Clackamas County - Peace Officers Non-Medicare Retirees & COBRA 2024	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	$1400/$2800	$0	$50/$150 Common Deductible		$1400/$2800 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$600/$1200	$3000/$9000	$1000/$3000	$2000/$6000 Common Maximum		$3000/$6000 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							
Primary Care/Naturopath Office visits	$10 (First 3 visits $5)	$25* primary care (First 3 visits $5); 20% specialty care	$15 (First 3 visits $5)	$10* (First 3 visits $5)	20%*	$25* (First 3 visits $5)	50%*
Allergy shots	Covered in full	Covered in full	$15	Covered in full	20%	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	$150/pregnancy	$50*/pregnancy	20%	$100*/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% (Up to $500 maximum)	20% (Up to $500 maximum)	20% (Up to $500 maximum)	30%	50%
EMERGENCY/URGENT & AMBULANCE SERVICES							
Emergency services	$75	20%	$100	$100*	$100*	$100*	$100*
Urgent care services	$10	$25*	$15	$10*	20%*	$25*	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%* (20 visits 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	Not Covered	30%	50%
Home health care	Covered in full (up to 130 visits per year)	20% (up to 130 visits per year)	Covered in full	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	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Same as Adult	Same as Adult	Same as Adult	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		
Kaiser Adult Vision Frequency - Every 24 months **Providence VSP Vision Frequency - Every 12 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 $175 every 12 months; Progressive lenses: Standard ($0 copay), Premium/Custom ($30 copay). Vision Therapy included.	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $175 every 12 months; Progressive lenses: Standard ($0 copay), Premium/Custom ($30 copay). Vision Therapy included.	Up to Limits - see VSP summary		
HEARING AID ALLOWANCE							
Children	One hearing aid per ear every 4 years	20% - One hearing aid per ear every 4 years	20% (One per ear every 3 years)	20% (One per ear every 3 years)	20% (One per ear every 3 years)	30% (One per ear every 4 years)	50% (One per ear every 4 years)
ALTERNATIVE CARE							
Office visits	$10* for chiropractic & acupuncture $25* massage Annual visit limits: 20 chiropractic, 12 acupuncture, 12 massage	$10* for chiropractic & acupuncture $25* massage Annual visit limits: 20 chiropractic, 12 acupuncture, 12 massage	$10*/chiropractic, acupuncture, massage** 30 visit annual limit each	$10*/chiropractic, acupuncture, massage** 30 visit annual limit each	N/A	$25 co pay* for chiropractic and acupuncture** 30 visit annual limit each	N/A
PRESCRIPTION DRUGS							
Generic/Brand copay at pharmacy	$10/$20	$20*/$40*	$10/$15	$10*/$15*	N/A	$10*/50%*	N/A
Generic/Brand copay for 90-day mail (maintenance drugs)	$20/$40	$40*/$80*	$10/$15	$10*/$15*	N/A	$30*/50%*	N/A

***Deductible does not apply**

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