

Clackamas County - Peace Officers Non-Medicare Retirees 2017	Kaiser		Kaiser		Providence		Providence		Providence	
			\$1000 Deductible		Personal Option		Open Option		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 care		\$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% <sup>1</sup>		20%** <sup>1</sup>	20%	30%** <sup>1</sup>	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 - every 12 months	\$10/exam + no charge for standard lenses and frames or six months supply of contact lenses every 24 months		\$25/exam + no charge for standard lenses and frames or six 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, naturopath <sup>2</sup> , \$25 massage, \$1500 combined annual max		\$10 for chiropractic, acupuncture, naturopath <sup>2</sup> , \$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.

\*\*Deductible does not apply to purchase of diabetic supplies.

<sup>2</sup>Physician-referred acupuncture visits is limited to 12 visits per calendar year

<sup>1</sup>Deductible does not apply to removable custom shoe orthotics

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