Kaiser Foundation Health Plan, Inc.
BNSF – Northern California

The services and supplies described below are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition
- The services and supplies are provided, prescribed, authorized, or directed by a Plan Physician
- You receive the services and supplies at a Plan Hospital, Plan Medical Office, or skilled nursing facility inside our Service Area, except where specifically noted to the contrary in your *Evidence of Coverage*

CATEGORY	SERVICE	COPAYMENT
Hospital Inpatient Care		
	Room and board, including obstetrics	No charge
	Physician, surgeon, and surgical services	No charge
	Nursing care, anesthesia, x-rays, lab tests, and medications	No charge
	Outpatient surgery	$15 per procedure
Outpatient Care		
	Primary and specialty care visits (includes routine and urgent care appointments)	$15 per visit
	Well-child preventive care visits (23 months or younger)	No charge
	Pediatric visits	$15 per visit
	Outpatient surgery	$15 per procedure
	Allergy testing and injection visits	$3 per visit
	Immunizations	No charge
	Routine physical exams	$15 per visit
	Scheduled prenatal care and first postpartum visit	No charge
	X-rays and lab tests	No charge
	Eye exams to provide a prescription for eyeglasses	$15 per visit
	Hearing exams	$15 per visit
	Physical, occupational, and speech therapy visits	$15 per visit
	Health education for specific conditions	$15 per visit
Emergency Department		
	Emergency Department visits	$50 per visit (waived if admitted directly to the hospital)
Prescription Drugs		
	Covered prescription drugs in accord with our formulary when obtained at Plan pharmacies	$15 up to a 100-day supply (or 3-cycles for oral contraceptives)
	In addition, the following are provided in accord with our formulary at Plan pharmacies:	
	Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are limited to 27 doses in any 100-day period)	50% of Member rate up to a 100-day supply
Mental Health Services		
	Inpatient psychiatric care (up to 30 days per calendar year)	No charge
	Outpatient visits:	
	Up to a total of 20 individual and/or group therapy visits per calendar year	$15 per visit
	Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	$15 per visit
	Note: Visit or day limits do not apply to certain mental health care described in the *Evidence of Coverage*.	
Chemical Dependency Services		
	Inpatient detoxification	No charge
	Outpatient individual therapy visits	$15 per visit
	Outpatient group therapy visits	$5 per visit
	Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any 5-year period)	$100 per admission
Infertility Services		
	Office visits and outpatient surgery	$15 per visit
	Outpatient lab tests, x-rays, and special procedures	No charge
	Hospital inpatient care	No charge
Hearing Aids		
	Hearing aids every 36 months	No charge
Additional Benefits		
	Skilled nursing facility care (up to 100 days per benefit period)	No charge
	Home health care	No charge
	Hospice care	No charge
	Ambulance service when medically necessary	$50 per trip
	Durable medical equipment in accord with our formulary	20% of non-Member rates
	External prosthetic and orthotic devices	20% of non-Member rates
	Coordination of benefits	Included

This is a summary of the most frequently asked about benefits and their Copayments. This chart does not describe benefits. Please refer to the *Evidence of Coverage* to learn about what is covered under each benefit (including exclusions and limitations) and additional benefits that are not included in this summary. Note: We cover benefits in accord with applicable law (for example, diabetes supplies).