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

WHEREAS, it has always been the Board of Trustees of the Sacramento Independent Hotel, Restaurant and Tavern Employees Welfare Plan's (the "Plan") intent to comply with the Patient Protection and Affordable Care Act's ("Act") requirement to cover recommended preventive care services at no charge if such services are received in-network;

WHEREAS, the Board of Trustees desires to amend the Plan to clarify that female sterilizations and smoking cessation services that are considered a recommended preventive service will be covered at no cost if received in-network;

WHEREAS, the Board of Trustees desires to amend the Plan to update its Benefit Comparison Chart to reflect the most recent benefits provided as of July 1, 2015 and to clarify that effective February 1, 2016, prescription drug coverage will be provided through Western Health Advantage ("WHA") for WHA enrollees; and

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

Amendment

ARTICLE I. DEFINITIONS

Effective January 1, 2016, Article IX (Clarification of Indemnity Plan Benefits), Subsection 3(b) of Section A (Indemnity Plan Covered Expenses) is amended to clarify that tobacco cessation services are covered preventive services, as follows:

(3) Routine Medical Examinations/Preventive Care ...

b. For children, adolescents, and adults (age 18 and older), medically necessary preventive services will be provided in accordance with recommendations made by the U.S. Preventive Services Task Force in effect at the time the service is provided (generally, those preventive services given a "grade" of A or B). The latest guidelines are available at www.us.preventiveservicetaskforce.org/Page/Name/recommendations. These guidelines include, but are not limited, to the following:

- Alcohol and Drug Use assessments for Adolescents.
- Aspirin to prevent cardiovascular disease for men and women age 45 and over.
- Autism Screening for children at 18 and 24 months.
- Behavioral assessments for children.
- Blood Pressure Screening for all adults and children.
- Cholestoral screening for adults of certain ages or at higher risk.
- Coverage of breast cancer mammograms.
- Colorectal Cancer screening for adults age 50 and older, including medically appropriate anesthesia services performed in connection with the preventive colonoscopy.

- Developmental Screening for children under age 3.
- Diabetes (Type 2) Screening for adults with high blood pressure.
- Depression Screening for adults.
- Dyslipidemia screening for children at higher risk of lipid disorders.
- Folic acid for women planning or capable of pregnancy.
- Food and Drug Administration (FDA) approved female over-the-counter contraceptives, patient education and counseling, and an office visit for contraceptive administration and/or removal of a contraceptive device.
- Fluoride supplementation for children from age 6 months through age 5.
- HIV Screening for all pregnant women, adolescents and adults ages 15 to 65 years, and younger adolescents and older adults who are at increased risk.
- Hypothyroidism screening for newborns.
- Hemoglobinopathies or sickle cell screening for newborns.
- Hematocrit or Hemoglobin screening for children.
- Obesity Screening and Counseling for all adults and children ages 6 years and older.
- Iron supplementation for asymptomatic children ages 6 to 12 months.
- Routine Breast Cancer Susceptibility Gene (BRCA) Testing, Genetic Counseling, Evaluation and Lab Tests. USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal or peritoneal cancer with 1 of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in BRCA 1 or BRCA 2. Women, with positive screening results should receive genetic counseling and if, indicated after, counseling, BRCA testing.
- Routine iron supplementation for asymptomatic children ages 6 to 12 months.
- Screening for tobacco use and for those who use tobacco products at least two tobacco cessation attempts per year. (For this purpose, covering a cessation attempt includes coverage for 4 tobacco cessation counseling sessions of at least 10 minutes each without prior authorization and all FDA-approved tobacco cessation medications for a 90 day treatment regimen when prescribed by a health care provider without prior authorization).
- Sexually Transmitted Infection prevention counseling for adults at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis.
- Vitamin D supplementation for men and women age 65 and older.
- Vision Screening for all children.

Effective July 1, 2014, Article IX (Clarification of Indemnity Plan Benefits), Subsection 13 of Section G (Indemnity Medical Plan Exclusions and Limitations) is amended to clarify that female sterilizations are covered preventive services, as follows:

G. **Indemnity Medical Plan Exclusions and Limitations** ...

(13) Any services, care, or treatment in connection with elective sterilization or reversal of surgically performed sterilization except for female sterilizations considered covered preventive care benefits in accordance with the recommendations and guidelines set by the federal government pursuant to the Affordable Care Act.

S.I.H.R.T.E. MEDICAL PLANS A and B BENEFIT COMPARISON AS OF 7/01/2015*

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

Effective July 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.)**	**(Effective 2/1/2016 Through WHA)**
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 PREFERRED BRAND-NAME NON-PREFERRED MEDICATION SPECIALTY DRUGS **MAIL ORDER PRESCRIPTION COVERAGE** **(Up to a 90 Day Supply)**	**MAGELLAN RX** **(Up to 30 Day Supply)** $10 Co-Pay Per Rx $DW $25 Co-Pay Per Rx $DW N/A N/A N/A $15 for 3 Month Supply		**MAGELLAN RX** **(Up to 30 Day Supply)** $10 Co-Pay Per Rx $DW $25 Co-Pay Per Rx $DW N/A N/A N/A $15 for 3 Month Supply		**KAISER PHARM.** **(Up to 30 Day Supply)** $10 Co-Pay Per Rx $20 Co-Pay Per Rx N/A N/A N/A 100 Day Supply - $20 Generic/$40 Brand	**WHA RX** **(Up to 30 Day Supply)** $10 Co-Pay Per Rx N/A $30 Preferred Brand $50 Non-Preferred N/A Contact WHA for Information

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 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.
	WESTERN HEALTH ADVANTAGE – PRESCRIPTION DRUG COVERAGE IS THROUGH WHA FACILITIES. See benefit coverage above.

S.I.H.R.T.E. MEDICAL PLANS A and B BENEFIT COMPARISON AS OF 7/01/2015*

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

BENEFITS	PLAN A (~~HIGH PLAN~~)		PLAN B (~~LOW PLAN~~)		KAISER PERMANENTE	
	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN	PPO INDEMNITY PLAN	NON PPO INDEMNITY PLAN		
MATERNITY CARE (PRE NATAL/DELIVERY/POST NATAL CARE) **For 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
FAMILY PLANNING	$15 Co-Pay Deductible Waived	NOT COVERED	80%****	NOT COVERED	NO CHARGE	
SPEECH THERAPY	$15 Co-Pay Deductible Waived	NOT COVERED	80%****	NOT COVERED	$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	
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	
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	
PHYSICAL THERAPY (OUTPATIENT)	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	
PHYSICAL THERAPY (INPATIENT)	95%**After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE	
DURABLE MEDICAL EQUIPMENT (DME)	80%**** Co-Pay Deductible Waived	50%♦♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	20% Co-Pay	
ALLERGY TREATMENT	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	$3 PER VISIT	

OUTPATIENT / MENTAL HEALTH	$15 Co-Pay Deductible Waived	70%♦♦♦ After Deductible	$15 Co-Pay	50%♦♦♦♦♦ After Deductible	$20 PER VISIT	
INPATIENT / MENTAL HEALTH	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	NO CHARGE	
CHEMICAL SUBSTANCE ABUSE-OUT PATIENT THERAPY	$15 Co-Pay After Deductible	70%♦♦♦ After Deductible	$15 Co-Pay	50%♦♦♦♦♦ After Deductible	Contact Kaiser for information	
CHEMICAL SUBSTANCE ABUSE-INPATIENT	95%** After Deductible	60%♦♦♦♦ After Deductible	80%****	50%♦♦♦♦♦ After Deductible	Contact Kaiser 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.				
	PPO = Preferred Provider Organization UCR = Usual, Customary & Reasonable				

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

S.I.H.R.T.E. MEDICAL PLANS A and B BENEFIT COMPARISON AS OF 7/01/2015*

(*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		
					$50 (When Medically	

**	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 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.
	WESTERN HEALTH ADVANTAGE – PRESCRIPTION DRUG COVERAGE IS THROUGH WHA FACILITIES. See benefit coverage above.

Approved: February 3, 2016

UNION TRUSTEES:

EMPLOYER TRUSTEES: