AMENDMENT #9
to the Plan Document/Summary Plan Description for the
Teamsters Security Fund For Southern Nevada-Hotel And Casino Workers
that was effective October 1, 2014

Effective April 1, 2018, the Plan Document/Summary Plan Description is amended as follows:

Article XIV, Claim Filing and Appeal Information, Section. S., How To File A Claim For Disability Income Benefits (Disability Claim Process). and Section T. Appeal Of A Denial Of A Disability Claim, are amended to remove the stricken through text and to add the following text in italics:

Section S. How To File A Claim For Disability Income Benefits (Disability Claim Process).

1. A claim for disability benefits is a request for disability plan benefits made by you (an individual covered under the Weekly Accident and Sickness benefits (also referred to as a Disability benefit) or your authorized representative (as defined in this Article) in accordance with the Plan's disability claims procedures, described below in this Article. See also the "Key Definitions" section of this Article for a definition of a "claim" and the information on what is and is not considered a claim.
2. Eligible Employees who become totally disabled from a non-occupational illness should apply (file a claim) for disability benefits within 30 calendar days after the date on which the illness or injury began, according to the following steps:
3. Obtain a disability claim form from the Administrative Office. Complete the patient portion of the form. Then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Administrative Office whose contact information is listed on the Quick Reference Chart in this document. **Disability claims will be determined no later than 45 calendar days after receipt of the claim for disability benefits by the Appropriate Claims Administrator.**
4. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information.
   (a) Proof of disability must be provided to the Plan no later than 90 calendar days after the end of the period for which disability benefits are payable. If you do not provide proof of disability within the time specified, you can still claim full benefits if you can show that proof was furnished as soon as reasonably possible.
   (b) The Plan reserves the right to have a Physician examine you (at the Plan's expense) as often as is reasonable while a claim for benefits is pending or payable.
5. The Board of Trustees determines if Employees are eligible to receive disability benefits under this Plan. The Plan will review your disability claim and notify you or your authorized representative in writing (or electronically, as applicable) no later than 45 calendar days from the date the Appropriate Claims Administrator receives the claim.
   (a) This 45-day period may be **extended for up to 30 calendar days** provided the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) *prior to the expiration of the initial* 45-day period, that additional time is needed to process the claim, the special

circumstances for this extension and the date by which it expects to render its determination.

(b) If, prior to the end of this first 30 day extension, the Appropriate Claims Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

(c) A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. **If the Appropriate Claims Administrator needs additional information from you to make its decision**, you will have at least 45 calendar days to submit the additional information. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

6. Disability benefits begin when the claim for disability benefits has been determined to meet the definition of total disability under this Plan and it is determined that Plan disability exclusions do not apply to the claim.

7. **If the claim for disability benefits is approved**, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

8. **If the claim for disability benefits is denied** in whole or in part, a notice of this initial denial (Adverse Benefit Determination) will be provided to the Employee in writing (or electronically, as applicable). This notice of initial denial will:
   (a) give the specific reason(s) for the denial;
   (b) reference the specific Plan provision(s) on which the determination is based;
   (c) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (d) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   (e) provide an explanation of the Plan's appeal procedure along with time limits;
   (f) contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;
   (g) ~~if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request~~ *either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist*; ~~and~~
   (h) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, ~~a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request~~ *either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request*; *and*
   (i) *a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the plan of health care*

professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

9. **If you disagree with a denial of a disability claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Section T. Appeal Of A Denial Of A Disability Claim.

1. Appeals must be submitted in writing to the Board of Trustees whose contact information is listed on the Quick Reference Chart in this document. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (e) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:
      1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
      2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
2. A determination on the appeal will be made as follows:
   (a) no later than the date of the Board of Trustees meeting that immediately follows the Plan's receipt of a request for review, when the request for appeal review is filed **within** 30 calendar days preceding the date of such meeting. If the appeal **is filed more than 30 days** before the next meeting, a benefit determination will be made no later than the date of the second meeting following the Plan's receipt of the request for review.
   (b) If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, a benefit determination will be made no later than the third meeting of the Board following the Plans' receipt of the request for review.
   (c) If such an extension is necessary the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) The Plan will notify you of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.

3. **The Plan may obtain a 45-day extension if** you are notified of the need and reason for an extension before expiration of the initial 45-day period. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)

4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   (a) the specific reason(s) for the adverse appeal review decision;
   (b) reference the specific Plan provision(s) on which the determination is based;
   (c) contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   (d) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal *and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the clai*m;
   (e) a statement of the voluntary Plan appeal procedures, if any;
   (f) ~~if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request~~ *the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the denial or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist*;
   (g) if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, ~~a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request~~ *either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of change upon request*; ~~and~~
   (h) the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency"*;*
   (i) *a statement that you will receive, free of charge, any new or additional rationale and/or evidence considered, relied on, or generated by the Plan (or at the direction of the Plan) in connection with your claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the adverse benefit determination is required in order to give you a reasonable opportunity to respond prior to that date; and*
   (j) a discussion of the decision, including an explanation of the basis for disagreeing with or *not following: a. the views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; b. the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and c. disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration;*

5. This concludes the disability appeal process under this Plan. This Plan does not offer an additional voluntary appeal process.

The undersigned Chairman and Co-Chairman of the **Teamsters Security Fund For Southern Nevada-Hotel And Casino Workers** do hereby certify that the foregoing Amendment to the 2014 **Plan Document/Summary Plan Description** was duly adopted by the Board of Trustees at a meeting duly called and held on April 30, 2018:

Sean Hamer — 4/30/18

Chairman — **Date**

Wendy R. Nutt — 4-30-18

Co-Chairman — **Date**

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