AMENDMENT #11
to the Plan Document/Summary Plan Description for the
Teamsters Security Fund for Southern Nevada-Local 14
that was effective May 1, 2019

Effective February 1, 2025, the Plan Document/Summary Plan Description is amended as follows:

Article II, Quick Reference Chart is amended to add the following text in italics and delete the text in strike-through:

ARTICLE II. QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Prescription Drug Program for the Medical PPO Plan, administered by the Prescription Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs • Information on Drugs with a Quantity Limit • Step Therapy Approval • Specialty Drug Program: Precertification and Ordering • *Select Drugs and Products Program*	~~**Envision Rx**~~ ***Elixir*** Retail Customer Service Phone: 1-800-361-4542 Website: ~~www.envisionrx.com~~ *www.elixirsolutions.com* Mail Order Customer Service: *Birdi* 7835 Freedom Ave. NW North Canton, OH 44720 Phone: 866-909-5170 Fax: 866-909-5171 ~~www.envisionpharmacies.com~~ *www.birdirx.com* Specialty Drug Customer Service: *Birdi* 7835 Freedom Ave. NW North Canton, OH 4472 Phone: 877-437-9012 Precert: 1-800-361-4542 ~~www.envisionspecialty.com~~ *www.birdirx.com* *Select Drugs and Product Program: 877-869-7772*

Article V, Schedule of Medical PPO Plan Benefits, the row "Drugs (Outpatient Retail/Mail Order Medicines) is amended with new language in italics:

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

Drugs (Outpatient Retail/Mail Order Medicines)
• Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the FDA as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician or other Health Care Practitioner authorized by law to prescribe them.
• Coverage is also provided for prenatal vitamins; drugs required to be covered due to Health Reform, FDA approved female contraceptives, insulin, diabetic supplies (including blood glucose meter and testing supplies such as lancets, test strips, and syringes), self-administered injectables such as Epipen and Glucagon.
• Contact the Prescription Drug Program administrator (whose phone number is listed on the Quick Reference Chart in the front of this document) for the following:
  • The list of drugs on the **Preferred Drug Formulary**.
  • Information on **drugs needing preapproval** by the clinical staff of the Prescription Benefit Manager (PBM) (e.g. certain pain medication, allergy treatment, hormone therapy, seizure and headache drugs, Advair, allergy medication, depression treatment drugs).
  • Information on which **drugs have a limit to the quantity** payable by this Plan (e.g. drugs to treat erectile dysfunction, ADHD, migraine, certain hormone therapy).
  • Information on which drugs are part of the **step therapy program** where you first try a proven, cost-effective medication before moving to a more costly drug treatment option. Step therapy drugs include GERD/ulcer treatment, statins for cholesterol, Cox 2 inhibitors like Celebrex or Vioxx, certain depression treatment drugs, Advair, nail fungus treatment, calcium channel blockers like Verapamil, allergy treatment and statins to treat high cholesterol/lipids.
Specialty drugs are available on an outpatient basis when ordered through and managed by the Prescription Benefit Manager (PBM). Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or hepatitis. These drugs may need precertification, often require special handling, are date sensitive, and are generally available only in a 30-day supply.
Select Drugs and Products Program. *Covered persons using Prescription Drugs included on the Select Drugs and Products List must enroll and complete the requirements of the Plan's Select Drugs and Products Program. Contact the Specialty Contact Center at 877-869-7772 for additional information.*
	The Prescription Drug Program: Benefits for prescription drugs are provided through the Plan's Prescription Benefit Manager (PBM) whose name is listed on the Quick Reference Chart in the front of this document.
	• **Retail Drugs**: To obtain up to a 30-day supply of medicine, for the cost-sharing noted to the right, present your ID card to any In-Network retail pharmacy. Contact the Prescription Benefit Manager (PBM) (whose name is listed on the Quick Reference Chart) for the location of In-Network retail pharmacies.
	• **Mail Order (Home Delivery) Drug Service:** The mail order service is the easiest and least expensive way to obtain many drugs, plus the medications are mailed directly to your home. You may use the mail order service (see the Quick Reference Chart) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure, arthritis or diabetes. Note that not all medicines are available via mail order. Check with the Prescription Benefit Manager (PBM) for further information. To use the mail order service:
	  a) Have your doctor write the prescription for a 90-day supply, with the appropriate refills.
	  b) Mail your prescription, Copay, and the mail order form to the Mail Order Services of the Prescription Benefit Manager (PBM) whose address is listed on the Quick Reference Chart. Mail order forms may be obtained from the Prescription Benefit Manager (PBM). Allow up to 14 days to receive your order.
	• **There is no coverage or reimbursement for drugs that you obtain at an Out-of-Network Retail Pharmacy.**
	• Note that if the cost of the drug is less than the Copay/Coinsurance you pay just the drug cost.
	• The Plan provides a **mandatory generic program** meaning that if a brand name drug is dispensed in place of a generic, regardless if you or your doctor request it, you will pay the brand cost-sharing plus the difference in cost between the generic and brand name drug.
	• ***Select Drugs and Products Program:*** *There is no Plan coverage for medications on the Select Drugs and Products List when you do not enroll in and complete the requirements of the Select Drugs and Products Program. Charges incurred for failure to enroll and complete the requirements of this Program do not apply toward your Out-of-Pocket Limit.*
	Some alternate funding programs in the Program require verification of income as a condition of meeting alternate funding program criteria. In such cases, the Covered Persons will be asked to provide the information directly to the alternate funding program. Failure to provide such information when required may lead to lack of coverage for medications on the Select Drugs and Products List. However, this information will not be provided to or reviewed by the Plan and will not otherwise be used to affect a Covered Persons coverage under the Plan.
	• ***Select Drugs and Products List.*** *This is a list of prescription drugs that are subject to step-therapy, prior authorization, and administrative review and must be acquired after enrollment in the Plan's Select Drugs and Products Program.*
	• **FDA-approved contraceptives for females:** covered at 100%, no cost-sharing for generic drugs submitted with a physician prescription purchased at an In-network Retail or Mail Order location. No charge for brand prescription contraceptive drugs only if a generic contraceptive is unavailable or medically inappropriate. No coverage from a Non-Network/Out-of-Network retail pharmacy.
	• In accordance with Health Reform, certain **over-the-counter (OTC) and prescription drugs** are payable at no charge when prescribed by a Physician or Health Care Practitioner (see page 28 for details).
	• Drugs not yet approved by the FDA are not covered. New FDA approved drugs will not be covered until a clinical review and formulary placement has been made by the Prescription Benefit Manager (PBM).
	• Certain CDC recommended **vaccinations** are payable at 100%, no cost-sharing when obtained at an in-network retail pharmacy. Contact the Prescription Benefit Manager for more information.
	• See also the Exclusions related to Drugs (Medicines) in the Medical PPO Plan Exclusions Article.
	• **Testosterone therapy for males requires prior authorization** by the Prescription Drug Program when diagnosed with clinically significant hypogonadism.
	• See the Quick Reference Chart for information about certain prescription drugs dispensed at **Family Wellness Centers at no cost**. See also the Family Wellness Centers (near-site health care clinics) row.
		No Deductible applies to outpatient drugs.
		In-Network Retail Pharmacy and Specialty Drugs (up to a 30-day supply):
		Generic: $5 Copay.
		Preferred Brand: You pay the greater of 20% or $20.
		Non-Preferred Brand: You pay the greater of 45% or $45.
		Specialty Drugs: $50 Copay.
		Certain generic drugs dispensed at Family Wellness Center clinics: No charge
		Diabetic Supplies: No charge.
		Female Contraceptives: No charge for generic drugs.
		Mail Order Service (up to a 90-day supply):
		Generic: No charge.
		Preferred Brand: $30 Copay.
		Non-Preferred Brand: $60 Copay.
			Retail drugs are only available In-Network.
			No coverage for drugs obtained out-of-network.

Benefit Description	Explanations and Limitations	In-Network	Out-of- Network
	• See the Out-of-Pocket Limit row in this Schedule for information on the amount of the annual Out-of-Pocket Limit for outpatient drugs.		

The undersigned Chairman and Co-Chairman of the **Teamsters Security Fund for Southern Nevada-Local 14** do hereby certify that the foregoing Amendment #11 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 23, 2025.

Chairman	**Date** 4/24/25
Co-Chairman	**Date**