AMENDMENT SEVEN

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 ("Plan") desires to amend the Plan's claims and appeals procedures relating to disability benefits, in order to meet the requirements of the Final Regulations released by the U.S. Department of Labor in 29 CFR Part 2560, 81 Federal Register 92316 (December 19, 2016);

WHEREAS, the Board of Trustees believes the amended ERISA disability claims and appeals rules would be in the best interest of its eligible participants and dependents; and

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

Amendment

ARTICLE XVIII. CLAIMS PROCEDURE FOR INDEMNITY MEDICAL AND DENTAL CLAIMS AND PRESCRIPTION DRUG CLAIMS

Effective January 1, 2018, Article XVIII, Sections C and D of the restated Summary Plan Description (also the Plan Document) is amended as follows:

C. Time Limits for Claims Procedure

Urgent Claims. The Plan will determine whether a Claim is an Urgent Claim as determined by the Provider or Physician with knowledge of the patient's medical condition that the Claim is an Urgent Claim, and notifies the Plan of such, it will be treated as an urgent Claim. You will be notified of a decision, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim is received.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, you will be notified as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. You will then be given a reasonable additional amount of time, but not less than 48 hours, to provide the information and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Pre-Service Claims. If the Plan requires you to obtain advance approval of a non-urgent service, supply, or procedure before a claim will be payable, such a request for prior approval is considered a Pre-Service Claim. You will be notified of the decision not later than 15 days after receipt of the Pre-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified of the extension before the end of the initial 15 or 30-day period. To illustrate, there may be an extension if you have not submitted sufficient information, in which case you will be notified of the information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

If a Pre-Service Claim is submitted, but which otherwise fails to follow the Plan's procedures for filing Pre-Service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed.

Concurrent Claims. If you received pre-authorization for an ongoing course of treatment that does not involve an Urgent Claim, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Plan and receive a decision on

that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment that is in progress at least 24 hours prior to the expiration of the approved Urgent Claim, you will be notified within 24 hours after receipt of the request.

Post-Service Claims. You will be notified of the decision not later than 30 days after receipt of the Post-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified, before the end of the extension before the end of the initial 30 day period. You will have 45 days from receipt of the notice to supply the additional information and will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

Disability-related Claims. Decisions on disability claims and appeals have different time periods. If the Plan denies any disability-related claim for benefits, the Plan will notify you of the denial within 45 days after the Plan's receipt of the claim. An extension of time not exceeding 30 days may be necessary due to matters beyond the Plan's control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30 day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30 day extension.

The notice of extension will include in addition to the information set forth above, the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

D. <u>If Your Claim Is Denied</u>

If all or part of your claim is denied, you will receive a written notice that explains:

The reason(s) for the denial, including references to specific Plan provision(s), as applicable, upon which the denial was based;

- The additional materials or information needed to support your claim and why such information or materials are necessary if the claim was denied because you did not furnish complete information or documentation;
- The appeals procedures and the time limits that apply to them; and
- Your right to bring a civil action under Section 502(a) of ERISA after an adverse benefit determination on appeal.
- Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);
- For an adverse benefit determination, a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable (the Plan will not consider a request for such diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review);
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
- A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

If the claim is denied on the basis of an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request. For Denial Notice on a Disability-related claim, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.

If the claim is denied on the basis of a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Effective January 1, 2018, the **Denial Notice on a Disability-related claim** shall include the same information as that set forth above and will also include the following information:

- Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

- Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;

- Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;

- Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and

- If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-english language spoken where you live.

Common reasons for denial are:

(1) The expenses were incurred during a month that the Employee and/or Dependent was not eligible.
(2) The expenses were incurred as the result of any injury which occurred on the job.
(3) The expenses were submitted after the 90-day filing limitation following the completion of treatment, or one year after this 90-day period.
(4) The expenses were for a non-covered procedure or service.

ARTICLE XVIII. APPEALS PROCEDURE FOR INDEMNITY MEDICAL (PLAN A AND B) AND DENTAL AND PRESCRIPTION DRUG CLAIMS

Effective January 1, 2018, Article XVIII, Section C of the restated Summary Plan Description (also the Plan Document) is amended as follows:

C. Notice of Final Internal Adverse Benefit Determination on Appeal

If the Board of Trustees determines that benefits should be paid, the Plan will take whatever action is necessary to pay them as soon as possible.

A **"Final Adverse Benefit Determination"** is an Adverse Benefit Determination that has been upheld by the Plan at completion of the Plan's Internal Appeals Procedures or an adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhaustion rules" (explained below in Subsection D.).

If your Appeal is denied, the Notice of Final Internal Adverse Benefit Determination will explain:

- The reason(s) for the denial, including references to specific Plan provisions, as applicable, upon which the denial was based; and
- Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits; and
- Your right to bring a civil action under section 502(a) of ERISA (if applicable).
- Information about your right to Independent External Review for certain types of claims (if applicable).

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request. For Appeal Denial Notice on a Disability-related claim, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.

If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan, as applicable, to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Effective January 1, 2018, for the Notice of Final Internal Adverse Benefit Determination of Disability-related claims, in addition to the information set forth above the Notice will also include:

- Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
- Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and
- If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-english language spoken where you live.

Approved: February 15, 2017

EMPLOYER TRUSTEES:

UNION TRUSTEES: