AMENDMENT THREE
TO THE
SACRAMENTO INDEPENDENT HOTEL,
RESTAURANT & TAVERN EMPLOYEES WELFARE TRUST

WHEREAS, the Board of Trustees of the Sacramento Independent Hotel, Restaurant and Tavern Employees Welfare Plan (the "Plan") adopts this amendment to comply with the Patient Protection and Affordable Care Act's ("Act") limitation on out-of-pocket maximums with respect to essential health benefits covered under the Plan and other applicable provisions of the Act;

WHEREAS, the Board of Trustees desires to amend the Plan to have two separate in-network, out-of-pocket maximums for the Plan's prescription drug benefits and medical benefits but, the combined amount of both out-of-pocket maximums will not exceed the Act's annual limit for out-of-pocket maximums; and

THEREFORE, the Board of Trustees amends the Plan as follows:

Amendment

ARTICLE I. DEFINITIONS

Effective July 1, 2015, a new definition of "Out-of-Pocket Maximum" is added to Article I as Section 19.

19. Out-of-Pocket Maximum – means the limit on the total amount you are required to pay in a calendar year for in-network covered charges, including medical and prescription benefits, before the Plan pays 100% of in-network covered benefits and subject to the requirements of the Affordable Care Act. This limit includes any deductibles, coinsurance, copayments or similar covered charges for essential health benefits. There are separate out-of-pocket maximums for medical and prescription drug benefits under this Plan.

NEW ARTICLE VI. PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Effective January 1, 2015, the old Article titled "Certificate of Creditable Coverage under HIPAA" is eliminated and replaced with new Article VI. Patient Protection and Affordable Care Act as follows:

(1) No Pre-existing Condition Exclusions for Any Individual. Effective for plan years beginning on or after January 1, 2014 (for this Plan July 1, 2014), except for grandfathered individual policies, the Patient Protection and Affordable Care Act ("PPACA") prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had cancer before getting insurance) and outright coverage denials (e.g., when insurer or employer health plan refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions.

(2) **Certificates of Creditable Coverage No Longer Required.** Effective December 31, 2014, Insurers and Group Health Plans are no longer required to provide a Certificate of Creditable Coverage upon termination of your health coverage.

(3) **Availability of Summary of Benefits and Coverage ("SBC").** Under the PPACA, Group Health Plans, Insurers, and HMOs are responsible for providing a Summary of Benefits and Coverage ("SBC") to eligible new participants and their dependents. The SBC provides a summary of what the Plan covers and what it costs. You have the right to request and receive within seven (7) business days a SBC for the Plan's benefits offered through the self-funded Indemnity Plan, Kaiser, and Western Health Advantage. If you want a copy of the SBC and/or more details about your coverage for the HMO benefits, please contact Kaiser at (800) 278-3296 or Western Health Advantage at (888) 563-2250. For a copy of the SBC for the Indemnity Plans, please contact the Trust office at (916) 921-3388 or (800) 562-9383.

Choice of Provider. The Plan's HMO benefits offered through Kaiser and Western Health Advantage and the Plan's indemnity benefits offered through Aetna PPO generally requires or allows the designation of a primary care provider and pediatrician. You have the right to designate any primary care provider and pediatrician for your child who participates in the network and who is available to accept you or your family members. If the Plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, the Insurer will designate one for you. For information on how to select a primary care provider, and for a list of participating providers, please contact the Trust office at (916) 921-3388 or Kaiser at (800) 278-3296 or Western Health Advantage at (888) 563-2250 or Aetna's contact number on the back of your ID card.

You do not need prior authorization from this Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's PPO or HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology in the Plan's HMO network, contact Kaiser or Western Health Advantage. For a list of participating health care professionals who specialize in obstetrics or gynecology in the Plan's indemnity PPO network, contact Aetna.

(4) **Out-of-Pocket Maximum (OPM).** Under the PPACA, effective for Non-Grandfathered Group health plan years beginning on or after January 1, 2014 (for this Plan July 1, 2014) the Out-of-pocket Maximum ("OPM") for In-Network, Essential Health Benefits cannot exceed $6,350 self-only and $12,700 family coverage. In 2015 (for this Plan July 1, 2015) the limit increases to $6,600 self-only and $13,200 family coverage. However, this limit does not apply to spending for Non-Essential Health Benefits or Out-of-Network cost-sharing.

In addition, effective for plan years beginning on or after January 1, 2015, Non-Grandfathered Group health plans and Group health insurance coverage must have an OPM which limits overall out-of-pocket costs on all Essential Health Benefits. To illustrate, if there is a Separate OPM for in-network prescription drugs and Separate OPM for major medical benefits that are considered Essential Health benefits, the combined amount cannot exceed the annual limit applicable for that year.

(5) **For More Health Care Reform Information.** Under the PPACA, this Plan is required, among other things, to include certain consumer protections, for example, requiring the provision of preventive health services without any cost sharing, elimination of annual and lifetime dollar limits on Essential Health Benefits, and extension of dependent coverage. Please visit the Department of Labor website at *www.dol.gov/ebsa/healthreform* for more information about the ACA's provisions.

S.I.H.R.T.E. MEDICAL PLANS A and B

BENEFIT COMPARISON AS OF 2/01/2015*

(*Note: Benefits are subject to change at any time.)

Effective February 1, 2015, the Board of Trustees amends the Plan's Chart of Benefit Comparison as follows:

BENEFITS	PLAN A (HIGH PLAN)		PLAN B (LOW PLAN)		KAISER PERMANENTE	WESTERN HEALTH ADVANTAGE
	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN		
PLAN YEAR DEDUCTIBLE July 1st through June 30th	$100 PER PERSON $250 PER FAMILY	$250 PER PERSON $500 PER FAMILY	NONE NONE	$1,000 PER PERSON $3,000 PER FAMILY	NONE NONE	NONE NONE
PLAN A & B ANNUAL LIMIT (applies to "essential health benefits" as provided by the Affordable Care Act of 2010) EMPLOYEE OR DEPENDENT	**No Limit (combined with non-PPO) for charges incurred after July 1, 2014**	**No Limit (combined with non-PPO) for charges incurred after July 1, 2014**	**No Limit (combined with non-PPO) for charges incurred after July 1, 2014**	**No Limit (combined with non-PPO) for charges incurred after July 1, 2014**	NO LIMIT	NO LIMIT
MEDICAL OUT OF POCKET LIMIT (PLAN YEAR) (ONCE MET $-0-CO-PAY FOR BALANCE OF YEAR) Excluding Durable Medical Equipment, Chiro & Acu	**$1,500 PERSON** **$3,000 FAMILY**	**$7,000 PERSON** **$14,000 FAMILY**	**$ 6,000 PERSON** **$12,000 FAMILY**	**No Maximum** **No Maximum**	$1,500 PERSON $3,000 FAMILY	$1,500 PERSON $2,500 FAMILY
PRESCRIPTION DRUG OUT OF POCKET LIMIT (PLAN YEAR)	**$5,100 PERSON $10,200 FAMILY (MAGELLAN)**	**NO LIMIT**	**$600 PERSON $1,200 FAMILY (MAGELLAN)**	**NO LIMIT**	**(Through KAISER PHARM.)**	**$5,100 PERSON $10,700 FAMILY (MAGELLAN)**
PARTICIPATING DOCTORS	AETNA PPO PROVIDERS	DOCTOR OF YOUR CHOICE	AETNA PPO PROVIDERS	DOCTOR OF YOUR CHOICE	KAISER PERMANENTE PHYSICIANS	WESTERN HEALTH ADVANTAGE NETWORK
DOCTOR OFFICE VISITS	$15 Co-Pay Deductible Waived; 100% # if preventive care	70%♦♦♦ After Deductible	$15 Co-Pay; 100% # if preventive care	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	$20 PER VISIT
DOCTORS HOSPITAL VISITS OR **SKILLED NURSING FACILITY**	95%** After Deductible	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
WELL BABY CARE (UNDER AGE 2)	No copayment	70%♦♦♦ After Deductible	No copayment	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
PEDIATRIC & ADULT IMMUNIZATION (AGE 2 & OLDER)	$15 Co-Pay Deductible Waived; 100% # if preventive care	70%♦♦♦ After Deductible	80%****; 100% # if preventive care	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
ROUTINE WELLNESS EXAMINATIONS (ROUTINE PREVENTIVE CARE): Include Routine Physicals, Routine Gynecological Examinations, Pap Smears, Mammograms, Prostate Exams, Pelvic Exams, And Other Exams Recommended By A Physician As Routine Preventive Care.	No cost sharing for routine preventive care.	$25 Co-Pay Deductible Waived UP TO $250 PER CALENDAR YEAR Balance paid at 70%♦♦♦ After Deductible	No cost sharing for routine preventive care.	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
PRESCRIPTION COVERAGE GENERIC BRAND-NAME	MAGELLAN RX Up to 30 Day Supply $10 Co-Pay Per Rx $DW $25 Co-Pay Per Rx $DW		MAGELLAN RX Up to 30 Day Supply $10 Co-Pay Per Rx $DW $25 Co-Pay Per Rx $DW		KAISER PHARM. Up to 30 Day Supply $10 Co-Pay Per Rx $20 Co-Pay Per Rx	MAGELLAN RX Up to 30 Day Supply $10 Co-Pay Per Rx $25 Co-Pay Per Rx
MAIL ORDER PRESCRIPTION COVERAGE (Up to a 90 Day Supply)	$15 for 3 Month Supply		$15 for 3 Month Supply		100 Day Supply - $20 Generic/$40 Brand	$15 for 3 Month Supply

HEARING TEST Once Per Year	$15 Co-Pay Deductible Waived	NOT COVERED	80%****	NOT COVERED	NO CHARGE	$20 PER VISIT
EYE EXAMS, REFRACTIONS (UNDER AGE 18)	NOT COVERED (but COVERED THROUGH VSP)	NOT COVERED (but COVERED THROUGH VSP)	NOT COVERED (but COVERED THROUGH VSP)	NOT COVERED (but COVERED THROUGH VSP)	NO CHARGE (and also COVERED THROUGH VSP)	$20 PER VISIT(and also COVERED THROUGH VSP)

**	OR 95% OF THE PLAN'S PPO ALLOWANCE	♦	OR 90% OF THE PLAN'S UCR SCHEDULE	♦♦♦♦	OR 60% OF THE PLAN'S UCR SCHEDULE
***	OR 90% OF THE PLAN'S PPO ALLOWANCE	♦♦	OR 80% OF THE PLAN'S UCR SCHEDULE	♦♦♦♦♦	OR 50% OF THE PLAN'S UCR SCHEDULE
****	OR 80% OF THE PLAN'S PPO ALLOWANCE	♦♦♦	OR 70% OF THE PLAN'S UCR SCHEDULE	#	OR 100% OF THE PLAN'S PPO ALLOWANCE IF PREVENTIVE CARE
	NOTE: INDEMNITY PLAN NON PPO ANESTHESIA CHARGES ARE PAID AT THE PPO LEVEL IF THE PRIMARY SURGEON IS A PPO PROVIDER.				
	PPO = Preferred Provider Organization UCR = Usual, Customary & Reasonable				

	INDEMNITY AND WESTERN HEALTH ADVANTAGE PLANS - PRESCRIPTION DRUG COVERAGE IS THROUGH MAGELLAN RX. See benefit coverage above. Pharmacy co-payments do not contribute to the medical out of pocket maximum.
	KAISER PLAN – PRESCRIPTION DRUG COVERAGE IS THROUGH KAISER FACILITIES. See benefit coverage above.

S.I.H.R.T.E. MEDICAL PLANS A and B

BENEFIT COMPARISON AS OF 2/01/2015*

(*Note: Benefits are subject to change at any time)

BENEFITS	PLAN A (HIGH PLAN)		PLAN B (LOW PLAN)		KAISER PERMANENTE	WESTERN HEALTH ADVANTAGE
	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN		
MATERNITY CARE (PRE NATAL/DELIVERY/POST NATAL CARE) **Employee and Spouse Coverage Only** Preventive care includes breastfeeding support, supplies, counseling, and rental of breastfeeding equipment.	95%** After Deductible TOTAL CHARGES No cost sharing for women's preventive care.	70%♦♦♦ After Deductible TOTAL CHARGES	80%**** TOTAL CHARGES No cost sharing for women's preventive care.	50%♦♦♦♦♦ After Deductible TOTAL CHARGES	NO CHARGE	NO CHARGE (After initial diagnosis, pre and post natal visits and laboratory tests)
FAMILY PLANNING	$15 Co-Pay Deductible Waived	NOT COVERED	80%****	NOT COVERED	NO CHARGE	$20 PER VISIT
SPEECH THERAPY	$15 Co-Pay Deductible Waived	NOT COVERED	80%****	NOT COVERED	$20 PER VISIT	$20 PER VISIT
SKILLED NURSING FACILITY	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE for up to 100 days per benefit period	NO CHARGE for up to 100 days per Year
X-RAY & LAB	$10 Co-Pay Deductible Waived; 100% # if preventive care	70%♦♦♦ After Deductible	80%****; 100% # if preventive care	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
CHIROPRACTIC	$15 Co-Pay Deductible Waived Maximum of 30 Visits Per Year	50%♦♦♦♦♦ After Deductible Maximum of 20 Visits Per Year	80%**** Maximum of 30 Visits Per Year	50%♦♦♦♦♦ After Deductible Maximum of 20 Visits Per Year	NOT COVERED	$15 Per Visit Maximum 20 Visits Per Year (Applies to Acupuncture as well)
PHYSICAL THERAPY (OUTPATIENT)	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	$20 PER VISIT
PHYSICAL THERAPY (INPATIENT)	95%**After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE	COVERED IN FULL
DURABLE MEDICAL EQUIPMENT (DME)	80%**** Co-Pay Deductible Waived	50%♦♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	20% Co-Pay	20% Co-Pay

ALLERGY TREATMENT	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$3 PER VISIT	$5 PER VISIT
OUTPATIENT / MENTAL HEALTH	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	$20 PER VISIT
INPATIENT / MENTAL HEALTH	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE	NO CHARGE
CHEMICAL SUBSTANCE ABUSE-OUT PATIENT THERAPY	$15 Co-Pay After Deductible	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	Contact Kaiser for information	Contact WHA for information
CHEMICAL SUBSTANCE ABUSE-INPATIENT	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	Contact Kaiser for information	Contact WHA for information

**	OR 95% OF THE PLAN'S PPO ALLOWANCE	♦	OR 90% OF THE PLAN'S UCR SCHEDULE	♦♦♦♦	OR 60% OF THE PLAN'S UCR SCHEDULE
***	OR 90% OF THE PLAN'S PPO ALLOWANCE	♦♦	OR 80% OF THE PLAN'S UCR SCHEDULE	♦♦♦♦♦	OR 50% OF THE PLAN'S UCR SCHEDULE
****	OR 80% OF THE PLAN'S PPO ALLOWANCE	♦♦♦	OR 70% OF THE PLAN'S UCR SCHEDULE	#	OR 100% OF THE PLAN'S PPO ALLOWANCE IF PREVENTIVE CARE
	NOTE: INDEMNITY PLAN NON PPO ANESTHESIA CHARGES ARE PAID AT THE PPO LEVEL IF THE PRIMARY SURGEON IS A PPO PROVIDER.				
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	INDEMNITY AND WESTERN HEALTH ADVANTAGE PLANS - PRESCRIPTION DRUG COVERAGE IS THROUGH MAGELLAN RX. See benefit coverage above. Pharmacy co-payments do not contribute to the medical out of pocket maximum.
	KAISER PLAN – PRESCRIPTION DRUG COVERAGE IS THROUGH KAISER FACILITIES. See benefit coverage above.

S.I.H.R.T.E. MEDICAL PLANS A and B

BENEFIT COMPARISON AS OF 2/01/2015*

(*Note: Benefits are subject to change at any time)

BENEFITS	PLAN A (HIGH PLAN)		PLAN B (LOW PLAN)		KAISER PERMANENTE	WESTERN HEALTH ADVANTAGE
	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN		
AMBULANCE	95%** After Deductible	80%♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$50 (When Medically Necessary & Authorized by a Plan Physician)	NO CHARGE
EMERGENCY ROOM	90%*** After Deductible + $150 Co-Pay. Co-Pay Waived if Admitted to Hospital at time of Visit. 60%♦♦♦♦ After Deductible LESS $150 PENALTY IF NOT LIFE THREATENING	90%♦ After Deductible + $150 Co-Pay. Co-Pay Waived if Admitted to Hospital at time of Visit for Emergency Care – Must transfer to a PPO hospital as soon as it is determined medically feasible. 60%♦♦♦♦ After Deductible LESS $150 PENALTY IF NOT LIFE THREATENING	80%**** + $150 Co-Pay. Co-Pay Waived if Admitted to Hospital at time of Visit. 50%♦♦♦♦♦ LESS $150 PENALTY IF NOT LIFE THREATENING	80%♦♦ After Deductible + $150 Co-Pay. Co-Pay Waived if Admitted to Hospital at time of Visit for Emergency Care – Must transfer to a PPO hospital as soon as it is determined medically feasible. 50%♦♦♦♦♦ After Deductible LESS $150 PENALTY IF NOT LIFE THREATENING	$50 Per Visit (Waived if Member is Admitted)	$100 Per Visit (Waived if Member is Admitted)
URGENT CARE FACILITY	95%** Deductible Waived	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	$35 Per Visit
INPATIENT HOSPITAL CHARGES						
Inpatient physician services (including pregnancy and maternity care)	95%** After Deductible	60%♦♦♦♦ After Deductible LESS $150 PENALTY	80%****	50%♦♦♦♦♦ After Deductible LESS $150 PENALTY	NO CHARGE	NO CHARGE
Semi-private Room & Board, Medically Necessary Services and Supplies	95%** After Deductible	60%♦♦♦♦ After Deductible LESS $150 PENALTY	80%****	50%♦♦♦♦♦ After Deductible LESS $150 PENALTY	NO CHARGE	NO CHARGE
OUTPATIENT SURGERY (FACILITY)	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$20 Per Visit	$100 Per Visit
INFERTILITY SERVICES	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	$20 Per Visit	NOT COVERED
STERILIZATION	95%** After Deductible	NOT COVERED	80%****	NOT COVERED	NO CHARGE	Female-$100 Male-$20
SLEEP APNEA	95%** After Deductible	NOT COVERED	80%***	NOT COVERED	Contact Kaiser for information	COVERED
TEMPOROMANDIBULAR JOINT DISORDERS (TMJ)	NOT COVERED	NOT COVERED	NOT COVERED	NOT COVERED	Contact Kaiser for information	Limited coverage if result of medical condition

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***	OR 90% OF THE PLAN'S PPO ALLOWANCE	♦♦	OR 80% OF THE PLAN'S UCR SCHEDULE	♦♦♦♦♦	OR 50% OF THE PLAN'S UCR SCHEDULE
****	OR 80% OF THE PLAN'S PPO ALLOWANCE	♦♦♦	OR 70% OF THE PLAN'S UCR SCHEDULE	#	OR 100% OF THE PLAN'S PPO ALLOWANCE IF PREVENTIVE CARE
	NOTE: INDEMNITY PLAN NON PPO ANESTHESIA CHARGES ARE PAID AT THE PPO LEVEL IF THE PRIMARY SURGEON IS A PPO PROVIDER.				
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	KAISER PLAN – PRESCRIPTION DRUG COVERAGE IS THROUGH KAISER FACILITIES. See benefit coverage above.

Approved: February 17, 2015

UNION TRUSTEES:

EMPLOYER TRUSTEES: