AMENDMENT #2
to the Plan Document/Summary Plan Description for the
Teamsters Security Fund for Southern Nevada-Local 14
that was effective May 1, 2019

Effective March 1, 2020, the Plan Document/Summary Plan Description is amended as follows:

Article III. Eligibility, Section. B. Bargaining Unit Employees is amended to add the following new text shown in italics:

Section B. Bargaining Unit Employees.

1. **Employee Eligibility**. You are eligible for health and welfare benefit coverage if your employer is required to make contributions to the Plan on your behalf as required by Collective Bargaining Agreement or other written agreement.

2. **When You Become Eligible**. You will be eligible for Benefits on the first day of the month following receipt of the Employer's first contributions on your behalf. You must also complete an enrollment card to be eligible for Benefits.

   For Employees hired <u>before</u> February 1, 2015, eligibility will begin the 1st of the month following receipt of three (3) consecutive months of Employer contribution on your behalf.

   For Employees hired <u>on or after</u> February 1, 2015, or who are re-establishing Eligibility on or after February 1, 2015, eligibility will begin the 1st of the month following receipt of the Employer's first contribution on your behalf.

   Contributions are late if not received by the Fund Office by the 20th of the month following the month in which the Employee was hired. Example: for an Employee hired on any date in February, contributions are late if not received by the Fund Office by March 20th for an April 1st effective date for health coverage.

3. **Breaks in Covered Employment**.

   (a) Participants who lose eligibility for more than 30 days will be required to satisfy the initial eligibility rule, before coverage can resume. This 30-day break rule will also apply to Non-Medicare Retirees who return to active employment.

   (b) Participants are permitted to make COBRA payments to avoid a break in coverage.

   (c) During the COVID-19 National Emergency Coverage Extension Period (as defined in Article XV. Section W. and Article XVII Section A. 48), any employee eligible who receives emergency coverage will not incur a break of coverage during such coverage period.

4. If an eligible Employee takes employment with another participating employer and does not lose eligibility under this Plan, the Employee will be eligible on the first day of the month following receipt of the first contribution to the Plan from the new employer on the Employee's behalf. However, if an Employee performs services for more than one participating employer, the Employee will not be entitled to Plan Benefits greater than those that would apply if services were performed for only one participating employer.

Article III. Eligibility, Section J., Termination of Coverage, Subsection 1 is amended to add the following new text shown in italics:

Section K. Termination of Coverage.

See also the COBRA provisions of this Plan for information on temporarily self-paying for benefits after coverage ends under this Plan.

1. **Employees.** Your coverage will end on the earliest of the:

   (a) Termination date of the Plan, or for a particular benefit, the termination date of the benefit;

   (b) Date of your death;

   (c) End of the period for which the last required contribution was made; *except during the COVID-19 National Emergency Coverage Extension Period as set forth in Article XV. Section W.;*

   (d) End of the period for which an employer has paid a contribution on your behalf;

   (e) The date on which you enter full-time military armed forces of any country; or

   (f) End of the month in which your eligibility ends, or

   (g) For Employees hired on or after February 1, 2015, or who are re-establishing Eligibility on or after February 1, 2015, the end of the month in which your employment ends.

Article XV. COBRA: Temporary Continuation of Coverage is amended to add the following new Section W. as shown in italics:

Section W. Continuation Of Health Care Coverage During COVID-19 National Emergency Coverage Extension Period

1. ***Entitlement to Emergency Coverage:*** *In light of the extraordinary events that have occurred to combat the spread of 2019 novel coronavirus ("COVID-19"), including the declaration of a National Emergency by the federal government and the temporary closure of Las Vegas area casinos, schools and other facilities, the trustees have approved a temporary period for trust-covered continuation of coverage for eligible employees. This continuation of coverage is available only for eligible employees who are laid off, terminated or for whom employer contributions otherwise terminated in connection with the National Emergency for COVID-19 after March 1, 2020. Such eligible employees will remain eligible for coverage from March 1, 2020 through August 31, 2020 (the "COVID-19 National Emergency Coverage Extension Period"). Thereafter, the plan's existing terms for eligibility, termination of coverage and COBRA continuation of coverage will apply.*

Article V. Schedule of Medical PPO Plan Benefits, the "Overall Annual Deductible" row is amended to add the following new text as shown in italics:

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS This chart explains the benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All benefits are subject to the deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network***
Overall Annual Deductible for the Medical Plan • The deductible is the amount you must pay each calendar year before the Plan pays benefits. • The amount applied to the deductible is the lesser of billed charges or the amount considered to be an Allowable Expense under this Plan.	• **Note that these deductibles are NOT interchangeable.** This means you **may not** use any portion of an In-Network deductible to meet an Out-of-Network deductible and vice versa. • Certain other benefits outlined in this Schedule may also have a **benefit-specific deductible** in addition to this overall annual medical plan deductible. • ***Covid-19 Test and Covid-19 Related Services will not be subject to the Deductible during the COVID-19 National Emergency Period.***	$500 per person $1,500 per family	$1,500 per person $4,500 per family

Article V. Schedule of Medical PPO Plan Benefits, the "Laboratory Services (Outpatient)" row is amended to add the following new text as shown in italics:

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS This chart explains the benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All benefits are subject to the deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of-Network***
Laboratory Services (Outpatient) • Technical and professional fees. • Some laboratory services are payable under the Wellness Benefits in this Schedule.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical PPO Plan Benefits. • No coverage for a sleep study or neuro-monitoring test performed by an out-of-network provider. • ***Coverage of Covid-19 Testing and Covid-19 Related Services is effective only for services received during the COVID-19 National Emergency Period.***	After deductible met, you pay a $5 copay per visit. *Covid-19 Test related visit: 100%, no deductible*	After deductible met the Plan pays 50% of allowable expenses. *Covid-19 Test related visit: 100%, no deductible*

Article V. Schedule of Medical PPO Plan Benefits, the "Emergency Room Facility, Urgency Care Facility" row is amended to add the text in italics and delete the text in strike-through:

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS This chart explains the benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All benefits are subject to the deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**			
Benefit Description	**Explanations and Limitations**	**In-Network**	**Out-of- Network***
Emergency Room Facility, Urgent Care Facility • Hospital emergency room (ER) for "emergency services" (as that term is defined in this Plan). • Urgent Care facility. Common medical conditions that may be appropriate for a Physician office or Urgent Care facility (instead of an Emergency Room) include, but are not limited to, fever, sore throat, earache, cough, flu symptoms, sprains, bone or joint injuries, diarrhea or vomiting, or bladder infections. • Ancillary charges (such as lab or x-ray) performed during the ER or Urgent care visit. • (See also the Ambulance section of this schedule.)	• See also the Definition of "Emergency Care" in the Definitions Article. • The ER visit Copayment will be waived if you are subsequently and immediately Hospitalized. • **IMPORTANT NOTE: For non-emergency but Medically Necessary services received in an emergency room the Plan pays a maximum of $75 per visit, including all related services.** • There is no requirement to precertify (obtain prior authorization) for the use of a hospital-based emergency room visit. Also, the Plan will pay a reasonable amount for hospital-based emergency services performed Out-of-Network, in compliance with the Affordable Care Act regulations. • See the Definition of "Allowable Expense" or contact the Administrative Office for more details on what the Plan allows as payment to Out-of-Network emergency service providers. • See the Quick Reference Chart for information about urgent care services provided at **Family Wellness Centers at no cost**. See also the Family Wellness Centers (near-site health care clinics) row. • ***Coverage of Covid-19 Testing and Covid-19 Related Services is effective only for services received during the COVID-19 National Emergency Period.***	**Emergency Services in an Emergency Room**: After deductible met, you pay a $25 copay/visit. **Emergency Room Physician for Emergency Services:** After deductible met, you pay a $25 copay/visit. **Urgent Care Facility**: After deductible met, you pay a $15 copay/visit. **Urgent Care services at a Family Wellness Center clinic**: No charge. **Non-emergency services in an Emergency Room:** After the deductible is met, Plan pays up to $75 maximum per visit including all related services. *Covid-19 Test related visit: 100%, no deductible*	**Emergency Services in an Emergency Room**: After deductible met, you pay a $25 copay/visit. **Emergency Room Physician for Emergency Services:** After deductible met, you pay a $25 copay/visit. **Urgent Care Facility**: After deductible met the Plan pays 50% of allowable expenses. **Non-emergency services in an Emergency Room:** After the deductible is met, Plan pays up to $75 maximum per visit including all related services. *Covid-19 Test related visit: 100%, no deductible*

Article V. Schedule of Medical PPO Plan Benefits, the "Physician & Health Care Practitioner Services" row is amended to add the text in italics and delete the text in strike-through:

ARTICLE V. SCHEDULE OF MEDICAL PPO PLAN BENEFITS

This chart explains the benefits payable by the Plan. See also the Medical PPO Plan Exclusions and Definitions Articles of this document for important information. All benefits are subject to the deductible except where noted. ***IMPORTANT: Out-of-Network providers are paid according to the Allowable Expense as defined in the Definitions Article and could result in balance billing to you.**

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network*

Physician & Health Care Practitioner Services
 	
• Benefits are payable for professional fees when provided by a Physician or other covered Health Care Practitioner in an office, hospital, urgent care facility or other covered health care facility location. Payable Physician and Health Care Practitioner professional fees include:
  • Hospitalist physician under the Hospitalist Program, Surgeon, Assistant Surgeon (if Medically Necessary) and Certified Surgical Assistant (CSA)/Certified Surgical Technician (CST)
  • Anesthesia provided by Physician and Certified Registered Nurse Anesthetist ("CRNA")
  • Pathologist; Radiologist, and Podiatrist (DPM)
  • Physician Assistant (PA), Nurse Practitioner (NP), and Certified Nurse Midwife
  • Breastfeeding/Lactation Educator
 	
• **Hospitalist Program:** means the program that provides hospital inpatient Physician services to Plan Participants. **The Hospitalist Program is mandatory (required) for inpatient primary physician care provided to Plan Participants**.
The Hospitalist Program utilizes licensed non-specialist hospital based Physicians who have directly contracted with the Plan or with the Health Services Coalition on behalf of the Plan. Plan Participants who use the Hospitalist Program will have no out-of-pocket expenses (like Deductible, Coinsurance, and Copays) for covered services performed by or ordered by a Hospitalist Program Physician.
Plan Participants who refuse care under the Hospitalist Program are responsible for 100% of the billed charges by the Non-Hospitalist Program physician.
Physician care by specialists such as an Obstetrician/Gynecologist ("OB/GYN") and a Pediatrician, will be payable for covered services, in a manner consistent with the payment rules outlined on this Schedule of Medical PPO Plan Benefits, since specialists are not part of the Hospitalist Program.
	• **Some Physician & Health Care Practitioner Services require precertification.** See the Utilization Review and Case Management Article for details on precertification requirements.
	• See also the Definition of "Physician," "Health Care Practitioner," and "Surgery" in the Definitions Article.
	• See the Quick Reference Chart for information about the **LiveHealth Online visit** service.
	• See the Quick Reference Chart for information about services provided at the **Family Wellness Centers without any cost**. See also the Family Wellness Centers (near-site health care clinics) row.
	• The Claims Administrator will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the Definition of "Surgery" in the Definitions Article.
	• **Assistant Surgeon** fees will be reimbursed only for Medically Necessary services to a maximum of 20% of the eligible expenses allowed for the Primary Surgeon. Services by a Certified Surgical Assistant (See Definition of "Certified Surgical Assistant" in the Definitions Article) are payable if the use of a Certified Assistant Surgeon was Medically Necessary.
	• **Anesthesia Services:** If both an Anesthesiologist Physician and a Certified Registered Nurse Anesthetist ("CRNA") bill the Plan for anesthesia services on the same procedure, the Plan will allow, as total payment, the amount that would have been payable had just one professional performed the anesthesia services. Plan payment will be split 50/50 between the Anesthesiologist and the CRNA.
	• **Primary Care Provider (PCP)** means a Physician (MD or DO) or other Health Care Practitioner who practices general medicine, family medicine, internal medicine, pediatrics or obstetrics/gynecology. All other Physicians are considered specialists under this Plan. Under this Medical PPO Plan, there is no requirement to select a PCP or to obtain a referral or prior authorization before visiting an OB/GYN provider.
	• **Routine Foot Care Benefit**: Routine foot care administered by a Podiatrist is payable when Medically Necessary for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.
	• Foot Care is payable when Medically Necessary for **symptomatic foot conditions** such as plantar fasciitis, bone spurs, hammertoes or bunions.
	• See also the Emergency Services row.
	• See also the Family Planning, Maternity, and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from in-network providers.
	• ***Coverage of Covid-19 Testing and Covid-19 Related Services is effective only for services received during the COVID-19 National Emergency Period.***
		Primary Care Provider (PCP) Office Visit: You pay a $10 copay per visit, after deductible met.
		Specialist Office Visit: You pay a $15 copay per visit, after deductible met.
		LiveHealth Online Visit: $10 copay/visit. Deductible does not apply. *(Copay waived for services on or after March 18, 2020 through December 31, 2020)*
		Office Visit at a Family Wellness Center clinic: No charge, no deductible.
		In Office Surgery: PCP $10 Copay (Specialist $15 Copay) per visit, after Deductible met.
		Inpatient Hospitalist Services: No charge, no deductible.
		Inpatient Visit by Specialist: $15 copay per visit (non-specialist provider: $10 copay/visit) after deductible met
		Surgeon or Injection for Pain Management: $50 Copay/visit, after Deductible met.
		Assistant Surgeon: No charge after Deductible met.
		Anesthesia Services and Physician Obstetrical Care: $100 Copay after Deductible met.
		Emergency Room Physician in an Emergency: $25 Copay after Deductible met.
		Covid-19 Test related office visit: 100%, no deductible.
			After deductible met the Plan pays 50% of allowable expenses.
			
			See also the Emergency Room row in this schedule.
			
			No coverage for professional fees associated with outpatient surgery performed by an out-of-network provider.
			
			Covid-19 Test related office visit: 100%, no deductible

Article VIII. Medical PPO Plan Exclusions, Section A. General Exclusions is amended to add the following new text as shown in italics:

28. **Internet/Virtual Office/Telemedicine Services:** Expenses related to a **non-network/non-contracted** online internet consultation with a Non-Network Physician or other Health Care Practitioner, also called a virtual office visit/consultation, web visit, Physician-patient web service or Physician-patient e-mail service, telemedicine (real time or store and forward types), telehealth, e-health, e-visit, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider. See the Quick Reference Chart for information on the network online visit service.

    NOTE: *Effective March 1, 2020 through the COVID-19 National Emergency Period, telephone calls and virtual visits for covered services performed by network providers outside of the Plan's contracted online visit services network are payable. Such services are subject to the normal deductible, copayment, and coinsurance provisions of the Plan, on the same basis as a face-to-face visit.*

Article XVII. Definitions, Section A. Definitions is amended to add the following three new definitions as shown in italics:

47. ***COVID-19 National Emergency Period:*** *Means any portion of the emergency period beginning on March 1, 2020 and ending when there is an end to the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b-5(g)), namely, the period during which there exists an emergency or disaster declared by the President pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act and a public health emergency declared by the Secretary pursuant to section 247d of the Social Security Act related to COVID-19.*

48. ***COVID-19 National Emergency Coverage Extension Period:*** *A temporary period for trust-covered continuation of coverage for eligible employees. This continuation of coverage is available only for eligible employees who are laid off, terminated or for whom employer contributions otherwise terminated in connection with the National Emergency for COVID-19 after March 1, 2020. Such eligible employees will remain eligible for coverage from March 1, 2020 through August 31, 2020 (the "COVID-19 National Emergency Coverage Extension Period"). See also COVID-19 National Emergency Period.*

49. ***COVID-19 Test:*** *Diagnostic tests to detect the virus that causes COVID-19 and detect COVID-19 virus antibodies:*

A. that are approved, cleared or authorized by the certain sections of the Federal Food, Drug and Cosmetic Act (the Drug Act);
B. for which the developer has requested, or intends to request, emergency use authorization under the Drug Act (and where such authorization has not been denied);
C. developed in and authorized by a State that has notified HHS of its intention to review tests to diagnose COVID-19; or
D. not previously mentioned that are determined appropriate by HHS.

*50. **COVID-19 Test Related Visit/Services:** Items and services furnished to individuals during provider office visits (whether in-person or via telehealth), urgent care visits, and emergency room visits that result in an order for, or the administration of, the Covid-19 Test, including the administration of such test, but only to the extent such items or services relate to the furnishing or administration of the test or the evaluation of whether the person needs the test.*

The undersigned Chairman and Co-Chairman of the **Teamsters Security Fund for Southern Nevada-Local 14** do hereby certify that the foregoing Amendment #2 to the 2019 **Plan Document/Summary Plan Description** was duly adopted by the Board of Trustees at a Meeting duly called and held on January 28, 2021.

Fred Horvath (Feb 19, 2021 13:36 PST)

Chairman

Feb 19, 2021

Date

Sally Ihmels

Sally Ihmels (Feb 18, 2021 12:23 PST)

Co-Chairman

Feb 18, 2021

Date

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