Clackamas County - Peace Officers Non-Medicare Retirees & COBRA 2019	Kaiser	Kaiser	Providence	Providence		Providence	
		High Deductible	Personal Option	Open Option		Open Option High 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	
PREVENTIVE HEALTH SERVICES							
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%
PHYSICIAN/PROVIDER SERVICES							
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%
HOSPITAL SERVICES							
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%
DURABLE MEDICAL EQUIPMENT							
Medical & diabetic supplies, appliances and prosthetics	Covered in full***	20%***	20%[1]	20%**[1]	20%	30%**[1]	50%
EMERGENCY/URGENT & AMBULANCE SERVICES							
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%
OTHER COVERED SERVICES							
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
VISION							
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		
HEARING AID ALLOWANCE							
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		30%	50%
ALTERNATIVE CARE							
Office visits	$10 for chiropractic, acupuncture, naturopath[2], $25 massage, $1500 combined annual max	$10 for chiropractic, acupuncture, naturopath[2], $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
PRESCRIPTION DRUGS							
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.**

[2]Physician-referred acupuncture visits is limited to 12 visits per calendar year

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

[1]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**