

Clackamas County - General County Employees	Kaiser	Providence Personal Option	Providence Open Option	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN
	Annual Deductible: Individual/Family Annual Out-of-Pocket Maximum: Individual/Family	\$250/\$500 Common Deductible \$1000/\$2000	\$1000/\$2000 Common Deductible \$3000/\$6000 Maximum Out-Of-Pocket	\$750/\$1500 Common Deductible \$2500/\$5000 Maximum Out-Of-Pocket
<b>PREVENTIVE SERVICES</b>				
Periodic health exams, well baby care, immunizations	Covered in full	Covered in full	Covered in full	30%*
Gynecology exams & tests	Covered in full	Covered in full	Covered in full	30%*
Mammograms	Covered in full	Covered in full	Covered in full	30%
Colonoscopy services & sigmoidoscopy	Covered in full	Covered in full	Covered in full	30%
<b>PHYSICIAN/PROVIDER SERVICES</b>				
Office visits	\$10	\$25*	\$20*	30%*
Allergy shots	Covered in full	\$25*	10%	30%
Maternity Services; pre- and postnatal visits	Covered in full	\$150/delivery*	\$150/delivery*	30%
<b>HOSPITAL SERVICES</b>				
Inpatient care & provider visits	10%	20%	10%	30%
Maternity care	10%	20%	10%	30%
Routine newborn nursery care	10%	20%*	10%*	30%
Surgery & anesthesia	10%	20%	10%	30%
Rehabilitative care (subject to limitations)	10%	20%	10%	30%
Skilled nursing facility (subject to limitations)	Covered in full	20%	10%	30%
<b>DURABLE MEDICAL EQUIPMENT</b>				
Medical & diabetic supplies, appliances and prosthetics	Covered in full**	20%*1	10%*1	30%
<b>EMERGENCY/URGENT &amp; AMBULANCE SERVICES</b>				
Emergency services	\$75	\$100*	\$100*	\$100*
Urgent care services	\$10	\$25*	\$20*	30%*
Emergency medical transportation	\$75	20%	10%	10%
<b>OTHER COVERED SERVICES</b>				
X-ray & lab services	Covered in full	10%*	Covered in full	30%
Outpatient rehabilitative services (subject to limitations)	\$10	\$25/visit*	10%	30%
Outpatient surgery	\$10	20%	10%	30%
Chemotherapy & radiation	\$10	20% (co-pays for self-administered)	10%	30%
Home health care (subject to limitations)	Covered in full	20%	10%	30%
Hospice	Covered in full	Covered in full	Covered in full	Covered in full
Mental Health/Chemical Dependency	Covered in full inpatient/\$10 outpatient	20% inpatient/\$25 outpatient	10% inpatient/\$20 outpatient	30%
<b>HEARING AID ALLOWANCE</b>				
Children	One hearing aid per ear every 4 years	20%* (One hearing aid per ear every 4 years)	10%* (One hearing aid per ear every 4 years)	30%
Adults	\$1500 per ear every 3 years	20%* (One hearing aid per ear every 4 years)	10%* (One hearing aid per ear every 4 years)	
<b>VISION</b>				
Children Vision	\$10 + no charge for standard lenses and frames or six months supply of contact lenses every 12months	Same as Adult	Same as Adult	Same as Adult
Vision Examinations - every 12 months	\$10 co pay	\$10 co pay	\$10 co pay	Up to Limits - see VSP summary
Benefit every 12/24 months	\$250 for lenses and frames every 12 months - Adults only	Lenses covered in full (up to limits); Frames or Contact lenses covered up to \$130 every 12 months; Progressive lenses: \$30/copy	Lenses covered in full (up to limits); Frames or Contact lenses covered up to \$130 every 12 months; Progressive lenses: \$30/copy	Up to Limits - see VSP summary
<b>ALTERNATIVE CARE</b>				
Office visits	\$10 for chiropractic, acupuncture <sup>2</sup> , naturopath, \$25 massage, \$1500 annual max	\$25/chiropractic, massage, acupuncture; \$2000 annual max* (eligible services (such as office visits, x-ray, lab, physical therapy etc.) by these providers, as well as all eligible naturopath services, will be covered under the medical plan at the applicable co-pay or coinsurance.)***	\$20/chiropractic, massage, acupuncture; \$2000 annual max* (eligible services (such as office visits, x-ray, lab, physical therapy etc.) by these providers, as well as all eligible naturopath services, will be covered under the medical plan at the applicable co-pay or coinsurance.)***	N/A
<b>PRESCRIPTION DRUGS</b>				
Generic/Brand at pharmacy	\$10/\$20	\$10*/50% (\$200 per script max)*	\$15*/\$30*	N/A
Generic/Brand for 90-day mail (maintenance drugs)	\$20/\$40	\$20*/50% (\$400 per script max)*	\$30*/\$60*	N/A
*Deductible does not apply		¹Deductible does not apply to removable custom shoe orthotics		
**Diabetic testing supplies treated as prescription drug items		²Physician-referred acupuncture is restricted to 12 visits per calendar year		
		***Participants could be responsible for more than 1 co-pay depending on how their provider bills Providence for their services		