AMENDMENT #8
to the Plan Document/Summary Plan Description for the
Teamsters Security Fund for Southern Nevada-Local 14
that was effective May 1, 2019

Effective January 1, 2022, the Plan Document/Summary Plan Description is amended as follows:

Article I, Introduction, the Section entitled "Quick Reference Chart – PPO Network for the Medical PPO Plan" is amended to add the following new text in italics:

PPO Network for the Medical PPO Plan • Medical Network Provider Directory (*for mental health and substance abuse network providers, refer to the Behavioral Health row of this Quick Reference Chart)* • Additions/Deletions of Network Providers Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price. *If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.* Effective August, 1, 2018, Cancer Treatment Centers of America is not covered by this Plan. You must obtain authorization for services from Mayo Clinic or the City of Hope by contacting both the Clinical Director (at the Administrative Office) and the Utilization Management Company.	**Anthem** Visit www.anthem.com and click "Find a Doctor" under "Menu." Under "Search as a Member," enter "JTF" below "Identification number or alpha prefix," then click "Continue" and follow the instructions. Or call the Administrative Office at 1-702-851-8286. You can also find network providers by downloading the Anthem Anywhere mobile app from the App Store (iPhone) or Google Play (Android). **Health Services Coalition (HSC) Hospitals** Phone: 1-702-734-8601 or www.lvhsc.org Includes all hospitals in Las Vegas, Henderson and Boulder City. BlueCard assistance while traveling or living outside the PPO network, call 1-800-810-2583. **CAUTION:** Use of a **non**-PPO network hospital, facility or Health Care Provider **could result in you having to pay a substantial balance on the provider's billing** (see the Definition of "Balance Billing" in the Definition Article of this document), *except for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.*. Your lowest out of pocket costs will occur when you use In-Network PPO providers.

Article IV, Medical PPO Plan Benefits, the Section entitled "PPO In-Network Health Care Provider Services" is amended to add the following new text in italics and delete the text in strikethrough:

2. **Out-of-Network (also called Non-Network, Non-PPO, Non-Participating or Non-Contracted):** refers to providers who are not contracted with the Plans' PPO Networks and who **do not** generally offer any fee discount to a Plan Participant or to the Plan. These Out-of-Network Health Care Providers **may bill a Plan Participant a non-discounted amount** for any balance that may be due **in addition to** the Allowable Expense payable by the Plan, also called balance billing, *except for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.* ~~See also the Medical Networks Article of this document~~. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. To avoid balance billing, use in-network providers.

Article IV, Medical PPO Plan Benefits, the Section entitled "Out-Of-Pocket Limit (Annual Limit On In-Network Cost Sharing)" is amended to add the following new text in italics and delete the text in strike-through:

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5. Covered emergency services *subject to the "No Surprises Act" as described in Article VI Medical Networks for the Medical PPO Plan* ~~performed in an Out-of-Network Emergency Room~~ apply to meet the in-network Out-of-Pocket Limit on cost-sharing.

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8. The Out-of-Pocket Limit **does not include or accumulate**:
   (a) Premiums and contributions for coverage (when applicable),
   (b) Expenses for medical services or supplies that are not covered by the Medical PPO Plan,
   (c) Charges in excess of the Allowable Expense determined by the Plan which includes balance billed amounts for non-network providers,
   (d) Penalties for non-compliance with Utilization Review and Case Management programs,

(e) Expenses for the use of non-network providers, *except for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan* ~~emergency services performed in an out-of-network~~ ~~Emergency Room~~ accumulate to the in-network out-of-pocket limit,

(f) Dental Plan or Vision Plan Benefits,

(g) Expenses that are not considered to be essential health Benefits,

Article V, Schedule of Medical PPO Plan Benefits, the header is amended to add the following new text 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. *Note: Balance billing does not apply to services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.***

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

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. • ***The in-network deductible applies to services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.*** • Certain other Benefits outlined in this Schedule may also have a **benefit-specific Deductible** in addition to this overall annual medical plan Deductible.	$500 per person $1,500 per family	$1,500 per person $4,500 per family

Article V, Schedule of Medical PPO Plan Benefits, the row entitled "Out-of-Pocket Limit" is amended to add the following new text in italics:

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
Out-of-Pocket Limit This Plan has an Out-of-Pocket Limit which caps your annual cost-sharing for covered essential health Benefits received from in-network providers related to Medical PPO Plan Deductibles, Coinsurance, and Copayments. • The Out-of-Pocket Limit is accumulated on a calendar year basis. • Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan. • The amount of the Out-of-Pocket Limit may be adjusted annually, in an amount as published by the Department of Health and Human Services. • Covered ~~emergency~~ *services subject to the "No Surprises Act" as described Article VI, Medical Networks for the Medical PPO Plan* ~~performed in an out-of-network emergency room~~ will apply to meet the in-network out-of-pocket limit on cost-sharing. • The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than the individual out-of-pocket limit.	• **The Out-of-Pocket Limit does not include or accumulate**: a) Premiums and contributions for coverage (when applicable), b) Expenses for medical services or supplies that are not covered by the Medical PPO Plan, c) Charges in excess of the Allowable Expense determined by the Plan which includes balance billed amounts for non-network providers, d) Penalties for non-compliance with Utilization Review and Case Management programs, e) Expenses for the use of non-network providers, except *for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan,* ~~emergency services performed in an out-of-network emergency room~~ accumulate to the in-network out-of-pocket limit, f) Dental Plan or Vision Plan Benefits, g) Expenses that are not considered to be essential health Benefits, • In addition to the Plan's Out-of-Pocket Limit, the Plan also has an annual Coinsurance/Copay Limit explained below: • **Annual Coinsurance/Copay Limit**: The annual (calendar year) Coinsurance/Copayment Limit is the most you pay in coinsurance or copayments related to any inpatient health care facility admission before the Plan starts to pay 100% toward eligible coinsurance and copayment. The Plan will continue the annual coinsurance/copay limit of $500/person; $1,500/family related to any inpatient health care facility admission.	The **annual Out-of-Pocket Limit for Medical Plan benefits** (excluding outpatient drugs) is: $5,600 per person $11,200 per family The **annual Out-of-Pocket Limit for outpatient drugs** is: $1,000 per person $2,000 per family The Plan will continue the annual coinsurance/copay limit of $500/person; $1,500/family related to an inpatient health care facility admission.	No limit, except *services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan* ~~emergency services performed in an out-of-network Emergency Room~~ accumulate to the in-network out-of-pocket limit.

Article IV, Schedule of Medical PPO Plan Benefits, the Section entitled "Hospital Services (Inpatient)" is amended to add the following new text in italics:

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

Hospital Services (Inpatient)
• Room & board facility fees in a semiprivate room with general nursing services.
• Specialty care units (e.g., intensive care unit, cardiac care unit).
• Lab/x-ray/diagnostic services.
• Related Medically Necessary ancillary services (e.g., prescriptions, supplies).
• Newborn care and newborn circumcision (hospital Deductible and medical plan waived for routine nursery care)
• For eligible females, Birth (Birthing) Center charges are paid in the same manner as a hospital is paid. See also the Maternity row for more information.
	• **A Hospital Admission Copay** is applied for each inpatient admission in addition to the annual medical plan Deductible.
	• **Elective Hospitalization requires precertification. All Hospitalization is subject to concurrent review.** See the Utilization Review and Case Management Article for details.
	• Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms.
	• Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with Medically Necessary dental services covered by a Dental Plan if the Utilization Review and Case Management firm determines that hospitalization or outpatient surgery facility care is Medically Necessary to safeguard the health of the patient during performance of dental services.
	  • No payment is extended toward the associated dental professional fee services provided while at a hospital or outpatient surgery facility.
	  • **Planned use of a hospital or outpatient surgery facility for a Dental purpose requires precertification.** See the Utilization Review and Case Management Article for details.
	• See the Eligibility Article for how to properly enroll Newborns so coverage can be considered.
	• Specialty care hospitals, also called long term care acute (LTAC) hospitals, are discussed under the Skilled Nursing Facility row in this Schedule.
	• See the Physician row below for information on the **Hospitalist Program**.
		After the Annual Deductible Is met there is a **$100 Inpatient Copay** per admission, then the member is responsible for 10% coinsurance, up to the Annual Coinsurance/copay limit of $500/person ($1,500/family) per calendar year then the Plan pays 100% of coinsurance.	After the Annual Deductible is met there is an additional **$1,000 Inpatient Copay** per admission, then the member is responsible for 50% Coinsurance, (Plan pays 50% of allowable expenses), up to the Annual Coinsurance/copay limit of $500/person ($1,500/family) per calendar year then the Plan pays 100% of coinsurance.
			
			Reminder, 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, *except for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.* Your least costs occur when you choose in-network providers.

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

Emergency Room
• Hospital emergency room (ER) *or "Nonparticipating Emergency Facility"* for "emergency services" (as ~~that~~ *those* terms ~~is~~ *are* 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 infection.
• 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 *or an independent freestanding emergency department 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.~~
	• *Your cost sharing amount for Emergency and Non-Emergency Services at Health Care Facilities by Non-Participating Providers will be based on the lessor of billed charges from the provider or the Qualifying Payment Amount.*
	• *Emergency services are covered:*
	  • *Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;*
	  • *Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility, as applicable, with respect to the services;*
	  • *Without imposing any administrative requirement or limitation on out-of-network emergency services that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities;*
	  • *Without imposing cost-sharing requirement for out-of-network emergency services that are greater than the requirements that would apply if the services were provided by a participating provider or a participating emergency facility;*
	  • *By calculating the cost-sharing requirement for out-of-network emergency services as if the total amount that would have been charged for the services were equal to the recognized amount for the services; and*
	  • *By counting any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network out-of-pocket maximums applied under the plan (and the in-network out-of-pocket maximum is applied) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.*
	• 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.
		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:
		The most the Plan pays is up to $75 maximum per visit including all related services. Deductible applies.
			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:
			The most the Plan pays is up to $75 maximum per visit including all related services. Deductible applies.

Article V, Schedule of Medical PPO Plan Benefits, the row entitled "Physician & Health Care Practitioner Services" is amended in the Explanation and Limitations column to add the following new text in italics:

(For claims not otherwise subject to the No Surprises Act as described Article VI, Medical Networks for the Medical PPO Plan):
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.

Article VI, Medical Networks for the Medical PPO Plan, the Section entitled "In-Network and Out-of-Network Services" is amended to add the following new text in italics:

1. Plan Participants may obtain health care services from In-Network or Out-of-Network Health Care Providers. But the amount that you pay for such services may vary. **Your lowest out-of-pocket costs occur when you use a network provider.**

   Because Health Care Providers are added to and deleted from networks during the year you should call the network or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need. *If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.*

2. **IN-NETWORK SERVICES:** In-Network Health Care Providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide health care services and supplies for a favorable negotiated discount fee for plan Participants.

   Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send the bills.

   (a) The In-Network Health Care Provider generally deals with the Plan directly for any additional amount due. Note that with respect to claims involving any third party payer, including auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the contract between the Health Care Providers and the PPO Network may not require them to adhere to the discounted amount the Plan pays for covered services, and the providers may charge their usual non-discounted fees.

   IMPORTANT NOTE
   Because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services. *If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.*

   (b) You may also verify if your Health Care Provider is an In-Network provider by contacting the PPO at their phone number and website listed on the Quick Reference Chart in the front of this document.

3. **OUT-OF-NETWORK SERVICES:** Out-of-Network Health Care Providers (also called Non-Network, non-PPO and Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan Participant for the Allowable Expense (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance (on non-discounted services), Copayments limitations and Exclusions.

   (a) Plan Participants must submit proof of claim before any such reimbursement will be made.

   (b) **CAUTION: Out-of-Network Health Care Providers may bill you for any balance that may be due in addition to the Allowable Expense amount payable by the Plan, also called balance billing. The amount of the Allowable Expense is generally much less than the billed charges. You can avoid balance billing by using In-Network providers.** *Note that balance billing will not apply to services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.* (See the Definitions of Allowable Expense and Balance Billing in the Definitions Article of this document. Refer also to the Special Reimbursement Provisions discussed later in this Article.)

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6. **Directories Of Network Providers.**

   (a) Physicians and Health Care Providers who participate in the Plan's Network are added and deleted during the year. At any time, you can find out if any Health Care Provider is a member of the Network by contacting the Medical PPO network at their website (to access their free provider network directory) shown on the Quick Reference Chart in the front of this document. The Administrative Office can also help you locate a network provider.

   Remember, because providers are added to and dropped from the PPO network periodically throughout the year **it is best if you ask your Health Care Provider IF they are still participating with the PPO or contact the network each time BEFORE you seek services.** *If you obtain and rely upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.*

Article VI, Medical Networks For The Medical PPO Plan, the Section entitled "Special Reimbursement Provisions" is amended to add the following new text in italics and delete the text in strike-through:

1. The following chart explains the Plan's special reimbursement for services when certain Out-of-Network providers are used. The Board of Trustees or its designee determines if and when the following special reimbursement circumstances apply to a claim.
2. Medical records may be requested in order to assist with a determination on the need for special reimbursement provisions. Allowable Expense is defined in the Definitions Article of this document.

The chart below outlines the Plan's Special Reimbursement provisions:

SPECIAL REIMBURSEMENT PROVISIONS This chart explains the Plan's special reimbursement provisions if the services of certain Out-of-Network Providers are used. The Board of Trustees or its designee determines if/when the following reimbursement applies to a claim. Without authorization there is no guarantee the claim can be considered for payment.	**WHAT THE PLAN PAYS** (toward eligible claims submitted by an Out-of-Network provider)
(a) The non-grandfathered medical plan does not have an in-network provider qualified or available to provide the preventive services required by Health Reform so the Participant must use the services of a non-network provider and claims will be reimbursed without any Participant cost-sharing, in the same manner as if an in-network provider had been used. (b) Child over 19 resides temporarily outside the service area while attending college. (c) The individual had care for a medical emergency (as emergency is defined in this Plan) at a provider outside the In-Network service area. (d) *If the individual obtained and relied upon incorrect information about whether a provider is a network provider from the Plan or its administrators, the Plan will apply In-Network cost-sharing to your claim, even if the provider was Out-of-Network.*	As if the care was provided In-Network including Deductible, Coinsurance, Copays and Out-of-Pocket Limit and the allowance for bills will be reimbursed according to the Allowable Expense for Non-Network providers. See the Definition of Allowable Expense in the Definitions Article of this Plan.
(e) The individual was treated/confined in an In-Network facility but an Out-of-Network provider ~~(outside the patient's control)~~ performed certain Medically Necessary covered services *without meeting the consent exception described below under "No Surprises Act" section as described in Article VI, Medical Networks for the Medical PPO Plan.* ~~such as emergency room visit, pathology, laboratory, radiology, anesthesia, or assistant surgeon services.~~ (f) Ancillary Services ~~(such as lab or x-rays)~~ received from an Out-of-Network provider in connection with a visit to an In-Network Health Care Facility Provider. ~~, if the choice of the Out-of-Network provider who performed ancillary services was outside the patient's control.~~ For example, the In-Network provider accidentally sends the patient's lab work to an Out-of-Network lab for processing. (g) The individual was treated by an Out-of-Network facility/professional because of the lack of availability of an In-Network facility/professional.	As if the care was provided In-Network including Deductible, Coinsurance, Copays and Out-of-Pocket Limit and the allowance for bills will be reimbursed according to the Allowable Expense for Non-Network providers. See the Definition of Allowable Expense in the Definitions Article of this Plan.
(h) Use of an Out-of-Network provider when an In-Network provider was available to be used.	As if the care was provided Out-of-Network including Deductible, Coinsurance, Copays and Out-of-Pocket Limit.

Article VI, Medical Networks for the Medical PPO Plan, a new section entitled "No Surprises Act" is added to follow the "Special Reimbursement Provisions" with the following new text:

NO SURPRISES ACT

Effective January 1, 2022, this section explains how claims subject to the No Surprises Act are generally administered. There are three (3) categories of claims subject to the No Surprises Act.

- Emergency Services
- Air Ambulance Services
- Covered services performed by out-of-network providers at in-network Health Care Facilities not otherwise addressed in the above categories.

Emergency Services from Out-of-Network Emergency Facilities and Providers

- The Plan will not impose prior authorization requirements for Emergency Services and will not impose more restrictive administrative requirements on Out-of-Network Emergency Services than requirements for Emergency Services received at an in-network facility or in-network provider.
- Participants only pay their In-Network cost sharing and cannot be balance billed by the Out-of-Network Emergency Provider or Out-of-Network Emergency Facility for Emergency Services.
- Participants pay the same Cost-sharing for covered Emergency Services from an Out-of-Network Emergency Facility or Provider or an in-network emergency facility or in-network provider.
- The Cost-sharing Amount will be based on the Recognized Amount. The Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.
- Any Cost-sharing for Out-of-Network Emergency Services will count toward the In-Network deductible and in-network Out-of-Pocket maximum in the same manner as those received from an In-Network provider.

Post-stabilization Services

- Emergency Services received at an In-Network or Out-of-Network facility or from an In-Network or Out-of-Network Provider include post-stabilization services (services after the patient is stabilized) and include services received in any part of the in-network or Out-of-Network Emergency Facility (regardless of the department of the Hospital in which such items and services are furnished).
- Emergency Services may also include outpatient observation or an inpatient or outpatient stay that is related to the Emergency Medical Condition until:
    - The provider or facility determines that the Participant is able to travel using nonmedical transportation or nonemergency medical transportation; or
    - The Participant is supplied with a written notice, as required by federal law, that the provider is an out-of-network Provider with respect to the Plan, of the estimated charges for treatment and any advance limitations that the Plan may put on such treatment, of the names of any in-network Providers at the facility who are able to provide treatment, and that the Participant may elect to be referred to one of the In-Network Providers listed; and
    - The Participant or Authorized Representative gives informed consent to continue treatment by the Out-of-Network provider, acknowledging that the Participant understands that continued treatment by the Out-of-Network Provider may result in greater cost to the Participant.

Air Ambulance services that are otherwise covered by the Plan from an out-of-network provider, are covered by the Plan as follows:

- Air Ambulance services received from an out-of-network provider are covered with a Cost-sharing requirement that is no greater than the Cost-sharing requirement that would apply if the services had been furnished by an in-network provider.
- Cost-sharing is calculated as if the total amount that would have been charged for the services by an in-network provider of Air Ambulance Services is equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any Cost-sharing payments relating to Air Ambulance services will count toward any in-network deductible and in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

Items or services that are otherwise covered by the Plan from an out-of-network provider who is working at an in-network Health Care Facility, are covered by the Plan as follows:

- The items or services received from an Out-of-Network Provider working at an In-Network Health Care Facility is subject to a Cost-sharing requirement that is no greater than the Cost-sharing requirement that would apply if the items or services had been furnished by an In-Network Provider.

- In general, Participants are not balance-billed for these non-emergency items or services. Participants' Cost-sharing will be based on the Recognized Amount payable for these services. The Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.
- Any Cost-sharing payments for covered services received from an Out-of-Network Provider working at an In-Network Health care Facility count toward any In-Network deductible and In-Network out-of-pocket maximum in the same manner as those received from an in-network provider.

Payments to Out-of-Network Providers and Facilities for Claims Subject to the No Surprises Act

- The Plan will make an initial payment or notice of denial of payment for claims subject to the No Surprises Act within 30 calendar days of receiving the information necessary to decide a claim for the payment for the services from an Out-of-Network provider or facility.
- If a claim is subject to the No Surprises Act, a Participant cannot be required to pay more than the Cost-sharing under the Plan, and the provider or facility is prohibited from billing the Participant in excess of the required Cost-sharing. The Plan's payment or denial of payment to the Out-of-Network provider does not affect the Participant's Cost-sharing Amount.
- The Plan will pay a total plan payment directly to the Out-of-Network provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the Cost-sharing Amount for the services, less any initial payment amount.

Exceptions to Prohibitions on Balance-Billing by Out-of-Network Providers and Facilities

- Participants can be billed by an Out-of-Network provider who works at an in-network facility for certain non-Emergency Services if the Out-of-Network provider satisfies the notice requirements under the No Surprises Act and the Participant provides informed consent.
- The Out-of-Network provider must provide notice that:
  - is in writing;
  - is provided at least 72 hours before the day of the appointment or at least 3 hours in advance of services rendered for a same-day appointment;
  - states the provider is an Out-of-Network provider;
  - includes the estimated charges for the treatment and any advance limitations that the Plan may put on the treatment;
  - includes the names of any in-network providers at the facility who are able to provide treatment;
  - states that the Participant may elect to be referred to an in-network provider; and
  - states the Participant costs will be greater if the Participant (or Authorized Representative) consents to the service or treatment
- If informed consent is provided, then the Plan pays for these services at the Out-of-Network Rate, and the provider bills the Participant for the balance directly.
- This rule does not apply to Ancillary Services.

Continuity of Coverage

The Plan provides Continuity of Coverage in instances when Termination of certain contractual relationships results in changes in a provider or facility's status as an In-Network provider. If you are a Continuing Care Patient:

- You will be notified in a timely manner of the contract Termination and of your right to elect continued transitional care from the provider or facility; and
- You will be allowed ninety (90) days of continued coverage at In-Network cost sharing to allow for a transition of care to an In-Network provider.

Article VII, Utilization Review and Case Management (UR/CM), the Section entitled "Precertification (Preservice) Review – How Precertification Review Works" is amended to add the following new text in italics:

1. **How Precertification Review Works**: Precertification Review is a procedure, administered by a review firm, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, Drug, Dental Service or other health care services are Medically Necessary. *There is no requirement to precertify emergency services or the treatment of an emergency medical condition.*

Article VII, Utilization Review and Case Management (UR/CM), the Section entitled "Precertification (Preservice) Review – Emergency Hospitalization" is amended to add the following new text in italics:

1. If an emergency requires hospitalization, there may be no time to contact the UR Company or Behavioral Health Program before you are admitted. If this happens, the UR Company or Behavioral Health Program must be notified of the hospital admission within 48 hours. You, your Physician, the hospital, a family member or friend can make that phone call to the UR Company or Behavioral Health Program. This will enable the UR Company or Behavioral Health Program to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Physician or other Health Care Providers of the various In-Network support providers and Benefits available for you and offer recommendations, options and alternatives for your continued medical care. *There is no requirement to precertify emergency services or the treatment of an emergency medical condition subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.*

Article XIII, Claim Filing and Appeal Information, the Section entitled "External Review of Claims" is amended to add the following new text in italics:

2. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

(a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, a determination that a treatment is experimental or investigational or a medical judgment for determinations of whether a plan is complying with the non-quantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act; and/or

(b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

(c) *The denial involves a claim subject to the protections of the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.*

Article XVII, Definitions, a new definition for "Air Ambulance" is added with the following text:

Air Ambulance: Medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Article XVII, Definitions, "Allowable Expense" is amended to add the following text in italics and delete the text in strike-through:

Allowable Expense: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. *For services subject to the "No Surprises Act" as described in Article VI, the Medical Networks for the Medical PPO Plan, the Allowable Expense is the Recognized Amount. For all other services,* the Allowable Expense amount is determined by the Board of Trustees or its designee to be the **lowest** of:

(a) **With respect to an In-Network provider** (PPO network Health Care provider/facility or Health Services Coalition (HSC) provider/facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care provider/facility and the PPO network or the Plan; **or**

(b) **With respect to a Non-Network provider**, Allowable Expense amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers. Note that **for non-contracted (non-network) hospital services** the allowable expense amount is capped at the lowest HSC contracted rate, amount or schedule, or such other rate, amount, schedule or percentage that is the lowest "reasonable amount" that complies with the requirements of PHSA Section 2719A and related federal guidance. **For non-contracted Dental plan services**, the Dental plan claims administrator maintains the schedule that the Dental Plan has determined it will allow for eligible medically necessary dental services or supplies performed by non-network dental providers. For non-network Behavioral Health providers, the Behavioral Health Program maintains the schedule that they have determined they will allow for eligible medically necessary behavioral health services performed by non-network behavioral health providers.

The Plan's Allowable Expense amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. See also the Definition of Balance Billing in this Definitions Article and the Special Reimbursement Provisions in Article VI; **or**

(c) For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation

or other individual insurance, or where this Plan may be a secondary payer, the Allowable Expense amount under this Plan is the **negotiated fee/rate** that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**

(d) The Health Care or Dental Care Provider's/facility's actual **billed charge**.

The Plan will not always pay Benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowable Expense" amount for health care services or supplies, as determined in the sole, exclusive and final judgment of the Board of Trustees or its designee.

Any amount in excess of the "Allowable Expense" amount does not count toward the Plan's annual Out-of-Pocket Limits/Maximums. Participants are responsible for amounts that exceed "Allowable Expense" amounts by this Plan.

Additionally, the Plan reserves the right to negotiate with a non-network provider to reduce their billed charges to a lower, discounted Allowable Expense amount. Such negotiation may be performed by the Board of Trustees or its designee. A designee may include, but is not limited to, a Utilization Review and Case Management Company, Administrative Office, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowable Expense" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, in-network/non-network plan design, and any Special Reimbursement Provisions adopted by the Plan.

~~In accordance with federal law, with respect to **emergency services performed in a Non-Network Emergency Room (ER),** the Plan's allowance for ER visit facility fees is to pay the **greater** of:~~

~~(a) the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or~~

~~(b) 100% of the Plan's usual payment (Allowable Expense) formula (reduced for cost-sharing) or~~

~~(when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).~~

See the Definition of **emergency services** in this Definitions Article.

NOTE: Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. If you use a non-network provider you may be balance billed by that provider *except for services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.* ~~Balance billing might not apply to emergency services in a hospital emergency room in cases where state law prohibits a person from being required to pay balance billed charges or where the Plan is contractually responsible for such charges.~~

Article XVII, Definitions, "Ancillary Services" is amended to add the following text in italics and delete the text in strike-through:

Ancillary Services: ~~Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.~~ *With respect to a participating Health Care Facility:*

- *Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,*
- *Items and services provided by assistant surgeons, hospitalists, and intensivists;*
- *Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary of the Department of Health and Human Services; and*
- *Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.*

Article XVII, Definitions, "Balance Billing" is amended to add the following text in italics:

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowable Expenses and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Limits are reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's Definition of Allowable Expense. Remember, amounts exceeding the Allowable Expense do not count toward the Plan's Out-of-Pocket Limit and may result in balance billing to you. **Out-of-Network Health Care Providers commonly engage in balance billing**. This means a plan Participant may be billed for any balance that may be due in addition to the amount payable by the Plan. Typically, In-Network providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid balance billing by using In-Network providers.** *If you use a non-network provider you may be balance billed by that provider. Note: This does not apply to services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan.*

Article XVII, Definitions, a new definition for "Continuing Care Patient" is added with the following text:

Continuing Care Patient: An individual who, with respect to a provider or facility –

1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt or postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Article XVII, Definitions, "Cost-sharing" is amended to add the following text in italics:

Cost-sharing: A term to mean the amount of money a plan participant is to pay toward a service or item, versus the amount of money the Plan is to pay. Plans typically have three different types of cost-sharing provisions: Deductibles, Copayments/Copays and Coinsurance, although not all plans feature each of these types of cost-sharing. It is common to have a Plan change the amount of its cost-sharing provisions at least once each 12 months (more often if necessary). Cost-sharing does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under the plan. *For services subject to the "No Surprises Act" as described in Article VI, Medical Networks for the Medical PPO Plan, the cost sharing amount will be based on the Recognized Amount.*

Article XVII, Definitions, "Emergency Medical Condition" is amended to add the following text in italics and delete the text in strike-through:

~~**"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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 serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn Child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.~~

Emergency Medical Condition: *means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.*

Article XVII, Definitions, "Emergency Services" is amended to add the following text in italics and delete the text in strike-through:

Emergency Services*: Means the following:*

1. *An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and*
2. *Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).*

~~**Emergency Services**: means, with respect to an Emergency or Emergency Situations,~~

~~(a) A medical screening examination that is **within the capability of the emergency department of a hospital**, including ancillary services routinely available to the emergency department to evaluate such **emergency medical condition**, and~~

~~(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to **stabilize** the patient.~~

~~For purposes of this Definition, **stabilize** means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, that the woman has delivered (including the placenta).~~

Article XVII, Definitions, "Health Care Facilities" is amended to add the following text in italics and delete the text in strike-through:

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include ~~O~~outpatient ~~A~~ambulatory ~~S~~surgical ~~F~~facilities, ~~B~~behavioral ~~H~~health ~~T~~treatment ~~F~~facilities, ~~B~~birthing ~~C~~centers, ~~H~~hospices, ~~S~~skilled nursing ~~F~~facilities, and ~~S~~subacute ~~C~~care ~~F~~facilities/~~L~~long ~~T~~term ~~A~~acute ~~C~~care ~~F~~facilities. ~~as those terms are defined in this Definitions chapter.~~ *For non-emergency services performed by an out-of-network provider at in-network Health Care Facilities: Health Care Facilities are each of the following:*

- *A hospital (as defined in section 1861(e) of the Social Security Act);*
- *A hospital outpatient department;*
- *A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and*
- *An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act*

Article XVII, Definitions, a new definition for "Independent Freestanding Emergency Department" is added with the following text:

Independent Freestanding Emergency Department: A health-care facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Article XVII, Definitions, a new definition for "No Surprises Act" is added with the following text:

No Surprises Act: The federal No Surprises Act means the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, Division BB.

Article XVII, Definitions, a new definition for "Non-Participating Emergency Facility" is added with the following text:

Non-Participating Emergency Facility: An emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to emergency services as defined), that does not participate in the Plan's Network.

Article XVII, Definitions, a new definition for "Non-Participating Provider (Non-Preferred Provider)" is added with the following text:

Non-Participating Provider (Non-Preferred Provider): A Health Care or Dental Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO). For emergency services and non-emergency services at Participating Facilities by a Non-Participating Provider, **Non-participating provider** means health care provider who does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage, respectively.

Article XVII, Definitions, a new definition for "Out-of-Network Rate" is added with the following text:

Out-of-Network Rate: The rate for services provided by a Health Care Provider that is not a member of the Plan's Network means one of the following:

- The amount the parties negotiate;
- The amount approved under the independent dispute resolution (IDR) process; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system

Article XVII, Definitions, a new definition for "Qualifying Payment Amount" is added with the following text:

Qualifying Payment Amount: Means generally the median contracted rates of the Network for the item or service in the geographic region.

Article XVII, Definitions, a new definition for "Recognized Amount" is added with the following text:

Recognized Amount: For items or services furnished by a nonparticipating provider or nonparticipating emergency facility, Recognized Amount means (in order or priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- An amount determined by a specified state law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount

For Air Ambulance services, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

Article XVII, Definitions, a new definition for "Serious and Complex Condition" is added with the following text:

Serious and Complex Condition: Means with respect to a participant, beneficiary, or enrollee under the Plan of the following:

- In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanency;
- In the case of a chronic illness or condition, a condition that is:
  - Life-threatening, degenerative, potentially disabling, or congenital; and
  - Required specialized medical care over a prolonged period of time.

Article XVII, Definitions, a new definition for "Termination" is added with the following text:

Termination: In the context of Continuity of Care, Termination includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

The undersigned Chairman and Co-Chairman of the **Teamsters Security Fund for Southern Nevada-Local 14** do hereby certify that the foregoing Amendment #8 to the 2019 **Plan Document/Summary Plan Description** was duly adopted by the Board of Trustees at a Meeting duly called and held on November 17, 2022.

Chairman

11/17/22

Date

Sally Ihmels

Sally Ihmels (Nov 18, 2022 10:25 PST)

Co-Chairman

Nov 18, 2022

Date

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