Clackamas County - General County Employees 2024	Kaiser	Providence Personal Option	Providence Open Option	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN
Annual Deductible: Individual/Family	$250/$500 Common Deductible	$850/$1700 Common Deductible	$600/$1200 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$1000/$2000	$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.**