AMENDMENT #4
to the Plan Document/Summary Plan Description for the
Teamsters Security Fund for Southern Nevada-Local 14
that was effective May 1, 2019

Effective June 1, 2021, the Plan Document/Summary Plan Description is amended as follows:

Article XII. Vision PPO Plan Benefits, Section. E. Schedule of Vision PPO Plan Benefits, the "Frames for Prescription Eyeglasses" row, "Lenses for Eyeglasses" row, and "Contact Lenses" row are amended to add the text in italics and delete the text in strike-through:

Section E. Schedule of Vision PPO Plan Benefits.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Frames for Prescription Eyeglasses The Plan provides a wide selection of quality frames. Because of the cosmetic nature of frames and rapidly changing styles, this Plan has a maximum allowance on the reimbursement for frames.	• One frame is payable each 24 months.	Plan Paid Frames: 100% up to the ~~$150~~ *$200* frame allowance. For other frame options not covered by the Vision Plan, the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	The Plan pays 100% to a maximum of $70.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Lenses for Eyeglasses	• A single vision, lined bifocal, lined trifocal or lenticular lens or lenticular lens is payable once every 12 months.	Single Vision (Standard): Plan pays 100% Lined Bifocal: Plan pays 100% Lined Trifocal: Plan pays 100% Lenticular: Plan pays 100% *Standard Progressive Lenses: Plan pays 100%* *Anti-reflective Coating: Plan pays 100% after you pay a $30 copay* For other lens options not covered by the Vision Plan, (such as *premium or custom* progressive lenses), the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	The Plan pays 100% up to the following maximum amounts: Single Vision: up to $30. Lined Bifocal: up to $50. Lined Trifocal: up to $65. Lenticular: up to $100.

Section E. SCHEDULE OF VISION PPO PLAN BENEFITS			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision PPO Plan Exclusions in Section F.*	**In-Network PPO Provider**	**Non-Network Provider**
Contact Lenses The Vision Plan covers both elective contact lenses and visually necessary contact lenses. The vision plan claims administrator determines when contact lenses are visually necessary.	• Elective contact lenses (instead of eyeglasses) are payable each 12 months. • ~~*When you choose contact lenses, you are not eligible for contact lenses again for 12 months and frames for 24 months.*~~ • When elective contact lenses are obtained from an in-network provider, the plan will provide an allowance toward the cost of professional fees and materials as shown to the right. A 15% discount will also be applied to the in-network provider's professional fees for contact lens evaluation and fitting.	For a contact lens exam (fitting and evaluation) Plan pays 100% after you pay a $60 Copay. Elective Contact Lenses: (contacts instead of eyeglasses) Plan pays up to $120. Visually necessary professional fees and contact lens materials: Plan pays 100% For other contact lens options not covered by the Vision Plan, the in-network provider offers you a discount. Discounts do not apply to non-network provider services.	Elective contact lenses instead of eyeglasses: the Plan pays 100% up to $105. Visually necessary professional fees and contact lens materials: Plan pays up to $210.

Article XII. Vision PPO Plan Benefits, Section. F. Vision PPO Plan Exclusions and Limitations is amended to add the text in italics and delete the text in strike-through:

Section F. Vision PPO Plan Exclusions and Limitations.

17. The Vision PPO Plan is designed to cover visual needs rather than cosmetic materials. When a covered person selects any of the following extras, the Vision PPO Plan will pay the cost of the allowed vision service/supply and the covered person will pay the additional cost for the extras. (Note that there is a discount on extras when obtained from In-network Vision providers.) Extras include:

    (a) oversized lenses (larger than 61mm),

    (b) optional cosmetic processes and cosmetic lenses.

    (c) coated lenses (e.g. ~~*anti-reflective,*~~ color, mirror, scratch).

    (d) blended lenses.

    (e) laminated lenses.

    (f) polycarbonate lenses.

(g) tinted lenses (addition of substance to produce a color) and photochromic lenses (lenses change from clear indoors to sunglass dark outdoors according to intensity of sunlight); except that Pink #1 and Pink #2 is covered.

(h) *custom* progressive multi-focal lenses.

(i) sunglasses/ultraviolet (UV) protected lenses (plain or prescription).

(j) certain limitations on low vision care.

(k) plano (non-prescription or less than ± .50 diopter power) lenses.

(l) orthokeratology lenses for reshaping the cornea of the eye to improve vision.

(m) a frame or other vision materials that cost more than the Plan allowance.

The undersigned Chairman and Co-Chairman of the **Teamsters Security Fund for Southern Nevada-Local 14** do hereby certify that the foregoing Amendment #4 to the 2019 **Plan Document/Summary Plan Description** was duly adopted by the Board of Trustees at a Meeting duly called and held on June 10, 2021.

Chairman	**Date** 6/15/21
Sally Ihmels Sally Ihmels (Jun 15, 2021 18:07 PDT) **Co-Chairman**	Jun 15, 2021 **Date**

5691395v2/13405.010