

Clackamas County - Peace Officers COBRA 2017	Kaiser	Kaiser \$1000 Deductible	Providence Personal Option	Providence Open Option		Providence Open Option \$1000 Deductible	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN	IN-PLAN	OUT-OF-PLAN
Annual Deductible: Individual/Family	\$0	\$1000/\$3000	\$0	\$50/\$150 Common Deductible		\$1000/\$2000 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	\$600/\$1200	\$3000/\$9000	\$1000/\$3000	\$2000/\$6000 Common Maximum		\$2000/\$4000 Common Maximum	
<b>PREVENTIVE HEALTH SERVICES</b>							
Periodic health exams	Covered in full	Covered in full	Covered in full	Covered in full	20%*	Covered in full	50%*
Well baby care, routine immunizations	Covered in full	Covered in full	Covered in full	Covered in full	20%*	Covered in full	50%*
Gynecology exams/tests	Covered in full	Covered in full	Covered in full	Covered in full	20%*	Covered in full	50%*
Mammograms	Covered in full	Covered in full	Covered in full	Covered in full	20%	Covered in full	50%
<b>PHYSICIAN/PROVIDER SERVICES</b>							
Office visits	\$10	\$25 primary care; 20% specialty	\$15	\$10*	20%*	\$15*	50%*
Allergy shots	Covered in full	\$5*	\$15	Covered in full	20%	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	\$150/pregnancy	\$50*/pregnancy	20%	\$150*/pregnancy	50%
<b>HOSPITAL SERVICES</b>							
Inpatient care & provider visits	Covered in full	20%	Covered in full	Covered in full	20%	30%	50%
Maternity care	Covered in full	20%	Covered in full	Covered in full	20%	30%	50%
Routine newborn nursery care	Covered in full	20%	Covered in full	Covered in full	20%	30%*	50%
Surgery & anesthesia	Covered in full	20%	Covered in full	Covered in full	20%	30%	50%
Rehabilitative care (subject to limitations)	Covered in full	20%	Covered in full	Covered in full	20%	30%	50%
Skilled nursing facility (subject to limitations)	Covered in full	20%	Covered in full	Covered in full	20%	30%	50%
<b>DURABLE MEDICAL EQUIPMENT</b>							
Medical & diabetic supplies, appliances and prosthetics	Covered in full***	20%***	20%¹	20%***¹	20%	30%***¹	50%
<b>EMERGENCY/URGENT &amp; AMBULANCE SERVICES</b>							
Emergency services	\$75	20%	\$100	\$100*	\$100*	\$100*	\$100*
Urgent care services	\$10	\$25*	\$15	\$10*	20%*	\$15*	50%*
Emergency medical transportation	\$75	20%*	\$50	\$50	\$50	30%	30%
<b>OTHER COVERED SERVICES</b>							
X-ray & lab services	Covered in full	20%	Covered in full	Covered in full*	20%	30%*	50%
Outpatient rehabilitative services	\$10/visit (20 visits per year)	20% (After deductible, limited to 20 visits per therapy per year)	\$15/visit (30 visits/calendar year)	\$10/Visit (30 visits/calendar year)	20% (30 visits/calendar year)	30% (30 visits/calendar year)	50% (30 visits/calendar year)
Outpatient surgery	\$10	20%	Covered in full	\$10	20%	30%	50%
Chemotherapy & radiation	\$10	20%	Covered in full	\$10	20%	30%	50%
Home health care	Covered in full (up to 130 visits per year)	20% (up to 130 visits per year)	\$15/visit	Covered in full	20%	30%	50%
Hospice care	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
<b>VISION</b>							
Children Vision	\$10/exam + no charge for standard lenses and frames or 6 months supply of contact lenses every 24 months	\$25/exam + no charge for standard lenses and frames or 6 months supply of contact lenses every 24 months	Covered in full (up to limits)	Covered in full (up to limits)	Up to Limits - see VSP summary	Discount available	
Vision Examinations - every 12 months	\$10 co pay	\$25 co pay	\$10 co pay	\$10 co pay	Up to Limits - see VSP summary		
Benefit every 24 months	\$200 for lenses and frames	\$200 for lenses and frames	Lenses covered in full (up to limits); Frames or Contact lenses covered up to \$130	Lenses covered in full (up to limits); Frames or Contact lenses covered up to \$130	Up to Limits - see VSP summary		
<b>HEARING AID ALLOWANCE</b>							
Children	One hearing aid per ear every 4 years	One hearing aid per ear every 4 years	Covered in full when medically necessary	Covered in full when medically necessary	Covered in full when medically necessary		
<b>ALTERNATIVE CARE</b>							
Office visits	\$10 for chiropractic, acupuncture, naturopath², \$25 massage, \$1500 combined annual max	\$10 for chiropractic, acupuncture, naturopath², \$25 massage, \$1500 combined annual max	\$10/chiropractic, \$1500 annual max***	\$10*/chiropractic, \$1500 annual max***	N/A	\$15 co pay for Spinal Manipulation/Acupuncture up to \$500 annual max***	Discount available
<b>PRESCRIPTION DRUGS</b>							
Generic/Brand copay at pharmacy	\$10/\$20	\$15*/\$30*	\$10/\$15	\$10*/\$15*	N/A	\$10*/50%*	N/A
Generic/Brand copay for 90-day mail (maintenance drugs)	\$20/\$40	\$30*/\$60*	\$10/\$15	\$10*/\$15*	N/A	\$30*/50%*	N/A

\*Deductible does not apply

\*\*\*Diabetic supplies treated as prescription drug items.

\*\*\*Participants could be responsible for more than 1 co-pay depending on how their provider bills Providence for their services