SACRAMENTO INDEPENDENT HOTEL, RESTAURANT & TAVERN EMPLOYEES WELFARE TRUST

DATE: October 2019

TO: Participants and Dependents

RE: ANNUAL NOTICES and IMPORTANT PLAN RULES

Dear Participant or Dependent,

Attached please find an Annual Notice the Plan is required to provide under the Affordable Care Act ("ACA") and other Federal Laws. No Action is necessary on your part. It also includes other reminders. This for informational purposes only. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE PLAN'S SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT. Depending on which medical option you are enrolled in, you should also review the Kaiser and Western Health Advantage evidence of coverage booklets for benefit information. If you have any questions on the enclosed materials, please call BeneSys Administrators at (925) 398-7044 or (877) 893-1500.

PATIENT PROTECTION & AFFORDABLE CARE ACT (ACA) NOTICES

Dependent Children Eligible for Coverage up to Age 26 (End of Month When Turn 26)

As a reminder, your eligible child(ren) may be enrolled and maintained as a Dependent under the Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Plan ("Plan") through the end of the month in which he or she attains age 26, regardless of whether the child is eligible for coverage under his or her Employer Sponsored Group Health Plan (or his or her Spouse's plan).

Availability of Summary of Benefits and Coverage ("SBC")

The self-funded indemnity Plan and Insurers (such as Kaiser and WHA) 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 and allows you to compare the Plan's benefit options (currently the self-funded indemnity Aetna PPO option, Kaiser HMO option, and WHA HMO option). **You have the right to request and receive within seven (7) business days an SBC for the Plan's HMO benefits offered through Kaiser and Western Health Advantage, and the Plan's self-funded benefits (Indemnity plans).**

If you want a copy of an SBC and/or more details about your coverage, please contact the Trust Fund Office at (925) 398-7044.

Minimum Essential Coverage & Individual Mandate (State Law Requirement)

The ACA establishes a minimum value standard of benefits for health plans such as this Plan.. Beginning in 2019, the federal individual tax penalty has been reduced to zero under the Tax Cut and Jobs Act of 2017. (This means you will no longer be required to meet the federal individual mandate for 2019.) Please keep in mind, although the federal individual tax penalty no longer applies, California has its own state individual health insurance mandate that requires California residents to have qualifying health coverage or pay a fee with your state taxes beginning with the 2020 Plan year unless an exception applies.

Under the ACA, the minimum value standard is 60% (actuarial value) and eligible employer-sponsored plans (such as this Plan) are considered minimum essential coverage. **As such, the Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.** Therefore, no action is necessary for your California mandate purposes as you have adequate coverage through the Plan.

Patient Protections- Designation of Providers

This Plan's Health Maintenance Organization ("HMO") benefits provided through Kaiser and Western Health Advantage generally requires or allows the designation of a primary care provider/pediatrician. You have the right to designate any primary care provider/pediatrician who participates in the HMO network and who is available to accept you or your family members. **For information on how to select a primary care provider/pediatrician, and for a list of participating providers, please contact Kaiser at 1-800-278-3296 or visit www.kp.org or contact Western Health Advantage at 1-888-563-2250 or visit www.westernhealth.com.**

You do not need prior authorization from this Plan or from any other person (including a primary care provider) 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 self-funded PPO network, contact the Trust Fund Office at (925) 398-7044. **For a list of participating health care professionals who specialize in obstetrics or gynecology in the Plan's HMO network, contact Kaiser at 1-800-278-3296 or Western Health Advantage at 1-888-563-2250.**

Patient Protections- Coverage of Emergency Services

Under the ACA, as a Non-Grandfathered plan, the self-funded indemnity plan and the Plan's Kaiser and WHA options provides benefits for emergency services it must cover emergency services without prior authorization and regardless of whether the provider is in-network or out-of-network, and any co-insurance or co-payment imposed on emergency services received out-of-network cannot exceed the amount imposed on emergency services received in-network. **For information on the self-funded indemnity Plan's emergency services coverage details, please contact the Trust Fund Office at (925) 398-7044. Please contact Kaiser at (800) 278-3296 or Western Health Advantage at 1-888-563-2250 for information on the HMO options emergency services coverage details.**

Coverage of Recommended Preventive Care Services

Under the ACA, Non-Grandfathered health plans such as the self-funded indemnity plan and the Plan's Kaiser and WHA options), must provide coverage for recommended preventive services (including, but not limited to routine medical examinations, office visits, immunizations and screenings) in accordance with the recommendations and guidelines set by the federal government, without imposing any co-payment, co-insurance, or deductible for in-network services. Please contact the Trust Fund Office at (925) 398-7044 for questions relating to the indemnity plan. If you are enrolled in the HMO option, please contact Kaiser at (800) 278-3296 or WHA at 1-888-563-2250 for more information. Please also refer to the latest list of the federal government's guidelines for preventive care at https://www.healthcare.gov/coverage/preventive-care-benefits.

Plan Out-of-Pocket Maximum ("OPM") Reminders

Non-Grandfathered health plans cannot impose an out-of-pocket maximum that exceeds the statutory limit for in-network benefits only. **For 2019, the federal maximum for self-only coverage is $7,900 and the maximum for family coverage is $15,800.** For 2020, the maximum statutory threshold for self-only increases to $8,150 and $16,300 for family coverage. This amount is subject to change every year. This Plan's out-of-pocket maximums for its in-network services are in compliance with the federal thresholds. **To illustrate see below summary of the Plan's applicable out-of-pocket maximums for the medical options it offers:**

	In-Network OPM
Kaiser HMO Option	$1,500 individual/$3,000 family
Western Health Advantage HMO Option	$1,500 individual/$2,500 family
Self-Funded Indemnity Plan A Option	$1,500 individual/ $3,000 family (medical benefits) $5,100 individual/$10,200 family (prescription drugs)
Self-Funded Indemnity Plan B Option	$6,000 individual/$12,000 family (medical benefits) $600 individual/$1,200 family (prescription drugs)

Please refer to your Plan Booklet (or SBC) for more information.

Rescission Prohibition by the ACA

The self-funded indemnity Plan and Insurers (such as Kaiser and WHA) cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to a divorce, if the Plan does not cover former spouses.

Notice of Nondiscrimination

The Plan is required by the Affordable Care Act to provide you with this Notice of Nondiscrimination about your rights under the law. The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national

origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of their race, color, national origin, age, disability, or sex. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a written grievance (including an appeal) in person or by mail, fax, or email with the Plan's Civil Rights Coordinator at the contact below. If you have questions on the Plan's grievance procedures or need help filing a grievance, please contact the Plan's Civil Rights Coordinator, Lois H. Chang Esq.

Lois H. Chang (Trust Fund Counsel)
Neyhart, Anderson, Flynn & Grosboll APC
369 Pine Street, Suite 800
San Francisco, CA 94104
T: (415) 677-9440 ext. 196
E-mail: LChang@neyhartlaw.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under a federal law known as the Women's Health and Cancer Rights Act of 1998, if the self-funded indemnity Plan (including Kaiser and Western Health Advantage) provides medical and surgical benefits for a mastectomy it must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed, including coverage for nipple and areola reconstruction, and repigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis, and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to the Plan's deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). **If you have any questions about whether the self-funded indemnity Plan covers mastectomies or reconstructive surgery, you may contact the Plan at (925) 398-7044, or if you are a Kaiser participant, you can contact Kaiser directly at (800) 464-4000 or 1-800-788-0616 (Spanish), or if you are a WHA participant you can contact WHA directly at (888) 563-2250.**

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal law, Group health plans (such as this Plan), Insurers, and HMOs (such as Kaiser and WHA) generally may not, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following natural birth delivery (vaginal delivery) or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan and Insurers cannot require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not more than 48 hours (or 96 hours as set forth above). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Trust Fund Office at (925) 398-7044 for more information.

ONE-YEAR LIMITATION PERIOD FOR FILING A LAWSUIT

To encourage the quick resolution of benefit disputes, the self-funded indemnity Plan provides that if an appeal has been denied or there has been a different form of adverse action taken, a Participant, Beneficiary or any other person or entity **has one year from the date of such denied appeal or adverse action to file a lawsuit against the Plan**, **a Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action**. **If you fail to do so, no lawsuit is permitted**. Thus, Participants and beneficiaries (and others) are encouraged to file timely appeals and to review and analyze their options sooner rather than later.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit

limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations), treatment limitations (e.g., number of visits or days of coverage), and non-quantitative treatment limitations (e.g., preauthorization requirement, exclusion based on medical necessity) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits.

Pursuant to the Final MHPAEA rules, the Plan or Health Insurer (ex. Kaiser or WHA) will provide any current participants or potential participants (including dependents), upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits.

It is the intention of the Board of Trustees and the contracted insurers (ex. Kaiser and WHA) that the self-funded indemnity Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa* . Please also refer to the respective Evidence of coverage booklets provided to you by Kaiser or WHA for a complete description of the mental health/substance use benefits available to you, if you are enrolled in the HMO options.

PREMIUM ASSISTANCE UNDER MEDICAID/CHILDREN'S HEALTH INSURANCE PROGRAM

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. **If you live in California, California is no longer a state that provides premium assistance to help pay for Medicaid or CHIP coverage. However, the Medi-Cal Program will continue to provide health, dental, and vision benefits to California's low-income uninsured children. Information is available at *www.coveredca.com/medi-cal/*.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you MAY contact the Department of Labor electronically at ***www.askebsa.dol.gov*** or by calling toll-free 1-866-444-EBSA (3272).

If you live in a different state, to find out if the State you reside in provides assistance in paying your health plan premiums, please contact the Plan Office (at the number indicated below) for a list of participating States. To see if any more States have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, you can also contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

MEDICARE COORDINATION

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called **Medicare Part A**, and the medical insurance portion, such as for the cost of physicians, is called **Medicare Part B**. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive such benefits based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

Under the Plan rules, if you and your spouse are age 65 and older and become eligible for Medicare, you and your spouse are permitted to permanently opt out of the Plan's coverage. If you wish to opt-out, please contact the Trust Fund Office. Please be aware that opting out of the Plan's coverage is permanent and you will not be permitted to re-enroll in the Plan.

HIPPA AVAILABILITY OF THE PLAN'S NOTICE OF PRIVACY PRACTICE

The Plan's Notice of Privacy Practice describes the ways that the Plan uses and discloses your medical information, your rights, the Plan's legal responsibility regarding your medical information, and how you can get access to your health information. **Under federal law, you have the right to request a copy the Plan's Privacy Notice at any time.** The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice. For a copy, please contact the Trust Fund Office at (925) 398-7044. Kaiser and WHA may have their own version of the Notice of Privacy Practice.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. If you or any of your family members are now eligible or will become eligible for Medicare Part A and/or enrolled in Medicare Part B (which would make you eligible to enroll in a Medicare prescription drug plan), this notice has information about your current prescription drug coverage with the Sacramento Independent Hotel Restaurant & Tavern Employees ("S.I.H.R.T.E.") Welfare Trust and about your options under Medicare's prescription drug coverage. This information can help you decide if you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Once you are a Medicare beneficiary, you will need to consider your own individual circumstances and the amount you are required to pay for your prescription drug coverage. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. **The S.I.H.R.T.E. Welfare Trust has determined that the prescription drug coverage offered by through the Trust is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

What do I need to do?
If you are not eligible for Medicare, you don't have to do anything – Medicare Part D does not apply to you. If you are eligible for Medicare [because of age (at least 65), disability or end-stage renal disease] and are happy with your current prescription drug coverage, you don't have to do anything. Just keep using your coverage as you always have. You can still use the same pharmacy network, and your copayments will stay the same. Also, you don't need to go through another enrollment process – you're already enrolled. Alternatively, you may decide to enroll in a Medicare Part D plan when you first become eligible for Medicare and each year from October15th through December 7th.

Why do I need to keep my notice of creditable coverage?
If you are happy with your current prescription drug plan, keep using your plan as you always have. However, if you decide that you would like to enroll in one of the new Medicare Part D prescription drug plans, you may be asked for a copy of your credible coverage notice. This notice will let your new plan know that you have creditable coverage and are not required to pay a higher premium amount (a penalty) on your new coverage.

Do I have to enroll in a Medicare Part D plan now?
No. You do not have to enroll in a Medicare Part D plan if you are satisfied with the coverage you now get from the S.I.H.R.T.E. Welfare Plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Medicare prescription drug plans work much like other insurance. You pay a monthly premium as well as a share of the cost of prescriptions. However, the premiums may vary based on the coverage you choose and your geographic location and some Medicare prescription drug plans have "coverage gaps". This means that plans will pay benefits up to a certain amount, and then it will be up to you to pay the full cost for prescription drugs. Then, after you have paid a certain amount of-of-pocket, the plan will start to pay benefits again. Medicare has estimated that the national average premium for 2018 will be approximately $33.50 per month for the standard plan. This premium is in addition to any premiums and/or deductibles you pay for your Medicare Part A (hospital insurance) and/or Part B (medical insurance) coverage. You can visit the Medicare website to find a Medicare drug plan near you https://www.medicare.gov/find-a-plan/questions/home.aspx or call 1-800 MEDICARE (1-800-633-4227).

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
You can keep using the S.I.H.R.T.E Welfare Plan's prescription drug program the same as you always have and your copayments will not change, nor will any pharmacy network. If you are eligible for Medicare Part D and decide to join a Medicare Part D drug plan during the Medicare open enrollment period, your health coverage through the Plan will not be affected. You should compare your current prescription drug program, including which drugs are covered at what cost, with the benefits and costs of the Medicare Part D plans available in your area. The S.I.H.R.T.E Welfare Plan cannot provide you with a comparison of such available plans.

If you decide to join a Medicare Part D drug plan and drop your current coverage with the S.I.H.R.T.E Welfare Plan, be aware that you and your dependents will not be able to later obtain medical, prescription drug and vision coverage.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage S.I.H.R.T.E. Welfare Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the S.I.H.R.T.E. Trust Customer Service line at (925) 398-7044 or (877) 893-1500. **NOTE:** You'll get this notice each year as required by law. You will also get it before the next enrollment period you can join a Medicare drug plan, and if this coverage through the S.I.H.R.T.E. Welfare Plan changes or terminates. You also may request a copy of this notice at any time by contacting the Trust Fund Office.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help or visit: https://www.medicare.gov/contacts/#resources/ships.
- Call 1-800-MEDICARE (1-800-633-4227). Participants who are deaf, hard of hearing, or speech-impaired should call 1-877-486-2048.

Those with Limited Income and Assets. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (Participants who are deaf, hard of hearing, or speech-impaired 1-800-325-0778). While most participants and retirees may find that prescription drug benefits under the Plan are greater than the benefits Medicare Part D provides, those with limited income and assets may find they have better benefits through a Medicare Part d plan.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium (a penalty).

Date:	October 2019
Name of Entity/Sender:	Sacramento Independent Hotel, Restaurant and Tavern Employees Trust Funds
Address:	P.O. Box 1306, San Ramon, CA 94583
Phone Number:	(925) 398-7044 or (877) 893-1500
Fax:	(925) 462-0108
Website:	www.SIHRTEbenefits.org

As in all cases and situations, the Plan reserves the right to modify benefits at any time, in accordance with applicable law. As required by law, this document is intended to serve as your Medicare Notice of Creditable Coverage.