Clackamas County - General County Employees 2019	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	$1000/$2000 Common Deductible	$750/$1500 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$1000/$2000	$3000/$6000 Maximum Out-Of-Pocket	$2500/$5000 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				
Office visits	$10*	$25*	$20*	30%*
Allergy shots	Covered in full	$25*	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 supplies, appliances and prosthetics	Covered in full**	20%*[1]	10%*[1]	30%
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services	$75*	$100*	$100*	$100*
Urgent care services	$10*	$25*	$20*	30%*
Emergency medical transportation	$75*	20%	10%	10%
OTHER COVERED SERVICES				
X-ray & lab services	Covered in full	10%*	Covered in full	30%
Outpatient rehabilitative services (subject to limitations)	$10*	$25/visit*	$20/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/$25 outpatient	10% inpatient/$20 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 hearing aid per ear every 4 years)	30%
Adults	$1500 per ear every 3 years	20%* (One hearing aid per ear every 4 years)	10%* (One hearing aid per ear every 4 years)	
VISION				
Children Vision	$10 + no charge for standard lenses and frames or six months supply of contact lenses every 12months	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 12/24 months	$250 for lenses and frames every 12 months - Adults only	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $130 every 12 months; Progressive lenses: Standard ($0 copay), Premium/Custom ($30 copay).	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $130 every 12 months; Progressive lenses: Standard ($0 copay), Premium/Custom ($30 copay).	Up to Limits - see VSP summary
ALTERNATIVE CARE				
Office visits	$10* for chiropractic, acupuncture[2], naturopath, $25* massage, $1500 annual max	$25/chiropractic, massage, acupuncture; $2000 annual max* **(eligible services (such as office visits, x-ray, lab, physical therapy etc.) by these providers, as well as all eligible naturopath services, will be covered under the medical plan at the applicable co-pay or coinsurance.)*** **	$20/chiropractic, massage, acupuncture; $2000 annual max* **(eligible services (such as office visits, x-ray, lab, physical therapy etc.) by these providers, as well as all eligible naturopath services, 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% ($200 per script max)*	$15*/$30*	N/A
Generic/Brand for 90-day mail (maintenance drugs)	$20/$40*	$20*/50% ($400 per script max)*	$30*/$60*	N/A

***Deductible does not apply**

****Diabetic testing supplies treated as prescription drug items**

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

[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**