

Clackamas County - General County Employees 2025	Kaiser	Providence Personal Option	Providence Open Option	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN
Annual Deductible: Individual/Family	\$400/\$800 Common Deductible	\$850/\$1700 Common Deductible	\$600/\$1200 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	\$1750/\$3500	\$2500/\$5000 Maximum Out-Of-Pocket	\$2000/\$4000 Maximum Out-Of-Pocket	
PREVENTIVE SERVICES				
Periodic health exams, well baby care, immunizations	Covered in full	Covered in full	Covered in full	30%*
Gynecology exams & tests/Prenatal care	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%
PHYSICIAN/PROVIDER SERVICES				
Primary Care/Naturopath Office visits	\$10* (First 3 visits \$5)	\$15* (First 3 visits \$5; covered in full after 30 visits)	\$15* (First 3 visits \$5; covered in full after 24 visits)	30%*
Allergy shots	Covered in full	\$15*	10%	30%
Maternity Services; postnatal visits	Covered in full	\$150/delivery*	\$150/delivery*	30%
HOSPITAL SERVICES				
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%
DURABLE MEDICAL EQUIPMENT				
Medical & diabetic equipment, appliances and prosthetics	Covered in full	20%*	10%*	30%
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services	\$75*	\$100*	\$100*	\$100*
Urgent care services	\$10*	\$15*	\$15*	30%*
Emergency medical transportation	\$75*	20%	10%	10%
OTHER COVERED SERVICES				
X-ray & lab services	Covered in full	Covered in full	Covered in full	30%
Outpatient rehabilitative services (subject to limitations)	\$10*	\$15/visit*	\$15/visit*	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	10% inpatient/\$10 outpatient*	20% inpatient/\$15 outpatient*	10% inpatient/\$15 outpatient*	30%
HEARING AID ALLOWANCE				
Children	One hearing aid per ear every 4 years	20%* (One hearing aid per ear every 4 years)	10%* (One per ear every 4 years)	30%
Adults	\$1500 allowance per ear every 3 years	20%* (One hearing aid per ear every 4 years)	10%* (One per ear every 4 years)	30%
VISION				
Children Vision	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	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 months	\$250 allowance for lenses and frames every 12 months - Adults only	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
ALTERNATIVE CARE				
Office visits	\$10* for chiropractic, and acupuncture \$25* massage. Chiropractic - 20 visit annual limit Acupuncture and Massage - 12 visit annual limit	\$15* for chiropractic, massage, acupuncture; 30 visit annual limit each (eligible services such as office visits, x-ray, lab, physical therapy etc.) by these providers will be covered under the medical plan at the applicable co-pay or coinsurance.***	\$15* for chiropractic, massage, acupuncture; 30 visit annual limit each (eligible services such as office visits, x-ray, lab, physical therapy etc.) by these providers will be covered under the medical plan at the applicable co-pay or coinsurance.***	N/A
PRESCRIPTION DRUGS				
Generic/Brand at pharmacy	\$10/\$20*	\$10*/50% (\$150 per script max)*	\$15*/\$30*	N/A
Generic/Brand for 90-day mail (maintenance drugs)	\$20/\$40*	\$20*/50% (\$300 per script max)*	\$30*/\$60*	N/A
*Deductible does not apply. **Participants could be responsible for more than 1 co-pay depending on how their provider bills Providence for services.				