflective Coating ▪ Tier I ▪ Tier II ▪ Tier III	 Paid in full; $57 Copayment Paid in full; $68 Copayment Paid in full; $85 Copayment
One pair of eyeglass frames ▪ At PLUS Providers* ▪ At non-PLUS Providers	 Up to $200; no Copayment; discount of 20% on amount over $200 Up to $150; no Copayment; discount of 20% on amount over $150
Conventional contact lenses**	Up to $130; discount to the member of 15% on the amount over $130
Disposable contact lenses**	Up to $130
Medically Necessary contact lenses, prescribed if: ▪ Your vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses, or ▪ You are being treated for a medical condition and contact lenses are routinely used as part of the treatment.	Paid in full; no Copayment
Polycarbonate, high index lenses ▪ Single ▪ Bifocal ▪ Trifocal ▪ Lenticular	 Paid in full Paid in full Paid in full Paid in full
▪ UV Coating ▪ Tint (Solid and Gradient) ▪ Standard Scratch-Resistance ▪ Standard Polycarbonate ▪ Standard Anti-Reflective Coating	Paid in full; $15 Copayment Paid in full; $15 Copayment Paid in full; $15 Copayment Paid in full: no Copayment Paid in full; $45 Copayment

** To find out if a provider is a PLUS Provider in the EyeMed Network, call 1-877-226-1115 or visit the EyeMed website at www.eyemedvisioncare.com.*

***If only one lens is necessary, the maximum benefit is one-half the amount of two lenses.*

➢ **Page 70: To: (a) integrate certain requirements for Non-Grandfathered Plan under the ACA, (b) integrate certain provisions of the No Suprises Act, and (c) clarify certain general exclusions, replace "What's Not Covered" in its entirety and replace with new "General Exclusions" as follows:**

General Exclusions

In addition to the specific information listed in each section, expenses for the following services are not covered under the Plan:

- Expenses for any service or supply that is not Medically Necessary. (See Glossary of Terms page 89)
- Expenses for any service not listed as a Covered Expense.
- Expenses for court costs and/or legal fees except as provided under the Plan's Member Assistance Program.
- Expenses for treatment or services for a person who is not covered by the Plan or was not covered at the time the treatment/service was performed.
- Expenses for Custodial Care.
- Expenses for early intervention services.
- Expenses for education or training, except as otherwise listed in this Summary Plan Description.
- Expenses for services that are paid for by another welfare benefit plan or other group plan.

- Expenses for which a claim is not received by the end of the second calendar year following the calendar year in which the expense occurred.
- Expenses resulting from an injury or Illness sustained while you were performing any occupation or employment for remuneration or profit.
- Expenses incurred by the genetic mother (donor) or gestational carrier (surrogate mother) related to the assisted reproduction, maternity care and delivery associated with a surrogate mother's pregnancy; however, if the genetic mother and the surrogate mother are both Covered Individuals, the Plan will provide maternity coverage for the gestational carrier; all other provisions of the SPD, including the other exclusions listed in this section, shall apply so that maternity and delivery claims relating to the gestational carrier's pregnancy shall be in accordance with what the Plan would otherwise provide a pregnant Covered Individual.
- Expenses that you are not obligated to pay.
- Experimental Treatments or Services and investigational services. However, in the case of a clinical trial with respect to the treatment of cancer or another life-threatening disease or condition, the Plan:
  - Will not deny a Covered Individual who is a "qualified individual" participation in an Approved Clinical Trial with respect to the treatment of cancer or another life-threatening condition;
  - Will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial, and
  - Will not discriminate against the Covered Individual on the basis of their participation in the clinical trial.

  For purposes of this provision, "qualified individual" is a Covered Individual who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring provider is a participating provider and has concluded that the Covered Individual's participation in such trial would be appropriate, or (2) the Covered Individual provides medical and scientific information establishing that their participation in such trial would be appropriate.
- Expenses for injury or Illness caused by war or intentional armed conflict.
- Expenses for interest.
- Expenses for late charges and/or collection fees of any type.
- Expenses for photos.
- Expenses for services performed by a provider whose credentials are not recognized by the Plan, including, but not limited to an O.M.D, A.C.R., A.T., C.D., C.L.C., C.M.T., C.N.T., C.P.M., C.S.C.S., L.M.T., M.A., N.D., acupuncture or acupressure providers not certified by the National Certification Commission for Acupuncture and Oriental Medicine, and P.T.A.
- Expenses for surface EMGs.
- Expenses for treatment by a Physician that is not within the scope of his or her license.
- Expenses for treatment not ordered by a Physician.
- Dental work, including care and treatment to the teeth and gums, when not paid under the Plan's Dental Benefits section, except for the following:
  - Cutting procedures on the gums, up to the UCR Rate;
  - Oral surgery to remove an impacted tooth, up to the UCR Rate; or
  - First repair and/or restoration to Sound Dentition as the sole result of a covered injury by an external, unexpected and violent accident. Sound Dentition is defined as a healthy tooth (stable, functional, free from decay and periodontal disease) or one that has been restored to a sound condition or replacement by a fixed or removable partial denture, crown or bridge. Treatment must be provided within twelve months of the accident date. Injury during chewing or biting is not considered accidental.
- Charges resulting directly or indirectly from the commission of a felony.
- Charges incurred for the treatment of a Cosmetic condition.
- Charges in excess of the UCR Rate for services provided by a non-PPO provider.
- Charges that are not Medically Necessary for the care or treatment of an injury, Illness or pregnancy (unless otherwise stated).
- Eye exam for glasses, except as otherwise listed as a Covered Expense under the Plan's Vision Benefits section.
- Eyeglasses and refraction because of a covered injury that is not paid under the Plan's Vision Benefits section.
- Home genetic testing kits and services.
- Medical care or treatment not recommended by a duly qualified Physician.
- Neurodiagnostic and electrodiagnostic testing not performed by a provider not duly licensed to perform such testing.
- Nutritional supplements, except as otherwise provided under the Plan's Preventive Services Benefit.
- Prescription drugs, except as otherwise listed under the Plan's Prescription Drug Benefits section.
- Radial keratotomy.
- Replacement of batteries or cords except as provided under the Plan's hearing care benefit.
- Services of a pastoral counselor in the course of his/her normal duties, except as provided under the Plan's Hospice Care section.

- Services provided by volunteers or individuals who do not normally charge for their services.
- Visits for consultation with a specialist after the first two visits.
- Weight loss programs other than weight loss programs provided through Virta Health's Type 2 Diabetes, Prediabetes, and Obesity Treatment Programs.

➢ **Page 75, Replace "Filing Your Claims" in its entirety to: (a) integrate certain requirements for Non-Grandfathered Plan under the ACA, (b) integrate certain provisions of the No Suprises Act, and (c) clarify the Plan's claims and appeals procedures as follows:**

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, or Express Scripts as applicable. Refer to chart below for the appropriate address.

In-Network and Out-of-Network Medical, Mental Health, and Substance Use Disorder Claims (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-EyeMed 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

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.

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 73 – 74 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 number 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 contact the workers' compensation carrier, or other third party, to verify the denial and to verify that you have filed an appeal of the carrier's denial of liability. 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, mental health and substance use disorder claims, preventive services claims, extended care claims, organ transplant claims, and dental, vision, 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.
- 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.

Applicable Definitions

As described below, the notification procedures following an initial benefit determination differ depending on whether your claim involves **Urgent Care,** is a **Pre-Service Claim**, **Post-Service Claim** or C**oncurrent Care Claim**. These terms are defined as follows:

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.

Urgent Care Claim.

An "Urgent Care Claim" is a Pre-Service 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. Only Pre-Service Claims may be Urgent Care Claims under this Plan and the applicable regulations.

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" has the meaning set forth below.

Rescission.

A Rescission of coverage is a retroactive cancellation or termination of your coverage. The Plan may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice, or omission that constitutes fraud, or if the individual makes an intentional misrepresentation of material fact. A prospective termination of coverage is not a rescission. Termination of coverage for failure to pay a required premium is not a rescission. Additionally, termination of coverage retroactive to the date of divorce (or other event making a dependent ineligible for coverage) is not a rescission if COBRA is not elected and/or the full COBRA premium is not paid by you or your dependent(s). A rescission is a benefit claims decision that you have the right to appeal. If your coverage is rescinded for a reason other than fraud or intentional misrepresentation of material fact, your coverage under the Plan will continue during the appeal period. Coverage will not continue during any applicable appeal period if your coverage is terminated due to failure to pay a premium.

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 period of 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, discloses the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793, and describes the Plan's internal and external appeals procedures, how to initiate them 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.

Internal Appeal Procedures

If any claim for benefits described above is denied, in whole or in part, or if there has been a Rescission of your coverage, you may request the Board of Trustees to review the benefit denial or Rescission of coverage. Your written appeal must be submitted within 180 days of receiving the denial notice. However, in the case of a Concurrent Care Claim, 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. Your written appeal should be filed at the following address:

Board of Trustees
National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073

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.

The Plan will provide you, free of charge, with new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable

opportunity for you to respond to such new evidence or rationale. In such cases, if the Plan receives new or additional information so late that it would be impossible to give it to you in time for you to have a reasonable opportunity for you to respond, the period for deciding your appeal will be tolled until you have a reasonable opportunity to respond.

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 a 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 of Decisions on Appeal

If the Trustees deny your appeal, in whole or in part, you will be provided with a written notice of denial. The notice will state:

- Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code, and the meanings of these codes;
- The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or Rescission;
- A description of any standard used to deny your claim;
- References to the specific Plan provisions on which the benefit determination or Rescission was based;
- If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
- If the denial is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
- The identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- 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;
- A description of the external review process, including information on how to initiate an external review and applicable time limits;
- A statement of the right to bring a civil action under Section 502(a) of ERISA;
- If applicable, disclosure of the availability of, and the contact information for, any applicable office of health insurance consumer or ombudsman established under the Public Health Service Act Section 2793.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable after receiving a request. The Plan will not consider a request for such diagnosis and treatment, in itself, to be an appeal or request for external review.

EXTERNAL REVIEW

Standard External Review

If you receive an Adverse Benefit Determination on your appeal concerning your health benefit claim or a Rescission of your coverage, you (or your authorized representative) have the right to request an external review. The external review process is limited to Adverse Benefit Determinations that involve medical judgment, whether the Plan is complying with applicable surprise billing and associated cost-sharing protections under federal law, and Recissions in coverage.

A determination involves medical judgment if, for example, it is based on the Plan's requirements for Medical Necessity, appropriate health care setting, level of care, or a determination that a treatment is experimental. Other determinations that involve medical judgment include whether:

- a treatment is for emergency services;
- a claim for items or services provided by an Out-of-Network provider or an In-Network facility are subject to the protections of the No Surprises Act;
- you were in a condition to receive a notice about the availability of the protections against balance billing and gave informed consent to waive those protections;
- a claim for items and services was coded correctly, consistent with the treatment you received, thus entitling you to the protections against balance billing, and
- cost-sharing was correctly calculated for ancillary services provided by an Out-of-Network provider at an In-Network facility.

Your request for external review should be sent to:

National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073
Attn: Robert O. Betts, Jr.

Your request for an external review must be made no later than four (4) months after the date you receive the Adverse Benefit Determination on appeal. If there is no corresponding date four (4) months after the date of receipt of such notice, the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is not February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. Failure to file a timely appeal will result in a complete waiver of your right to external appeal, and the Plan's determination regarding the claim will be final.

Within five (5) business days following receipt of your request for external review, the Benefits Office will conduct a preliminary review to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);
- You have exhausted the Plan's internal appeals process unless you are not required to exhaust the final internal appeals process; and
- You have provided all the information and forms required to process an external review.

Within one (1) business day after completion of its preliminary review, the Benefits Office will issue a written notification to you. If your request is complete but not eligible for external review, the notification will include the reasons for your request's ineligibility for external review and the toll-free (if available) contract information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow you to perfect the request for external review within the later of: (i) the four-month filing period, or (ii) the 48-hour period after the receipt of notification.

If your case is eligible for external review, it will be forwarded to an Independent Review Organization (IRO) accredited by a nationally recognized accrediting organization, and the IRO will contact you. The Benefits Office will contract with at least three (3) IROs for assignments under the Plan and rotate claim assignments among them or incorporate other independent, unbiased methods for selection of IROs, such as random selection.

Once you are contacted in writing by the IRO, you will have ten (10) business days to submit additional information directly to the IRO if you choose to do so. The IRO is not required to but may accept and consider additional information submitted after ten (10) business days. The IRO will use legal experts where appropriate to make coverage determinations under the Plan. Within five (5) business days after the assignment of the IRO, the Benefits Office will provide to the IRO the documents and information considered in making the Adverse

Benefit Determination and final internal appeal, including information that you previously submitted to the Benefits Office. Failure by the Benefits Office to timely provide the documents and information will not delay the conduct of the external review. If the Benefits Office does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or final Adverse Benefit Determination on internal appeal. Within one (1) business day after making such decision, the IRO must notify you and the Plan.

Upon receipt of any information that you submit, the IRO must forward the information to the Plan within one (1) business day. The Plan may, but is not required to, reconsider its Adverse Benefit Determination or final Adverse Benefit Determination on internal appeal. Reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its Adverse Benefit Determination or final Adverse Benefit Determination on internal appeal and provide coverage or payment, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Plan.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records,
- The attending health care professional's recommendation,
- Reports from appropriate health care professionals and other documents submitted by you, your treating provider, or the Plan,
- The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law,
- Appropriate practice guidelines developed by the federal government, national or professional medical societies, boards, and associations,
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law, and
- The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

Within 45 days after the IRO receives your request for external review from the Benefits Office, the IRO will issue you a written notice of its final external review decision. The written decision of the IRO will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnostic code and treatment code and their corresponding meanings, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to you;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Upon receipt of a notice of final external review decision reversing the Adverse Benefit Determination or final Adverse Benefit Determination on internal appeal, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Expedited External Review

When external review is available, the Plan will allow you to make a request for expedited external review at the time you receive:

- An Adverse Benefit Determination on appeal involving a medical condition for which the timeframe to complete an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal, or
- A final internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal Adverse Benefit Determination appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency care services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Benefits Office will review the request to determine whether the request meets the reviewability requirements using the same criteria above that apply to a standard external review. The Plan will immediately send a notice of its eligibility determination that meets the requirements for a standard external review eligibility determination notice.

Upon determination that a request is eligible for expedited external review following the preliminary review, the Plan will assign an IRO in accordance with the requirements for assigning an IRO for standard external review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The IRO's decision is binding on you and the Plan, except to the extent other remedies are available under state or federal law, and except that the requirement that the decision be binding shall not preclude the Plan form making payment on the claim or otherwise providing benefits at any time. The Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision, and unless or until there is a judicial decision otherwise.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard external review. In reaching a decision, the IRO will review the claim *de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The IRO will provide written notice to you and the Plan of the final external review decision, in accordance with the requirements above for standard external review, except that the notice will be provided as expeditiously as possible, but not more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing the notice, the IRO must provide written confirmation of that decision to you and the Plan.

If the IRO reverses the Plan's Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

IROs must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

SPECIAL RULES FOR DISABILITY DETERMINATIONS

Overview

The Plan has established 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,
- Eligibility for extended benefits due to disability, and
- Eligibility determinations for disabled adult Children.

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, 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 is 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 five (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 (or Urgent Claim), Concurrent Care Claim and Adverse Benefit Determination set forth above 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, your provider should submit a prior authorization request electronically. Alternatively, your provider or dispensing pharmacist may call the Express Scripts Coverage Review Department at 1-800-753-2851 or may fax a completed coverage review form to 1-877-329-3760. Forms may be obtained online at www.expressscripts.com/services/physicians. 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
Attention: 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 five (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 Benefit Determination. To initiate the appeal, the following information must be submitted by fax or mail to the appropriate department for Clinical Coverage or Administrative Coverage 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 Claim 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 Claim 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 Claim Appeals**

  Pre-Service Claim 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 Claim 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 Claim 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 Claim Appeals**

  Express Scripts will only perform one level of review for Urgent Claim appeals. Express Scripts will notify you and your provider whether your Urgent Claim 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 Claim 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.

External Review: Denial of Appeal for Coverage of a Drug Requiring Pre-Authorization

The right to request an independent external review may be available for an Adverse Benefit Determination involving medical judgment, Rescission, or a decision based on medical information, including determinations involving treatment that is considered Experimental or investigational.

Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization (IRO) with medical experts that were not involved in the prior determination of the claim.

To submit an external review request, the request must be mailed or faxed to:

MCMC, LLC
Attention: Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169-0929

Phone: 617-375-7700 ext. 28253
Fax: 617-375-7683

The request for external review must be received within four (4) months of the date of the final internal Adverse Benefit Determination of a Coverage Review Request for a drug requiring preauthorization. (If the date that is 4 months from the date is a Saturday, Sunday, or holiday, the deadline will be the next business day). As explained above, Urgent Claim appeals of a denial of a Coverage Review Request for a drug requiring preauthorization have only one required level of internal appeal before external appeal may be requested. A voluntary appeal to the Board of Trustees is also available but not required.

- **Standard External Review**

  MCMC will review the external review request within five (5) business days to determine if it is eligible to be forwarded to an IRO, and the patient will be notified within one business day of the decision.

  If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within five (5) business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review, and, if the IRO has determined that the claim involves medical judgment, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan, and Express Scripts written notice of its decision. If the IRO has determined that the claim does not involve medical judgment, the IRO will notify the claimant in writing and that the claim is ineligible for a full external review.

- **Expedited External Review**

  Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is an urgent external review. An urgent situation is one where, in the opinion of the attending 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 ability for the patient to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the claim is eligible for urgent processing, the claim will be reviewed immediately to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will be assigned randomly to an IRO, and the appeal information will be complied and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

TRUSTEE REVIEW OF PRESCRIPTION DRUG CLAIMS (VOLUNTARY APPEALS)

If you exhaust your appeal rights with Express Scripts, and if Express Scripts denied your appeal for Prescription Drugs, 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 benefits are resolved appropriately.

Your written appeal should state your name and address, the date of the denial by Express Scripts, 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:

- 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;
- Agrees that any statute of limitations or other defense based on timeliness is tolled during the time that such voluntary appeal is pending; and
- Will not require you to pay any fees or costs associated with the voluntary review.

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 INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

To file a claim for Life Insurance or Accidental Death and Dismemberment Benefits ("AD&D Benefits") contact the Benefits Office for a Life Insurance or AD&D claim form.

Submit your claim form to:
National Elevator Industry Health Benefit Plan
19 Campus Blvd., Suite 200
Newtown Square, PA 19073
Attn: Eligibility Unit

Life Insurance and AD&D 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 Life Insurance or AD&D 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 is 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 Life Insurance Benefits and AD&D Benefits, eligibility is determined by the insurance carrier providing the Life Insurance Benefit or 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.

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 above.

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.

DECISIONS OF THE TRUSTEES ARE FINAL AND BINDING

- **Trustee Discretion and Authority**

  The Board of Trustees has the exclusive discretionary authority to interpret the Plan and to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, benefits, eligibility and application of the Plan and other policies and rules. The Board of Trustees has the exclusive discretionary authority to determine if a benefit is covered or subject to reimbursement under the Plan.

- **Decisions are Final and Binding | Option to Reconsider if New Information is Presented**

  The Board of Trustees' decision on review or appeal is final and binding on all parties, including anyone claiming a benefit on your behalf. Except in cases where the Trustees determine that reconsideration of your claim or appeal is appropriate, there is no further level of appeal under this Plan besides those described in this booklet.

➢ **Page 89 (Glossary of Terms), to integrate certain requirements for Non-Grandfathered Plan under the ACA into the Plan, add the following definition:**

Approved Clinical Trial: An Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described as any of the following:

➢ Federally funded trials: The study or investigation is approved or funded by one or more of the following: (1) the National Institutes of Health; (2) the Centers for Disease Control and Prevention; (3) the Agency for Health Care Research and Quality; (4) the Centers for Medicare & Medicaid Services; (5) a cooperative group or center of any of the entities described in clauses (1) through (4) or the

[1] See pages 64 through 68 of the SPD for more information.

Department of Defense or the Department of Veterans Affairs; (6) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; (7) the Department of Veterans Affairs, the Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and that assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration, or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- **Page 93 (Glossary of Terms), to integrate certain provisions of the No Suprises Act into the Plan, amend "UCR Rate" as follows:**

UCR Rate: The UCR Rate (also known as the Usual, Customary and Reasonable Rate) is the lesser of:

1. the amount the provider charged the patient for services or supplies, or
2. the usual fee charged to most patients for similar services or supplies that falls within the range charged by providers with comparable training and experience for the same or similar services or supplies within the same geographic area.

UCR Rates as defined in 2 above are established by an independent group contracted by the Plan which maintains a national database of UCR Rates. In addition, secondary PPO networks and negotiated rates may be utilized if they result in lower costs to the Plan or Covered Individual.

Notwithstanding the foregoing, for a service or supply rendered by an out-of-network provider that is subject to the No Surprises Act, the UCR Rate is the Qualifying Payment Amount ("QPA"), determined in accordance with applicable federal regulations, based on the median contracted rate for the service, as adjusted periodically by the consumer price index. Participant cost-sharing will be based on the QPA. Initial payment to the provider will be based on the QPA, after which, if necessary, the Fund will resolve the remainder of the provider's bill in accordance with the negotiation and dispute resolution provisions of the No Surprises Act and its underlying regulations.

Notices

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 فإن خدمات المساعدة اللغوية اللغة، اذكر تتحدث كنت إذا :ملحوظة 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