All plans offered and underwritten by Kaiser Foundation Health Plan
of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232

Summary of medical benefits

Spada Properties, Inc 18365-001
Oregon Deductible Plan BC15
December 1, 2015 through November 30, 2016

Deductible	
For one Member	$750 per Calendar Year
For an entire Family	$2,250 per Calendar Year
Out-of-Pocket Maximum (All Deductible, Copayment, and Coinsurance amounts count toward the maximum, unless otherwise noted.)	
For one Member	$3,250 per Calendar Year
For an entire Family	$9,750 per Calendar Year
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$20
Specialty Care	$30
Urgent Care	$40
Tests (outpatient)	
Preventative Tests	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
CT, MRI, PET scans	$100 per department visit
Medications	
Prescription drugs (outpatient)	$15 generic/$30 brand. $0 for formulary contraceptives. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments.
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Nurse treatment room visits to receive injections	$10
Maternity Care	
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$20 per department visit
X-ray, imaging, and special diagnostic procedures	$20 per department visit
Inpatient Hospital Services	20% Coinsurance after Deductible
Hospital Services	
Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible
Outpatient Services (other)	
Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	$30 after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$30 after Deductible
Alternative Care	

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Alternative care (physician-referred) (Acupuncture is limited to 12 visits per calendar year.)	$30
Alternative care (self-referred)*	Not covered
Vision Services	
Routine eye exam	$20
Vision hardware and optical Services (ages 18 years and younger)	Not covered
Vision hardware and optical Services (ages 19 years and older)*	Not covered
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	
Outpatient Services	$20
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Hearing Aids	
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	20% Coinsurance after Deductible
Hearing aids (ages 19 years and older)*	Not covered
Student Out-of-Area Coverage	
Routine, continuing, and follow-up Services (up to $1,200 per Calendar Year)	20% of the actual fee the provider, facility, or vendor charged for the Service

*Amounts do not count toward Out of Pocket Maximum.

Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*.

Acupuncture. Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) the Alternative Care (self-referred Acupuncture Services) rider has been purchased.; **Certain exams and Services**; **Chiropractic Services received without a referral.** Limited to the following: (a) when a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care Services or Chiropractic Services (self-referred Chiropractic Care) rider has been purchased.; **Cosmetic Services**; **Custodial Services**; **Dental Services.** Except when Medically Necessary for Members who have a medical condition that would place undue risk if performed in a dental office. The procedure is subject to Utilization Review.; **Designated blood donations**; **Detained or confined members**; **Employer responsibility**; **Experimental or investigational Services**; **Eye surgery.** Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.; **Family Services.** Services provided by a member of your immediate family.; **Genetic testing**; **Government agency responsibility**; **Hearing aids.** Unless the Hearing Aid rider has been purchased.; **Hypnotherapy**; **Intermediate Services**; **Massage therapy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria or (b) Alternative Care (Massage Therapy) rider has been purchased.; **Naturopathy Services.** Limited to when: (a) a Participating Physician makes a referral for Services in accord with Medical Group criteria; or (b) Alternative Care (Naturopathy Services) rider has been purchased.; **Non-Medically Necessary Services**; **Nonreusable medical supplies**; **Outpatient Prescription Drugs.** Unless the Outpatient Prescription Drug rider has been purchased. Our drug formulary applies. We cover non-formulary drugs only when you meet exception criteria unless specifically covered by your prescription drug plan.; **Professional Services for fitting and follow-up Services for contact lenses**; **Services performed by unlicensed people; Services related to a non-covered Service**; **Services that are not health care Services, supplies, or items; Supportive care and other Services**; **Travel and lodging.** Limited to: (a) Medically Necessary ambulance Services, and (b) certain expenses that we preauthorize.; **Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless the Travel Services rider has been purchased.; **Vision hardware and optical Services (ages 18 and younger)**. Unless the

Pediatric Vision Hardware and Optical Services rider has been purchased.; **Vision hardware and optical Services (ages 19 and older)**. Unless the Adult Vision Hardware and Optical Services rider has been purchased.; **Vision therapy and orthoptics or eye exercises.**

Questions? Call Member Services (M-F, 8 am-6 pm) or visit **kp.org**, Portland area..503-813-2000. All other areas..1-800-813-2000, TTY..711, Language Interpretation Services, all areas..1-800-324-8010

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your *EOC* or call Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.