AMENDMENT FIFTEEN
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") previously temporarily amended the self-funded indemnity PPO Plan (with Aetna) and HMO coverages with Kaiser and Western Health Advantage (WHA) to comply with the Families First Coronavirus Response Act ("FFCRA Act") and Coronavirus Aid, Relief and Economic Security Act ("CARES Act") to allow for coverage at no cost-sharing for COVID-19 screening and testing and no prior authorization for covered testing during the period of the 2020 declared public health emergency;

WHEREAS, the Board of Trustees intends to clarify that during the period of the public health emergency serological tests (antibody tests) for COVID-19 will be covered if the antibody test meets the requirements of FFCRA, as amended by the CARES Act and pursuant to the jointly released U.S. Department of Labor, Health and Human Services, and the Treasury Guidelines dated April 11, 2020 (FFFCRA-Part-42-FAQ, Q.4);

WHEREAS, the Board of Trustees previously temporarily amended the self-funded indemnity PPO Plan (with Aetna) to cover COVID-19 treatment including out-of-pocket costs received with an Aetna PPO network provider at 100% but treatment for COVID-19 received at a non-network Aetna PPO facility will be treated in the same manner as other treatment when performed at a non-PPO network facility pursuant to the Plan terms only till June 1, 2020 and hereby extends COVID-19 treatment until December 31, 2020;

WHEREAS, the Board of Trustees temporarily amends the Plan's COBRA Election rules, Special Enrollment period, Claims & Appeals Procedures, and External Review rules, only during the Outbreak Period (unless extended by Federal Mandate), pursuant to the jointly released DOL and IRS Emergency Rules and Regulations entitled "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak" dated April 29, 2020 (Federal Register, Vol. 85, No. 86, May 4, 2020);

WHEREAS, the Board of Trustees previously temporarily amended the Plan to provide for subsidized coverage without a premium through July 31, 2020 during the COVID-19 public health emergency for a Participant who would otherwise lose coverage under the Plan during May, June and/or July 2020 and now extends that coverage for an additional month through August 31, 2020;

WHEREAS, the Plan Consultant has determined there is enough in the Plan's reserves to accommodate another month of subsidized health coverage during the public health emergency for those participants whose covered employment is impacted by COVID-19;

WHEREAS, the Board of Trustees of the Plan believes it is in the best interest of its Plan Participants and Dependents during this COVID-19 pandemic to adopt this amendment and reserves the right to extend these provisions beyond the 2020 declared public health emergency at any time; and

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

Amendment

The Board of Trustees of the Plan has amended Sections C.11 and 13 "Other Covered Indemnity Plan Benefits" under Article IX. CLARIFICATION OF INDMENITY PLAN BENEFITS on page 36 of the Summary Plan Description (also known as the Plan Document), as follows:

(11) **COVID-19 Testing, Diagnostic Services or Items (During Public Health Emergency).** Effective for services or items received on or after March 18, 2020, the Plan's self-insured coverage through Aetna will cover charges for the following tests only to detect the SARS-COV-2 or COVID-19 or the diagnosis of the virus that causes COVID-19 (including serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19) at no cost (meaning no copayment, deductible or coinsurance) at both an in-network Provider or non-network Provider facilities:

(a) tests approved, cleared or authorized by the FDA,
(b) a test that a test developer intends or has requested FDA authorization for emergency use,
(c) a state authorized test and the state has notified the Department of Health and Human Services, or
(c) other tests that the Secretary of Health and Human Services determines appropriate in guidance, developed during the COVID-19 public health emergency period.

This COVID-19 coverage extends to any diagnostic items or services provided during a medical visit including an in-person or telehealth/telemedicine visit (such as virtual check-ins or e-visits) to a doctor's office, urgent care visit or an emergency room visit that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services or items related to SARS-COV-2 or COVID-19 testing.

Pricing of Out-of-Network Diagnostic Testing. Pursuant to Section 3202 of the CARES Act and subject to any further government regulation and guidance, the Plan or Insurer will pay or reimburse for covered COVID-19 diagnostic tests as follows: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the diagnostic test provider on the public internet website of such provider.

...

(13) COVID-19 Treatment. Effective March 25, 2020 to December 31, 2020, if a Plan Participant or Dependent is diagnosed with COVID-19, charges for treatment of the Coronavirus will be covered in full (including hospital admission if applicable) if performed at an Aetna PPO network Provider facility as provided in this Plan (without a co-pay or deductible or coinsurance). However, COVID-19 treatment received at a non-Aetna PPO network Provider will be covered in the same manner and cost-sharing as other medical necessary treatments performed at a non-network Provider pursuant to the Plan terms.

The Board of Trustees of the Plan has amended Article VIII. MEDICAL BENEFIT CHOICES on page 30 of the Summary Plan Description (also known as the Plan Document) as follows:

A. **KAISER HMO Plan- COVID-19 Testing and Treatment Coverage During Public Health Emergency.**

1. **Kaiser COVID-19 Testing, Diagnostic Services or Items.** Effective March 18, 2020, the Plan's HMO coverage through Kaiser will waive all cost-sharing (deductibles, copayments, and coinsurance) for all medically necessary screening and tests to detect COVID-19 during the COVID-19 public health emergency period. Kaiser will also cover serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19 pursuant to federal and state mandates including Kaiser's own infectious disease medical experts. This COVID-19 coverage extends to any diagnostic services or items including the visit (such as an in-person or telehealth visit), associated lab testing, and radiology services provided in an urgent care center, hospital, an emergency room or medical office that results in an order for an administration of the COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. This cost-sharing reduction applies to all Kaiser Permanente and other participating providers. Prior authorization is not required for diagnostic services related to COVID-19 testing.
2. **Kaiser COVID-19 Treatment Coverage.** Effective April 1, 2020 to December 31, 2020 unless superseded by government action or extended by Kaiser, if a Kaiser Plan Participant or Dependent is diagnosed with COVID-19, charges such as out-of-pocket costs for treatment of COVID-19 will be covered for inpatient medical, inpatient pharmacy, outpatient medical, office visits, telemedicine, hospitalization, emergency room, urgent care and transportation costs). This means any out-of-pocket costs, co-payments or other cost-share related to a positive COVID-19 diagnosis and treatment (including hospital stay) will be waived by Kaiser.

B. **WHA HMO Plan COVID-19 Testing During Public Health Emergency.**

1. **WHA COVID-19 Screening, Testing, and Visits Coverage.** Effective March 18, 2020, the Plan's HMO coverage through WHA will waive all cost-sharing for medically necessary screening and tests to detect COVID-19 or the diagnosis of the virus that causes COVID-19, including hospital/emergency room, urgent care, and provider office visits where the purpose of the visit is to be screened and/or tested for COVID-19, during the COVID-19 public health emergency period. WHA will also cover serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19 pursuant to federal and state mandates if obtained through the advice and authorization of the primary care physician and their preferred network of labs.

Article IV of the Sacramento Independent Hotel, Restaurant and Tavern Employees Welfare Plan is temporarily amended by adding the following after subsection (6) relating to coverage for Participants:

COVID-19 Impact on Covered Employment (Continued Coverage). Effective as of May 1, 2020, a Participant who worked in Covered Employment during February 2020, that provided coverage during April 2020, who would otherwise lose coverage under the Plan because of lack of Covered Employment

due to the COVID-19 public health emergency and/or the failure of an Employer to make the required contributions to the Plan is eligible for continued coverage under the Plan through August 31, 2020 (previously this expired July 31, 2020).

The Board of Trustees of the Plan has temporarily amended the Plan by adding New Section "Temporary Emergency Extension Rules" under Article XXI. MISCELLANEOUS to the Summary Plan Description (also known as the Plan Document), by adding the following paragraphs:

TEMPORARY EMERGENCY EXTENSION RULES. Effective immediately, joint IRS and DOL emergency regulation requires the Plan (and insurance carriers) must disregard the period from **March 1, 2020 until sixty (60) days after the announced end of the National Emergency or another date determined by the agencies in a future notice** (referred to as the "**Outbreak Period**") for all plan participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates:

1. **COBRA Qualifying Event Notice.** For Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the 60-day period to give a Qualifying Event Notice will be temporarily tolled until 60 days after the end of the Outbreak Period.
2. **COBRA Premium Payments (For Initial Payment and Ongoing Monthly Payments).** If COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily due no later than the end of the 45-day period after the end of the Outbreak Period. For all ongoing monthly premium payments, coming due during the Outbreak Period are temporarily due no later than 30 days after the end of the Outbreak Period because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 day grace period of the due date.
3. **COBRA Election Notice.** A Qualified Beneficiaries 60 day right to elect COBRA upon receipt of the Notice is temporarily tolled until after the end of the Outbreak Period, calculated from the later of the date of the Qualifying Event, if the Qualifying Event is a divorce or a child losing Dependent status, or the date the Qualified Beneficiary loses coverage. For Qualifying Events occurring on or after March 1, 2020, this period is extended until the end of the sixty (60) period after the end of the Outbreak Period.
4. **Special Enrollment Rights.** For participants that experience a birth, marriage or adoption as of March 31, 2020, their 30-day period to special enroll an eligible Dependent in the Plan upon birth, marriage, or adoption has been extended until 30 days from the end of the Outbreak Period. If you or your dependent lose coverage under CHIPRA or Medicaid, you or your dependents 60-day period to special enroll in the Plan (subject to meeting the Plan's eligibility rules) upon a loss of CHIPRA or Medicaid coverage has been extended until 30 or 60 days from the end of the Outbreak Period.
5. **Plan's Claims Filing Procedure.** Any benefit claims filing requirements (including 1 year period to file suit) mentioned throughout this booklet, for claims as of March 1, 2020, has been temporarily tolled and counted from the end of the Outbreak Period. If applicable, for those claims received/processed earlier than March 1, 2020, any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your claims filing deadline but the days that fall within the Outbreak Period will be temporarily tolled and counted from the end of the Outbreak Period.
6. **Plan's Appeals Procedure.** For those claimants (or their authorized representatives) who received an adverse benefit determination/claims denial as of March 1, 2020 the claimant (or authorized representative) has 180 days counted from the end of the Outbreak Period to file an appeal. If applicable, for those claimants who received an adverse benefit determination earlier than March 1, 2020 any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your appeals filing deadline but the days that fall within the Outbreak Period will be temporarily tolled and counted from the end of the Outbreak Period.
7. **Request for External Review.** If applicable, claimant (or authorized representative) has up to 4 months from the receipt of an adverse benefit determination to file a request for external review with the Trust Fund Office counted from the end of the Outbreak Period.
8. **File Information to Perfect Request for External Review.** If applicable, claimant (or authorized representative) has up to 4 months or within 48 hour period following receipt of the notice of incomplete request, whichever is later, to provide information to perfect a request for external review counted from the end of the Outbreak Period.

Approved:

UNION TRUSTEES:	EMPLOYER TRUSTEES:
Regina Longo	

Approved:

UNION TRUSTEES:

Regina Longo

EMPLOYER TRUSTEES: