AMENDMENT NO. 5
TO THE SAN FRANCISCO CULINARY, BARTENDERS AND
SERVICE EMPLOYEES RESTATED PENSION PLAN

WHEREAS, Article 9, Section 9.01 of the San Francisco Culinary, Bartenders and Service Employees Pension Plan ("Plan"), permits the Trustees to amend or modify this Plan;

WHEREAS, the Trustees, upon discussion at their meeting on April 16, 2018, decided to amend the Plan;

A. Effective April 1, 2018, Section 7.04 of the Plan shall be amended and state as follows:

Section 7.04 - Right of Appeal and Determination of Disputes.

(a) No Employee, Pensioner, or Beneficiary or claimant shall have any right or claim to benefits under the Plan, other than as specified herein. Any dispute as to eligibility, type, amount, or duration of benefits shall be resolved by the Board of Trustees under and pursuant to the Pension Plan, and its decision of the dispute shall be final and binding upon all parties thereto.

(b) Any person whose application for benefits under the Plan has been denied in whole or in part by the Board of Trustees, or whose claim to benefits is otherwise denied by the Board, shall be notified of such decision in writing by the Board of Trustees within 90 days (or 45 days for disability claims) and may petition the Board to review the decision. The 90-day period (45 days for disability benefit applications) may be extended an additional 90 days (30 days for disability claims) by the Fund Manager due to matters beyond the Plan's control. If the period is extended, the Fund Manager shall notify the Claimant of the extended period of determination before the initial 90 days (45 days for disability benefit applications) have passed. The notice of extension shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render a benefit determination. In the case of a disability claim, if, prior to the end of the first 30-day extension period, the Fund Manager determines that, due to matters beyond the Plan's control, a decision cannot be rendered within that extension period, the period for making a benefit determination may be extended for up to 30 days, provided the Fund Manager notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring an extension of time and the date by which the Plan expects to render a benefit determination. In the case of any extension related to a disability claim, the notice of extension shall explain the standards upon which the determination and entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and any additional information needed

to resolve those issues. If additional information is needed from the Claimant, the Claimant shall have 60 days (45 days for disability benefit applications) from the date of the notice to provide said information to the Fund Manager. In the case of an adverse benefit determination for disability benefits, the Fund Manager shall inform the Claimant of the determination in writing (and also, in the case of a disability benefit claim, in a culturally and linguistically appropriate manner). In the event that a period of time is extended due to a Claimant's failure to submit information necessary to make a benefit determination, the time period for such a benefit determination by the Plan shall be tolled from the date on which the Claimant responds to a request for additional information. The written notice will specify the reason or reasons for the denial or adverse benefit determination and will also include in the determination a discussion of the following (to the extent applicable):

(1) An explanation as to why the Plan agreed or disagreed with the views of the health care professionals and/or vocational professionals presented by the Claimant, health care professionals and/or vocational professionals consulted by the Plan or the disability determination made by the Social Security Administration.

(2) If the denial or adverse benefit determination is based upon medical necessity or experimental treatment, an explanation of the scientific or clinical judgement for the determination.

(3) The specific internal rules, guidelines, protocols, standards or other similar criteria, or lack thereof, which the Plan relied on for making the adverse determination.

(4) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.

(5) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.

(6) A statement describing the voluntary appeals procedures offered by the Plan and the Claimant's right to bring action under Section 502(a) of ERISA after receiving an adverse benefit determination on appeal.

A petition for review of a denial or adverse benefit determination shall be in writing, shall state in clear and concise terms the reason or reasons for disagreement with the decision of the Board of Trustees, and shall be filed with or received by the Board of Trustees within 60 days (or 180 days for disability claims) after the date shown on the notice to petitioner of the decision. The appeal petition should be addressed to the Board of Trustees as follows:

(c) Upon good cause shown, the Board of Trustees may permit the petition to be amended or supplemented. Except for good cause shown, the failure to file a petition for review within such 60 day (or 180 days for disability claims) period shall constitute a waiver of the Claimant's right to review the decision on the basis of the information and evidence submitted prior to the decision. Such failure will not, however, preclude the Claimant from establishing eligibility for benefits at a later date based on additional information and evidence which was not available to the Claimant at the time of the decision.

(d) In considering an appeal of a denial or adverse benefit determination, the Plan shall:

(1) Provide for a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(2) Provide that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training experience in the field of medicine involved in the medical judgment who will conduct an independent medical exam (or IME) of the Participant;

(3) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;

(4) Provide that the health care professional engaged for purposes of a consultation under Paragraph 2 above shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

(5) Provide Claimant and/or his or her authorized representative the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(6) Provide that Claimant and/or his or her authorized representative shall be provided, upon request and free of charge,

reasonable access to, and copies of, all documents, records and other information relevant to his or her claim for benefits; and

(7) Provide for a review that takes into account all comments, documents, records, and other information submitted by Claimant and/or his or her authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(e) Prior to a determination on the appeal petition, the Claimant and/or his or her authorized representative shall be provided, free of charge, any new evidence upon which the denial of the appeal, in whole or in part, is based and may submit written issues and comments pertinent to the appeal. The additional evidence shall be provided to the Claimant and/or his or her authorized representative as soon as possible and sufficiently in advance of the issuance of any adverse benefit determination on appeal to give Claimant and/or his or her authorized representative a chance to respond. For appeals to denials or adverse benefit determinations, before the Board of Trustees issues an adverse benefit determination upon appeal based on new or additional rationale, the Board shall provide the Claimant and/or his or her authorized representative with the rationale and give the Claimant and/or his authorized representative a reasonable opportunity to respond to the rationale prior to the notice of any adverse benefit determination on appeal.

(f) The Board of Trustees shall consider the Claimant's appeal of a denial or adverse benefit determination upon his or her benefit claim no later than its regular quarterly meeting, which immediately follows the receipt of the appeal petition, unless such notice was filed within thirty (30) days preceding the date of such meeting. If the appeal petition was received within thirty (30) days prior to the next regular quarterly meeting, the Board of Trustees may consider the appeal at the second regular quarterly meeting following the receipt of the appeal petition.

(g) If special circumstances exist regarding a benefit claim, the Board of Trustees may take an extension of time, to the next regularly scheduled meeting, to review the claim, provided that the Claimant and/or his or her authorized representative are given a notice describing the special circumstances prior to the expiration of the original review period. However, in no case shall a determination on an appeal be made any later than the third regular meeting of the Board of Trustees following the Plan's receipt of the appeal petition.

(h) After consideration of the appeal petition as set forth above, the Board of Trustees shall advise the Claimant and/or his or her authorized representative of its decision in writing within five (5) days following the meeting at which the appeal was considered. The decision of the Board of Trustees shall set forth specific reasons for their conclusions and shall be written in a manner designed to be understood by the Claimant and shall, to the extent applicable, make references to the pertinent Plan provision(s)

upon which the decision is based. The Board of Trustees shall have the discretionary authority to determine the eligibility for benefits of all Participants and/or to construe the terms of the Plan. A decision of the Board of Trustees with respect to the appeal petition for review shall be final and binding upon all parties, including the Claimant and any person claiming under the applicant or petitioner. The provisions of this section shall apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under the Plan or against the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

(i) In the case of an adverse benefit determination on appeal, the Board of Trustees shall inform the Claimant and/or her authorized representative in writing (and, in the case of a disability benefit claim, also in a culturally and linguistically appropriate manner), the following:

(1) The specific reason or reasons for the adverse benefit determination on appeal;

(2) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;

(3) An explanation as to why the Board of Trustees agreed or disagreed with the views of the health care professionals and/or vocational professionals presented by the Claimant, health care professionals and/or vocational professionals consulted by the Board of Trustees, or the disability determination made by the Social Security Administration;

(4) If the adverse benefit determination is based on a medical necessity or experimental treatment, an explanation of the scientific or clinical judgement for the determination, including but not limited to the Independent Medical Examiner's findings;

(5) The specific internal rules, guidelines, protocols, standards or other similar criteria, or lack thereof, that the Board of Trustees relied on for making the adverse determination; and

(6) A statement of the Claimant's right to file a civil action under Section 502(a) of ERISA.

(j) The Trustees may delegate to a subcommittee authority to review any appeal petition, grant or conduct a hearing on a petition (in the manner set forth above), accept an extension, or perform any other act that could be performed by the Board of Trustees under this section. Any action by an appointed subcommittee of the Board of Trustees will be considered to be an action by the Board of Trustees.

(k) Compliance with the provisions of this Plan and any rules and regulations adopted by the Trustees will be a condition precedent to any legal action against the Trust or the Board of Trustees. The right of any person to receive a benefit under the Plan will be determined in accordance with the relevant provisions of the Plan and without regard to any failure of the Fund Manager or the Board of Trustees to satisfy any of the provisions of this Section 7.04.

(l) In the event of any dispute concerning the interpretation, election or enforcement of any of the provisions of this Plan that has not been resolved pursuant to the appeals procedure above described, the dispute may be submitted to voluntary arbitration solely upon mutual agreement between the Board of Trustees and any Claimant. The issue or issues to be so arbitrated and the terms and conditions applicable to such arbitration must be mutually agreed upon between the parties to the arbitration.

B. Effective May 1, 2018, Section 8.04 of the Plan shall be amended and state as follows:

Section 8.04 - I.R.C. Section 432. Upon any certification by the Plan's actuary that the Plan is in "Endangered Status," "Seriously Endangered Status," "Critical Status" or "Critical and Declining Status", the Plan shall comply with the applicable sections of Code Section 432 and any regulations promulgated thereunder.

C. Effective May 1, 2018, Section 11.01 of the Plan shall be amended and state as follows:

Section 11.01 - General. This Article sets forth rules applicable to the determination and payment of Employer Withdrawal Liability as established under the Multiemployer Pension Plan Amendments Act of 1980 (the "Act"), as amended by the Multiemployer Pension Reform Act of 2014. These rules shall apply to complete or partial withdrawals, as defined in the Act, occurring after February 2, 1981. The relevant provisions of the Act shall apply to any matter affecting an Employer's withdrawal liability to the extent that rules determining such matter are not expressly set forth herein.

IN WITNESS WHEREOF, this Amendment has been executed by the Trustees on this 16th day of April 2018.

UNION TRUSTEES:

Charles Gilchrist

Michael Casey

Kim Wirshing

Tina Chen

EMPLOYER TRUSTEES

Douglas Cornford

Robert Berger

Dean Lehr