**BAY AREA AUTOMOTIVE GROUP WELFARE FUND**

**Important Notice From the Board of Trustees**

**To Active Employees**

**Comparison of Active Employees Medical Benefits**

**December 1, 2024**

**For**

**Kaiser Health Plan HMO**

**Plan PPK, PPKVD**

**Administrative Offices of the Fund**

**4160 Dublin Blvd., Ste 100**

**Dublin, CA 94568**

**1-800-267-3232**

Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 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) |
| 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.**