H.I.H.I.T.
Hospitality Industry Health Insurance Trust

2021 • BENEFITS

Healthcare Solutions for the Hospitality Industry

Medical Plan Options:

We are very happy to announce that HIHIT will be offering 13 medical plan options for 2021. This gives us a total of 7 PPO options and 6 HMO options available for groups with 2 or more eligible employees. We will also have 4 virtual plus plans available in November for a total of 17 options.

1. **Diamond -** $500 deductible PPO with only a co-pay for office visit.
2. **Emerald -** $1000 deductible PPO with first 4 office visits and first $500 lab & X-ray.
3. **Sapphire -** $1500 deductible PPO with first 4 office visits and first $500 lab & x-ray.
4. **Quartz -** $2500 deductible PPO with first 4 office visits and first $500 lab & x-ray.
5. **Pearl -** $2500 deductible HMO.
6. **Jade -** $2500 deductible HMO with first 4 office visits and first $500 lab & x-ray.
7. **HSA -** $2500 deductible with first 4 office visits and first $500 lab & x-ray
8. **Ruby -** $3000 deductible PPO with only a co-pay for all office visits.
9. **Ruby (no spouse) -** $3000 deductible PPO same as above.
10. **Opal -** $5000 deductible PPO.
11. **Onyx -** $5000 deductible HMO with first 4 office visits and first $500 lab & x-ray
12. **Topaz -** $5000 deductible HMO.
13. **Zircon - $5000 deductible HMO – New option with better benefits and lower rates****

- All medical plans except Diamond and Emerald include Teladoc for the entire family when employee only coverage is elected. This benefit can be added to all plans or sold on a stand-alone basis or to enhance any high deductible medical plan.

Dental Plan Options:

1. **Delta Dental - $1000 PPO (Ortho rider available).**
2. **Delta Dental - $1000 PPO with increasing annual maximum ($100 annually).**
3. **Delta Dental - $1500 PPO (Ortho rider available).**
4. **Delta Dental - $1500 PPO with increasing class II benefits (80-100%).**
5. **Delta Dental - $2000 PPO (Ortho rider available).**
6. **Delta Dental - $2000 PPO with increasing annual maximum ($250 annually).**
7. **Dental Health Services – Voluntary Super Smart Smile. *Rate pass for 2021**
8. **Dental Health Services – Employer Paid Select Plan. *Rate pass for 2021**
9. **Willamette Dental HIHIT option. * Rate pass for 2021**

*** All Delta Dental plans are available as contributory or voluntary for one great price ***
*****Check out the new Zircon $5000 deductible plan with better benefits and a lower rate*****

*** Minimum Contribution = 50%**
*** Minimum Participation = 50%**
*** Minimum group size = 2 enrolled employees or 50% participation**
*** Carve-outs allowed for up to 3 classes of employees**
*** Dual or triple plan options available with 3 enrolled employees on each plan**
*** SIMON benefit administration system for eligibility and billing**
*** Free COBRA administration for all group sizes**
*** Owners are covered for on the job injuries through HIHIT medical plans**

H.I.H.I.T. Requires direct membership in the Washington Hospitality Association
-Employers must maintain membership to continue benefits-

Hospitality

HIHIT plans are available only to members of the Washington Hospitality Association who have an eating place, drinking place, or lodging place as part of their business.

Vision Plan Options:

We offer 10 Ameritas vision options including VSP & Eyemed plans with employer paid and voluntary coverages available.

Coming in November

HIHIT will be offering 4 virtual plus medical plans with deductible options of $5,000, $3,000, $2,000, and $1000 for 1-1-2021 coverage.

Other benefits & services:

1. **ComPsych EAP @ $1.80 per employee per month.**
2. **Teladoc telemedicine @ $2.33 per employee per month.**
3. **$10k Basic Life & AD&D @ $1.41 per employee per month.**
4. **Voluntary Life Insurance**
5. **Accident Insurance**

- Our Teladoc and EAP plans cover the entire family for the employee only price.

We can design a custom benefit package to meet your needs and budget.

Washington Hospitality Association

To find out more, contact H.I.H.I.T. @ **877-892-9203** or by email: **hihit@hihittrust.com**

Hospitality Industry Health Insurance Trust

2020 Vision Plans

Benefit Summary	EyeMed Materials-only Network Plan	EyeMed Network Plan	VSP Network Plan	No-network Plan	No-network Materials-only Plan
	In-network/Out	In-network/Out	In-network/Out	In-network/Out	In-network/Out
Benefit frequencies	Contacts or eyeglass lenses and frame every 12 months	Exam every 12 months, contacts or eyeglass lenses every 12 months, frame every 24 months		N/A	N/A
Annual deductible	None	$10 exam, $25 lenses / none	$10 exam, $25 materials	None	None
Annual eye exam	No benefit, materials-only coverage	100% / up to $35	100% / up to $45	Members will be reimbursed up to $200 for eligible vision expenses including exams, eyeglasses and contacts	No benefit, materials-only coverage
Single vision lenses	100% / up to $25		100% / up to $30		Members will be reimbursed up to $200 for eligible vision materials including eyeglasses and contacts
Bifocal lenses	100% / up to $40		100% / up to $50		
Trifocal lenses	100% / up to $55		100% / up to $65		
Lenticular lenses	20% discount / no benefit		100% / up to $100		
Frames	$130 / $65		$130 / $70		
Contacts elective	$130 / $104		$130 / $105		
Contacts medically necessary	100% / $200		100% / $210		
Contact fit & follow up exam	No benefit, materials-only coverage	Member cost up to $55 / no benefit	15% discount / no benefit		No benefit, materials-only coverage

Ameritas
fulfilling life.

GR 7485 10-19

Member in-network discounted lens option cost
(may vary by prescription, option chosen and retail location)

Benefit Summary	EyeMed Materials-only Network Plan	EyeMed Network Plan	VSP Network Plan	No-network Plan	No-network Materials-only Plan
Std. Polycarbonate	$40		100% children / $33 adults		No discounts—Eyeglass lens options such as coating are not reimbursable under this plan.
Scratch Resistant	$15		$17 - $33		
Anti-reflective coating	$45		$43 - $85		
Ultraviolet	$15		$16		
Tint	$15		$15 - $17		

LASIK benefits are included in all vision plans. Enjoy a $250 lifetime maximum ($125 per eye) with no network restrictions.

Contributory Plan Monthly Rates – effective 1/1/2020 – employer and employee share the cost of coverage					
Employee participation requirements: minimum 3 lives					
	Plan 2	Plan 3	Plan 4	Plan 1	Plan 9
Employee only	$3.96	$6.08	$6.41	$4.85	$3.96
Employee + children	$7.80	$10.74	$11.07	$9.55	$7.80
Employee + spouse	$9.31	$12.90	$13.55	$11.43	$9.31
Employee + family	$13.14	$17.55	$18.21	$16.12	$13.14
Voluntary Plan Monthly Rates – effective 1/1/2020 – employee pays the full cost of coverage Employee participation requirements: VSP and EyeMed plans all eligible employees, Vision Perfect minimum 60%					
	Plan 6	Plan 7	Plan 8	Plan 5	Plan 10
Employee only	$5.71	$8.37	$8.73	$7.06	$5.71
Employee + children	$9.80	$13.67	$14.00	$12.12	$9.80
Employee + spouse	$11.43	$16.12	$16.81	$14.13	$11.43
Employee + family	$15.51	$21.43	$22.09	$19.18	$15.51

Your VSP vision plan

VSP offers the nation's largest network of independent providers. With 91% of VSP doctors offering early morning, evening or weekend hours, you can visit a provider on your schedule. Find VSP network providers at vsp.com.

COSTCO OPTICAL Visionworks

eyeconic

Browse and buy online at eyeconic.com and get the most current deals on eyewear. Eyeconic.com is in the VSP network, and your vision benefits are applied directly to your online order.

VSP provider discounts. Take advantage of 20% off the remaining frame balance, additional prescription glasses, and non-covered lens options. And receive an extra $20 to spend on featured frame brands. Find more ways to save at vsp.com/specialoffers.

Based on applicable laws, reduced costs may vary by doctor location.

No claim form. When you visit a VSP provider, your claim form is submitted for you.

LASIK or PRK. Have you always dreamed of better vision without glasses or contacts? Make your dream a reality by using your VSP laser vision correction discount.

Out-of-network benefits. Walmart and Sam's Club will file your claim for you, but your benefit amount will be higher if you visit a VSP network provider.

Your EyeMed vision plan

EyeMed offers one of the largest vision networks in the nation with a mix of independent providers and retail chains. Find EyeMed network providers at eyemed.com.

LensCrafters PEARLE VISION TARGET OPTICAL

contactsdirect
GLASSES.COM

Browse and buy online at contactsdirect.com and glasses.com. At checkout, each site applies the plan benefit then shows the remaining cost.

EyeMed provider discounts. Take advantage of 20% off the remaining frame balance, materials not covered by the plan, and nonprescription sunglasses.

Based on applicable laws, reduced costs may vary by doctor location.

No claim form. When you visit an EyeMed provider, your claim form is submitted for you.

LASIK or PRK. Fifteen percent average off retail price for LASIK or PRK laser vision correction, or 5% off promotional price, at U.S Laser Network locations.

Extended hours. EyeMed providers are open an average of 10 evening hours and 12 weekend hours each week.

Set your sights on perfect vision. All plans include LASIK benefits. Enjoy a $250 lifetime maximum, up to $125 per eye, with no network restrictions.

Vision limitations/exclusions

Covered Expenses will not include and no benefits will be payable for expenses incurred for:

Limitations for all plans
- lenses more than the frequency as indicated on the plan summary page.
- frames more than the frequency as indicated on the plan summary page.

Limitations for Plan(s) 1, 5, 9, 10
- examinations performed or frames or lenses ordered before the member was covered under the eye care expense benefits.
- subject to extension of benefits, any examination performed or frame or lens ordered after the member's coverage under the eye care expense benefits ceases.
- sub-normal eye care aids; orthoptic or eye care training or any associated testing.
- non-prescription lenses.
- replacement or repair of lost or broken lenses or frames except at normal intervals.
- any eye examination or corrective eyewear required by an employer as a condition of employment.
- medical or surgical treatment of the eyes.
- any service or supply not shown on the Schedule of Eye Care Procedures.
- coated lenses; oversize lenses (exceeding71mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

Limitations for no-network plans and EyeMed plans that cover exams and materials
- vision examinations more than the frequency as indicated on the plan summary page.

Limitations for no-network plans and EyeMed plans that cover materials only
- vision examinations.

Limitations for all EyeMed plans
- contact lenses more than once in any twelve month period. When chosen, contact lenses shall be in lieu of any other lens benefit during the twelve month period. When eyeglass lenses are chosen, expenses for contact lenses are not Covered Expenses during the twelve month period.
- contacts limited to the amount shown on the plan summary page unless they are medically necessary. Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:
  - keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.
  - high Ametropia exceeding -12 D or +9 D in spherical equivalent.
  - anisometropia of 3 D or more.
  - patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

If the member is diagnosed with a medically necessary condition, the Provider will submit a request for pre-authorization to EyeMed. The Medical Director reviews all requests for medically necessary contact lenses. If approved, the member will be covered for medically necessary contact lenses up to the plan allowance.

Such payment is limited to once in any twelve month period and is in lieu of lens benefits under this proposal.
- orthoptics or eye care training and any associated testing.
- planonon-prescriptionlensesandnon-prescriptionsunglasses (except for 20% discount).
- two pairs of glasses in lieu of bifocals. (Does not apply to Secondary Discounts).
- lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
- medical and/or surgical treatment of the eye, eyes, or supporting structures.
- services for which a claim is filed more than 1 year after completion of the service.
- for any procedure not listed on the Schedule of Eye Care Services.

The VSP plans have the following limitation:
Some brands of spectacle frames may be unavailable at all locations for purchase as Covered Expenses, or may be subject to additional out-ofpocket expenses. Members may obtain details regarding frame brand availability from their treating provider or by calling VSP's Customer Care Division at (800) 877-7195.

The VSP plans to not cover
- More than one eye exam in the frequency as indicated on the plan summary page.
- More than one pair of lenses in the frequency as indicated on the plan summary page.
- More than one set of frames in the frequency as indicated on the plan summary page.
- Services and/or materials not specifically included in the Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than plus or minus .50 diopter) except as specifically allowed in the frames benefit section of the Plan Benefits.
- Services or materials that are cosmetic, including Plano contact lenses to change eye color and artistically painted Contact Lenses.
- Two pairs of glasses in lieu of Bifocals.
- Replacement of Spectacle Lenses, Frames, and/or contact lenses furnished under this plan that are lost or damaged, except at the normal intervals when services are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens modification, polishing or cleaning.
- The refitting of Contact Lenses after the initial 90-day filing period.
- Contact Lens insurance policies or service contracts.
- Additional office visits associated with contact lens pathology.
- Local, state and/or federal taxes, except where law requires us to pay.
- Membership fees for any retail center in which an Affiliate or Open Access provider office may be located. Covered persons may be required to purchase a membership in such entities as a condition of accessing Plan Benefits.

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fulfilling life

GuidanceResources®
Employee Assistance Program (EAP)

H.I.H.I.T.
Hospitality Industry Health Insurance Trust

"Whenever I have questions or need help, I call GuidanceResources for confidential information and assistance."

ComPsych® GuidanceResources®

The single source for confidential support, expert information and valuable resources, when you need it the most.

Call: 844.837.9296

COMPSYCH®
GuidanceResources® Worldwide

Call ComPsych® GuidanceResources® anytime for confidential assistance.

Call: **844.837.9296**

Confidential Counseling on Personal Issues

An Employee Assistance Program (EAP) is a confidential counseling service to help address the personal issues your workforce is facing. This service, staffed by experienced clinicians, is available by calling a toll-free phone line 24 hours a day, seven days a week. A GuidanceConsultant℠ will refer employees to local counselors or to resources in the community. Call any time with concerns, including:

- Relationships
- Problems with your children
- Substance abuse
- Stress, anxiety or depression
- Job pressures
- Marital conflicts
- Grief and loss
- Empty-nesting

FinancialConnect®

Financial issues can arise at any time, from dealing with debt to saving for college. Our financial professionals are here to discuss concerns and provide the tools and information needed to address finances, including:

- Getting out of debt
- Retirement planning
- Credit card or loan problems
- Saving for college
- Tax questions
- Estate planning

LegalConnect®

When a legal issue arises, attorneys are available to provide confidential support with practical, understandable information and assistance. If representation is required, individuals can also be referred to a qualified local attorney for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call with legal concerns including:

- Divorce and family law
- Debt obligations
- Landlord and tenant issues
- Real estate transactions
- Bankruptcy
- Criminal actions
- Civil lawsuits
- Contracts

H.I.H.I.T.
Hospitality Industry Health Insurance Trust

FamilySource®

New parents, caregivers for elders, parents sending a child off to college, individuals buying a car or doing home repairs are bound to have questions or need resource referrals. Work-life specialists can help sort
out the issues and provide information based on the individual's specific criteria. Individuals receive a personalized reference package containing helpful resources and literature, covering areas such as:

- Finding child or elder care
- Planning for college
- Relocating to a new city
- Entertaining family and friends
- Finding pet care
- Purchasing a car
- Home repair

GuidanceResources® Online

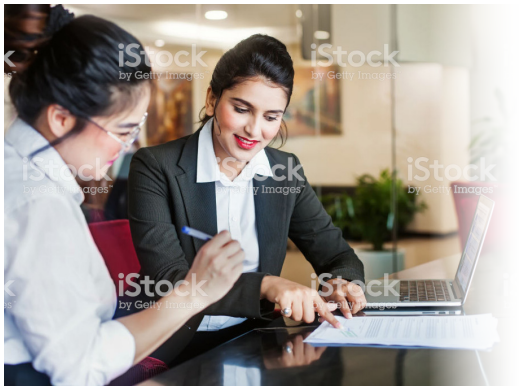
GuidanceResources® Online is the one stop for expert information to assist individuals with the issues that matter to them, from personal or family concerns to legal and financial concerns. Each time, individuals will receive personalized, relevant information based on their individual life needs, They can:

- Review in-depth HelpSheets℠ on your topics
- Get answers to specific questions
- Search for services and referrals
- Use helpful planning tools
- Order pre-screened reference books

Cost of the Program

	6-session
Fully Integrated GuidanceResources **EAP, FamilySource, LegalConnect, FinancialConnect and GuidanceResources® Online**	**$1.80***

*** per employee per month**



Dental Plan Comparison Sheet

Healthy smiles are our passion.
We make it easy to choose a plan, use your benefits, and find the perfect dentist. That's why H.I.H.I.T is partnering with Delta Dental of Washington to offer comprehensive dental plans.

H.I.H.I.T (Hospitality Industry Health Insurance Trust) members can choose from six dental plan options.
With a variety of deductibles, coinsurance agreements, and annual maximums, it's easy to find a plan that meets your coverage and budget needs. There are even dental plans that reward members for receiving regular preventive care.

PLAN HIGHLIGHTS

- ✓ **In-network dentist discounts**, saves members money on their dental treatment
- ✓ **Hassle-free claims processing**
- ✓ **Dependent coverage** (to age 26) and **domestic partnership coverage** available
- ✓ **100% coverage for preventive care** plus choice of incentive plans to increase annual maximums
- ✓ **Child orthodontia coverage** can be added to any plan
- ✓ **Choice of two dental networks:** Delta Dental PPO and Delta Dental Premier
- ✓ **6 plan designs at varying price points**, flexibility to choose the option that best suits their needs
- ✓ **Free Cobra administration**
- ✓ **Low employer contributions:** As low as 50% towards employee premium and 50% participation requirement
- ✓ **Small group coverage** of two+ enrolled employees

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400 Fairview Ave N, Suite 800
Seattle WA 98109
206.522.1300 or 800.367.4104
GroupSales@DeltaDentalWA.com

EASTERN WASHINGTON
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Spokane WA 99202
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DeltaDentalWA.com

DELTA DENTAL®
Delta Dental of Washington

H.I.H.I.T. Plan	Option I	Option II	Option III	Option IV	Option V	Option IV	Orthodontia
Plan Type	Passive PPO	PPO	PPO	Incentive PPO	Max Well PPO	Max Well PPO	Rider
Annual Deductible (Waived on Class I)	$50 $150 Family Max	$50 $150 Family Max	$50 $150 Family Max	$50 $150 Family Max	$50 $150 Family Max	$50 $150 Family Max	Orthodontia riders may be added to any plan option
Annual Maximum	$1,000	$1,500	$2,000	$1,500	$1,000-$1,500	$2,000-$2,500	
TMJ $1,000 Annual $5,000 Lifetime	50%	50%	50%	50%	50%	50%	Orthodontia riders provide Child Only coverage
Class I							**Ortho Option I**
Cleanings Exams Sealants Fluoride X-Rays	100%	100%	100%	100%	100%	100%	50% to $1,000 Lifetime Maximum Add $5.58 to Ee & Child(ren) and $6.84 to Ee & Family rates
Class II							**Ortho Option II**
Fillings Endodontics* Periodontics* Oral Surgery*	80%*	90% PPO 80% Premier and Non-Network	90% PPO 80% Premier and Non-Network	80%-100%	80%	80%	P50% to $1,500 Lifetime Maximum Add $7.81 to Ee & Child(ren) and $9.57 to Ee & Family rates
Class III							**Ortho Option III**
Crowns Implants Bridges Dentures	50%	50%	50%	50%	50%	50%	50% to $2,000 Lifetime Maximum Add $9.95 to Ee & Child(ren) and $11.96 to Ee & Family rates
Rates – Guaranteed 1/1/19 - 12/31/19							**Use our Find a Dentist tool on DentalWA.com**
Employee Only	$36.89	$47.43	$53.72	$46.17	$39.24	$52.95	
Ee & Spouse	$73.79	$94.89	$107.43	$101.47	$78.46	$105.92	
Ee & Child(ren)	$78.79	$98.17	$110.08	$104.98	$83.38	$108.53	
Ee & Family	$124.70	$157.08	$176.57	$167.97	$132.60	$174.08	

*For Option I, Endodontics, Periodontics and Oral Surgery are covered under Class III.

All plan options require a six month waiting period on Class III benefits and a twelve month waiting period on Orthodontia benefits for all new enrollees.

For more information about these plan options, please contact your broker or H.I.H.I.T. at 1.877.892.9203 or hihit@hihittrust.com.

H.I.H.I.T.
Hospitality Industry Health Insurance Trust

Washington Hospitality Association

HIHIT Comparison-0420

WESTERN WASHINGTON
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GroupSales@DeltaDentalWA.com

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509.535.1080 or 800.564.8832
Spokane@DeltaDentalWA.com

DeltaDentalWA.com

DELTA DENTAL®
Delta Dental of Washington

Willamette Dental Group

AFFORDABLE DENTAL INSURANCE + QUALITY DENTAL CARE

OPEN ENROLLMENT JUST BECAME AN EASY DECISION

SWITCH TO A SIMPLER SOLUTION

With no maximums*, no deductibles and predictable copays for covered services, Willamette Dental Group helps you plan for your care and treatments rather than being surprised by a bill based on unknown fees and percentages after the fact.

Willamette Dental Group Insurance

- No Annual Maximum*
- No Deductible
- Out-of-Pocket Costs Based on Predictable Copays
- Comprehensive Orthodontia Coverage for Adults and Children
- Exclusive Provider Network

Traditional Dental Insurance

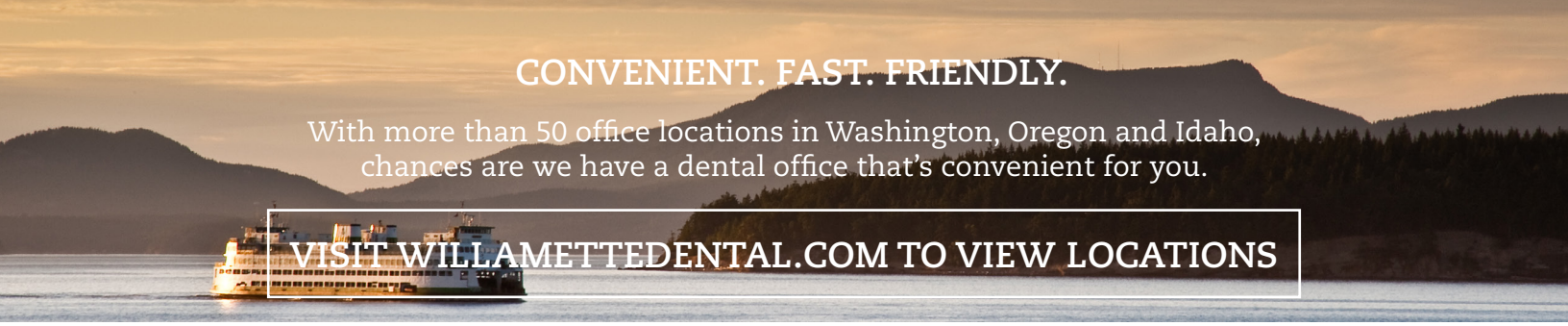
- Annual Maximum Coverage
- Annual Deductible to Meet Before Insurance Pays
- Out-of-Pocket Costs Based on a Percentage of What Your Provider Charges
- Orthodontia Coverage Typically Only for Children with Maximum Coverage
- Provider Network Based on Insurance Plan

**Benefits for TMJ, orthognathic surgery, and implant surgery have a benefit maximum, if covered.*

MEET OUR DENTISTS

Willamette Dental Group is determined to create the best patient experience possible. That's why we share patient ratings and comments for all of our dentists and dental specialists right on our website. As a patient, you're welcome to choose the office and provider that's best for you.

VISIT WILLAMETTEDENTAL.COM TO VIEW PATIENT RATINGS & COMMENTS



H.I.H.I.T.
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YOUR RATES & BENEFITS

Tier	Monthly
Employee	$51.08
Employee & Spouse	$96.77
Employee & Child(ren)	$107.82
Employee, Spouse & Child(ren)	$153.51

Rates shown are the dental plan premiums plus the policyholder's additional administrative charge.

Covered Service	Benefit
Annual Maximum	No Annual Maximum*
Deductible	No Deductible
General & Ortho Office Visit	$20 Copay per visit
Diagnostic & Preventive Services	Covered with the Office Visit Copay
Fillings	$30 Copay
Porcelain-Metal Crown	$300 Copay**
Complete Upper or Lower Denture	$400 Copay**
Bridge (per Tooth)	$300 Copay**
Root Canal Therapy - Anterior / Bicuspid / Molar	$150 / $225 / $300 Copays
Osseous Surgery (per Quadrant)	$350 Copay
Root Planing (per Quadrant)	$115 Copay
Routine Extraction (Single Tooth)	$20 Copay
Surgical Extraction	$175 Copay
Comprehensive Orthodontia Treatment	$2,500 Copay
Dental Implant Surgery	Benefit maximum of $1,500 per calendar year
Nitrous Oxide	$40 Copay
Specialty Office Visit	$30 Copay per visit
Out of Area Emergency Care Reimbursement	Up to $100

**Benefits for TMJ, orthognathic surgery, and implant surgery have a benefit maximum, if covered.*
***Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.*

Underwritten by Willamette Dental of Washington, Inc. Please refer to your Certificate of Coverage for limitations and exclusions.

Questions?

Contact our Member Services team via email at memberservices@willamettedental.com or by phone at

1.855.4DENTAL (1.855.433.6825)

019-WA742R(6/20)

Willamette
Dental Group

TELADOC™

H.I.H.I.T.
Hospitality Industry Health Insurance Trust

Talk to a doctor anytime

Teladoc® gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

MEET OUR DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- **Cold & flu symptoms**
- **Allergies**
- **Sinus problems**
- **Urinary tract infection**
- **Respiratory infection**
- **Skin problems**
- **And more!**

WHEN CAN I USE TELADOC?

Teladoc does not replace your primary physician it is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short term prescription refills

***Employee and family coverage for only $2.33 per employee per month.**

Talk to a doctor anytime for **FREE!***

Teladoc.com

1-800-Teladoc (835-2362)

Available on the iPhone App Store

ANDROID APP ON Google play

04042016
10E-100B

TRANSAMERICA®

$10,000.00 Basic Life Insurance

Underwritten by Transamerica Life Insurance Company
Customer Service: 1-888-763-7474 or www.tebcs.com

Martin has worried for a while that he doesn't have enough life insurance for a dad with teenagers at home and a love for steak. When he found out a potential employer included a basic term life policy as part of their compensation for each employee, it encouraged him to accept their offer. He feels relieved of that nagging worry that's been bothering him.

A simple, valuable benefit

Three out of 10 U.S. households have no life insurance at all, and half said they needed more life insurance.[1] Basic term life insurance helps fill that need, providing a death benefit to assist with final expenses and to help protect your family's finances.

You are automatically enrolled by your employer. You can keep this insurance as long as you're actively working at the company, regardless of age.

A company you can trust

In today's financial environment, working with a reliable company with a heritage of over 100 years of helping families is a smart way to do business. Feel confident that Transamerica will be there when your family needs us most.

Product Highlights

- employer-paid premiums
- no blood tests or physicals
- convertible when employment ends

Benefits included with policy

This policy includes two riders (additional benefits). The Accelerated Death Benefit for Terminal Illness Rider advances a portion of the life insurance death benefit to you if diagnosed for the first time with a terminal illness and still provides the remaining benefit to your beneficiary after death. The Waiver of Premium Rider waives premiums while maintaining a life insurance benefit up to age 65 if the insured becomes totally disabled.

You can convert your policy if it terminates.

If you retire or leave your job, you can convert it to a permanent[2] insurance policy (without any optional riders). It allows you to maintain the same death benefit amount (with premiums based on attained age, class of risk and death benefit amount) without having to provide evidence of insurability like a blood test or physical exam.

1 Facts About Life 2013, LIMRA. Use of statistics does not imply endorsement.

2 "Permanent" is a type of insurance that can be kept throughout life, such as a whole life or universal life insurance policy. Your policy can still lapse prior to maturity date if you don't pay premiums.

CBT01C-1015

Life Insurance benefit amount = $10,000.00
The following options are included with your policy:
1. Accidental Death and Dismemberment Rider
2. Accelerated Death Benefit for Terminal Illness Rider
3. Waiver or Premium Benefit Rider
4. Benefit Reduction Schedule - Life insurance proceeds automatically reduce starting on the anniversary date following your 65th birthday.
Please see your insurance certificate for more details regarding your coverage.

Benefit Summary

Hospitality Industry (HIHIT) - Diamond

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151015

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $500 per calendar year Family deductible: $1,000 per calendar year	Individual deductible: $1,000 per calendar year Family deductible: $2,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Deductible and coinsurance do not apply to outpatient visits; in-network only (excludes lab/xray)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $5,000 Family out-of-pocket limit: $10,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $10,000 Family out-of-pocket limit: $20,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$25 copay ($15 copay enhanced benefit) Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** $200 copay, per admit Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** $200 copay, per admit Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $25 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit)	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$25 copay ($15 copay enhanced benefit)	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $25 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit). Routine care not subject to outpatient services copay.	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit)	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$25 copay	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay	Shared with preferred provider network **Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. $200 copay, per admit Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay ($15 copay enhanced benefit)	**Inpatient:** Day limits shared with preferred provider network $200 copay, per admit Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year $200 copay, per admit Deductible and coinsurance apply	Day limits shared with preferred provider network $200 copay, per admit Deductible and coinsurance apply

Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit)	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Emerald

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151016

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $1,000 per calendar year Family deductible: $2,000 per calendar year	Individual deductible: $2,000 per calendar year Family deductible: $4,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Covered at outpatient services copay for 1st 4 office visits per calendar year (deductible and coinsurance waived), after the 4 visits, covered at deductible and coinsurance (copay waived)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $5,000 Family out-of-pocket limit: $10,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $10,000 Family out-of-pocket limit: $20,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$25 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	Shared with preferred provider network **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply

Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Sapphire

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151010

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $1,500 per calendar year Family deductible: $4,500 per calendar year	Individual deductible: $3,000 per calendar year Family deductible: $9,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Covered at outpatient services copay for 1st 4 office visits per calendar year (deductible and coinsurance waived), after the 4 visits, covered at deductible and coinsurance (copay waived)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $12,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $8,000 Family out-of-pocket limit: $24,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$40 copay ($30 copay enhanced benefit), deductible and coinsurance apply Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $40 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$40 copay ($30 copay enhanced benefit), deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $40 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit), deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$40 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply	Shared with preferred provider network **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $40 copay ($30 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply

Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Quartz

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151021

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Covered at outpatient services copay for 1st 4 office visits per calendar year (deductible and coinsurance waived), after the 4 visits, covered at deductible and coinsurance (copay waived)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $14,300 Family out-of-pocket limit: $28,600 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** $200 copay, per admit Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** $200 copay, per admit Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Lab and xray services are covered in full up to $500 per calendar year (limit shared with preferred provider and out-of-network provider), then deductible and coinsurance apply. High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay Deductible and coinsurance apply	$200 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$25 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	Shared with preferred provider network **Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply

Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. $200 copay, per admit Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network $200 copay, per admit Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year $200 copay, per admit Deductible and coinsurance apply	Day limits shared with preferred provider network $200 copay, per admit Deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** $200 copay, per admit Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Jade

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-151013

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%
Deductible and/or coinsurance waiver riders	1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to $500 per calendar year.
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$25 copay primary/$50 copay specialty, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay primary/$50 copay specialty, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $25/$50 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full up to $500 per calendar year, then deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$25 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $25 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay primary/$50 copay specialty, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$25 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Pearl

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-151019

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$40 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $40 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $25/$50/$75 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $40 copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$40 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $40 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $40 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $40 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$40 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) HSA Individual

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-151018

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $2,500 per calendar year Family deductible: $5,000 per calendar year Until the total family annual deductible is met, benefits will not be provided for any family member
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%
Out-of-pocket limit	Individual out-of-pocket limit: $4,500 Family out-of-pocket limit: $7,150 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services If enrolled on the family plan you must meet the family out-of-pocket maximum
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** No copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$40/$60 copay per 30 day supply, deductible applies. Certain preventive medications are covered in full.
Prescription mail order	3 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%, deductible applies
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$0 copay Deductible and coinsurance apply
Hearing exams (routine)	No copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	No visit limit, deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's contraception is covered as preventive, and Men's contraception is covered in full after annual deductible has been satisfied
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	No copay, deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Ruby

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151011

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $3,000 per calendar year Family deductible: $6,000 per calendar year	Individual deductible: $6,000 per calendar year Family deductible: $12,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%	Plan pays 50%, you pay 50% of the Allowed Amount.
Deductible and/or coinsurance waiver riders	Deductible and coinsurance do not apply to outpatient visits; in-network only (excludes lab/xray)	Not applicable
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $14,300 Family out-of-pocket limit: $28,600 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$40 copay ($30 copay enhanced benefit) Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $40 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit)	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$250 copay Deductible and coinsurance apply	$250 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$40 copay ($30 copay enhanced benefit)	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $40 copay	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit). Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit)	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$40 copay	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay	Shared with preferred provider network **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $40 copay ($30 copay enhanced benefit)	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay ($30 copay enhanced benefit)	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply

Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Opal

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Access PPO	**Ref** RQ-151017

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Preferred Provider Network**	**Out-of-Network**
Plan deductible	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year	Individual deductible: $10,000 per calendar year Family deductible: $20,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 50%, you pay 50%	Plan pays 50%, you pay 50% of the Allowed Amount.
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services	Individual out-of-pocket limit: $14,300 Family out-of-pocket limit: $28,600 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC	Same as preferred provider network
Lifetime maximum	Unlimited	Shared with preferred provider maximum
Outpatient services (Office visits)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply Enhanced benefit applies when services are provided by an Enhanced provider.	No copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $20/$50/$95 ($15/$45/$85 enhanced) copay up to a 30 day supply.	Preferred generic/preferred brand/non-preferred Not covered
Prescription mail order	2x the enhanced benefit prescription drug cost share up to a 90 day supply	Not covered
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Preferred provider deductible and coinsurance apply
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Deductible and coinsurance apply	Deductible and coinsurance apply

Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$250 copay Deductible and coinsurance apply	$250 copay Preferred provider deductible and coinsurance apply
Hearing exams (routine)	$25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	No copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	No visit limit, deductible and coinsurance apply	No visit limit Deductible and coinsurance apply
Hospice services	Deductible and coinsurance apply	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 8 visits per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply	Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Naturopathy	$25 copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	Shared with preferred provider network **Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full	Deductible and coinsurance apply Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Day limits shared with preferred provider network Deductible and coinsurance apply **Outpatient:** Visit limits shared with preferred provider network No copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with preferred provider network, deductible and coinsurance apply

Sterilization (vasectomy, tubal ligation)	Covered in full	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply **Outpatient Surgery:** See Hospital services; Outpatient surgery section Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay ($15 copay enhanced benefit), deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** No copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	Covered in full	Covered in full
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Onyx

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-151020

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%
Deductible and/or coinsurance waiver riders	1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to $500 per calendar year.
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$25 copay primary/$50 copay specialty, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay primary/$50 copay specialty, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $25/$50 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full up to $500 per calendar year, then deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$25 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $25 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay primary/$50 copay specialty, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$25 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Topaz

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-151014

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 50%, you pay 50%
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$40 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient surgery:** $40 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand $20/$40 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $40 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$40 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $40 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $40 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $40 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** $1000 copay, per admit Deductible and coinsurance apply **Outpatient:** $40 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$40 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Zircon

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Core HMO	**Ref** RQ-154364

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 50%, you pay 50%
Deductible and/or coinsurance waiver riders	1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to $500 per calendar year.
Out-of-pocket limit	Individual out-of-pocket limit: $7,150 Family out-of-pocket limit: $14,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$25 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/non-preferred $25/$50/$75 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Covered up to 12 visits per calendar year $25 copay, deductible and coinsurance apply
Ambulance services	Deductible and coinsurance
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 50%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full up to $500 per calendar year, then deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.

Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$25 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $25 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $25 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$25 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Virtual Plus 1000

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Virtual Plus	**Ref** RQ-156610

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $1,000 per calendar year Family deductible: $2,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%
Deductible and/or coinsurance waiver riders	All services delivered via telehealth and 1st non-preventative primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.
Out-of-pocket limit	Individual out-of-pocket limit: $3,000 Family out-of-pocket limit: $6,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$20 copay primary/$40 copay specialty Deductible and coinsurance do not apply for authorized visits. Self-directed visits are subject to deductible and coinsurance, copay waived. Virtual visits are covered in full.
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/preferred specialty $15/$35/$150 up to a 30 day supply
Prescription mail order	$5 copay/2x prescription cost share up to a 90 day supply; After 1st fill, maintenance drugs must be filled through KFHPWA mail order
Acupuncture	Covered up to 12 visits per calendar year $20 copay Deductible and coinsurance do not apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$20 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $20 copay Deductible and coinsurance do not apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $20 copay Deductible and coinsurance do not apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay Deductible and coinsurance do not apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $20 copay primary/$40 copay specialty
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $20 copay Deductible and coinsurance do not apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$20 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Virtual Plus 2000

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Virtual Plus	**Ref** RQ-156609

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In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $2,000 per calendar year Family deductible: $4,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%
Deductible and/or coinsurance waiver riders	All services delivered via telehealth and 1st non-preventative primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $8,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$30 copay primary/$60 copay specialty Deductible and coinsurance do not apply for authorized visits. Self-directed visits are subject to deductible and coinsurance, copay waived. Virtual visits are covered in full.
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/preferred specialty $15/$35/$150 up to a 30 day supply
Prescription mail order	$5 copay/2x prescription cost share up to a 90 day supply; After 1st fill, maintenance drugs must be filled through KFHPWA mail order
Acupuncture	Covered up to 12 visits per calendar year $30 copay Deductible and coinsurance do not apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$30 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $30 copay Deductible and coinsurance do not apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $30 copay Deductible and coinsurance do not apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay Deductible and coinsurance do not apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $30 copay primary/$60 copay specialty
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay Deductible and coinsurance do not apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$30 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Virtual Plus 3000

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Virtual Plus	**Ref** RQ-156608

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $3,000 per calendar year Family deductible: $6,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%
Deductible and/or coinsurance waiver riders	All services delivered via telehealth and 1st non-preventative primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.
Out-of-pocket limit	Individual out-of-pocket limit: $6,000 Family out-of-pocket limit: $12,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$30 copay primary/$60 copay specialty Deductible and coinsurance do not apply for authorized visits. Self-directed visits are subject to deductible and coinsurance, copay waived. Virtual visits are covered in full.
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/preferred specialty $20/$40/$150 up to a 30 day supply
Prescription mail order	$5 copay/2x prescription cost share up to a 90 day supply; After 1st fill, maintenance drugs must be filled through KFHPWA mail order
Acupuncture	Covered up to 12 visits per calendar year $30 copay Deductible and coinsurance do not apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$30 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $30 copay Deductible and coinsurance do not apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $30 copay Deductible and coinsurance do not apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay Deductible and coinsurance do not apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $30 copay primary/$60 copay specialty
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $30 copay Deductible and coinsurance do not apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$30 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Benefit Summary

Hospitality Industry (HIHIT) - Virtual Plus 5000

Group Number: SP00100

KAISER PERMANENTE®

Effective Date 1/1/2021	**Health Plan** Virtual Plus	**Ref** RQ-156607

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	**Inside Network**
Plan deductible	Individual deductible: $5,000 per calendar year Family deductible: $10,000 per calendar year
Individual deductible carryover	4th quarter carryover does not apply
Plan coinsurance	Plan pays 70%, you pay 30%
Deductible and/or coinsurance waiver riders	All services delivered via telehealth and 1st non-preventative primary care office visit are covered in full. Deductible and coinsurance do not apply to authorized outpatient visits in the clinic but do apply to all non-authorized outpatient services, including all surgical services. All other services covered at applicable cost shares.
Out-of-pocket limit	Individual out-of-pocket limit: $8,150 Family out-of-pocket limit: $16,300 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$40 copay primary/$80 copay specialty Deductible and coinsurance do not apply for authorized visits. Self-directed visits are subject to deductible and coinsurance, copay waived. Virtual visits are covered in full.
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** Deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Preferred generic/preferred brand/preferred specialty $20/$40/$150 up to a 30 day supply
Prescription mail order	$5 copay/2x prescription cost share up to a 90 day supply; After 1st fill, maintenance drugs must be filled through KFHPWA mail order
Acupuncture	Covered up to 12 visits per calendar year $40 copay Deductible and coinsurance do not apply
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay
Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered at 80%
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.

Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$200 copay at a designated facility $200 copay at a non designated facility Deductible and coinsurance apply
Hearing exams (routine)	$40 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $40 copay Deductible and coinsurance do not apply
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $40 copay Deductible and coinsurance do not apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered
Organ transplants	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay Deductible and coinsurance do not apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women’s contraception is covered as preventive, and Men’s contraception is covered in full
Rehabilitation services Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 30 days per calendar year. Services with mental health diagnoses are covered with no limit. Deductible and coinsurance apply **Outpatient:** 45 visits per calendar year. Services with mental health diagnoses are covered with no limit. $40 copay primary/$80 copay specialty
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Covered in full
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $40 copay Deductible and coinsurance do not apply
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$40 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	Not covered