BAY AREA AUTOMOTIVE GROUP WELFARE FUND

Important Notice From the Board of Trustees
To Active Employees

Comparison of Active Employees Medical Benefits
December 1, 2021

For

Kaiser Health Plan HMO
Plan PPK

Administrative Offices of the Fund
4160 Dublin Blvd., Ste 400
Dublin, CA 94568
1-800-267-3232

Benefit	Kaiser Permanente HMO
Calendar Year Deductible	$250 per member/$500 family
Maximum Benefit (per covered individual)	Unlimited
Maximum Co-payment (member/family)	$3,000 per member/$6,000 family
Emergency Room	20% coinsurance after deductible (waived if admitted directly to the hospital)
Urgent Care Center	$20 Co-pay
Physician Office Visits	$20 Co-pay
Surgical Benefits (No Cosmetic Surgery)	20% coinsurance after deductible
Inpatient Hospitalization	20% coinsurance after deductible
Skilled Nursing Facility (SNF)	20% coinsurance after deductible (up to 100 days per benefit period)
Physician's Services in Hospital/Skilled Nursing Facility (SNF)	No additional charge
Organ Transplants	20% coinsurance after deductible
Specialist Consultation (including self-referral to Ob/Gyn)	$40 Co-pay
Ambulance Services	$150 per trip after deductible
Maternity Office Visits	No charge
Normal Delivery/C-Section	20% coinsurance after deductible
Well Baby Preventive Care (0-23 months)	No charge
Routine Physical Exams	No charge
Vision (Eye exam for refraction)	No charge (exam only)

Benefit	Kaiser Permanente HMO
Immunizations	No Charge
X-ray, Imaging & Lab Services	No charge after deductible most X-rays; $50 per procedure after deduct for MRI, CT & PET Scans; No charge; no deductible for preventive as described in EOC
Rehab Therapy (inpatient)	20% coinsurance after deductible
Rehab Therapy (PT, OT, ST) (outpatient)	$20 Co-pay after deductible
Infertility Services	50% coinsurance
Mental Health Care - Inpatient	20% coinsurance after deductible
Mental Health Care - Outpatient	$20 Co-pay
Alcohol & Drug Treatment - Inpatient	20% coinsurance after deductible for detoxification
Alcohol & Drug Treatment - Outpatient	$20 Co-pay
Hemodialysis	$40 Co-pay; no deductible
Hospice Care	No Charge
Home Health Care	No Charge (limited to 3 visits per day/100 visits per year)
Prescription Drug	Retail: (30-day supply): $10 Co-pay/generic; $30 Co-pay/ brand. Mail Order: (31-100 day supply): $20 Co-pay generic; $60 Co-pay brand (KFHP Formulary only); Member pays full cost for "brand" when a generic drug can be substituted and is refused
Durable Medical Equipment	20% coinsurance
Chiropractic Care	Not Covered

- **Note: This summary chart is provided to facilitate comparison only. Refer to the summary plan description and plan inserts for exclusions, limitations and exact terms. HMO contains exclusions and limitations not listed above, HMO medical service contract and combined evidence of coverage must be consulted to determine the exact terms and conditions. HMO will furnish these documents upon request.**