Clackamas County - General County 2024 Non-Medicare Retirees and COBRA	Kaiser	Kaiser High Deductible Plan	Providence Personal Option	Providence Open Option		Providence High Deductible Open Option	
	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	$250/$500	$1400/$2800	$850/$1700 Common Deductible	$600/$1200 Common Deductible		$1400/$2800 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$1000/$2000	$3000/$9000	$2500/$5000 Common Maximum	$2000/$4000 Common Maximum		$3000/$6000 Common Maximum	
PREVENTIVE SERVICES							
Periodic health exams	Covered in full	Covered in full	Covered in full	Covered in full	30%*	Covered in full	50%*
Well baby care, routine immunizations	Covered in full	Covered in full	Covered in full	Covered in full	30%*	Covered in full	50%*
Gynecology exams & tests	Covered in full	Covered in full	Covered in full	Covered in full	30%*	Covered in full	50%*
Mammograms	Covered in full	Covered in full	Covered in full	Covered in full	30%	Covered in full	50%
Colonscopy & sigmoidoscopy	Covered in full	Covered in full	Covered in full	Covered in full	30%	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; covered in full after 30 visits)	$15* (First 3 visits $5; covered in full after 24 visits)	30%*	$25* (First 3 visits $5)	50%*
Allergy shots	Covered in full	Covered in full	$15*	10%	30%	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	$150/pregnancy*	$150*/pregnancy	30%	$100*/pregnancy	50%
HOSPITAL SERVICES							
Inpatient care & provider visits	10%	20%	20%	10%	30%	30%	50%
Maternity services	10%	20%	20%	10%	30%	30%	50%
Routine newborn nursery care	10%	20%	20%*	10%*	30%	30%*	50%
Surgery & anesthesia	10%	20%	20%	10%	30%	30%	50%
Rehabilitative care (subject to limitations)	10%	20%	20%	10%	30%	30%	50%
Skilled nursing facility (subject to limitations)	Covered in full	20%	20%	10%	30%	30%	50%
DURABLE MEDICAL EQUIPMENT							
Medical supplies, appliances and prosthetics	Covered in full	20%	20%*	10%*	30%	30%	50%
Diabetic equipment (glucose monitors, insulin pumps, etc)	Covered in full	20%	20%*	10%*	30%	30%	50%
EMERGENCY/URGENT & AMBULANCE SERVICES							
Emergency services	$75*	20%	$100*	$100*	$100*	$100*	$100*
Urgent care services	$10*	$25*	$15*	$15*	30%*	$25*	50%*
Emergency medical transportation	$75*	20%	20%	10%	10%	30%	30%
OTHER COVERED SERVICES							
X-ray & lab services	Covered in full	20%	Covered in full	Covered in full	30%	30%*	50%
Outpatient rehabilitative services	$10/visit* (limited to 20 visits per therapy per year)	20%* (limited to 20 visits per therapy per year)	$15/visit*	$15/visit*	30%	30%	50%
Outpatient surgery	$10*	20%	20%	10%	30%	30%	50%
Chemotherapy & radiation	$10*	20%	20%	10%	30%	30%	50%
Home health care (subject to limitations)	Covered in full	20%	20%	10%	30%	30%	50%
Hospice	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
HEARING AID ALLOWANCE							
Children	One hearing aid per ear every 4 years	20% - 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% (One per ear every 4 years)	30% (One per ear every 4 years)	50% (One per ear every 4 years)
Adults	$1500 allowance every 3 years for each ear	$1500 allowance every 3 years for each ear	20%* (One hearing aid per ear every 4 years)	10%* (One per ear every 4 years)	30% (One per ear every 4	30% (One per ear every 4 years)	50% (One per ear every 4 years)
VISION							
Children Vision - every year	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 Adults	Same as Adults	Same as Adults	Discount available	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	Discount available	
Benefit every 12/24 months	$250 for lenses and frames every year	$200 for lenses and frames or contact lenses every 2 years	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $175 every 12 months; Progressive Lenses: Standard $0 copay, Custom/Premium $30 copay.	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $175 every 12 months; Progressive Lenses: Standard $0 copay, Custom/Premium $30 copay.	Up to Limits - see VSP summary	Discount available	
ALTERNATIVE CARE							
Office visits	$10* for chiropractic & acupuncture** $25* massage Annual visit limits: 20 chiropractic, 12 acupuncture, 12 massage		$20*/chiropractic, acupuncture, massage*** 30 visit annual limit each	$20/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 at pharmacy	$10/$20*	$20/$40	$10*/50% ($150 per script max)*	$15*/$30*	N/A	$10*/50%*	N/A
Generic/Brand for 90-day mail (maint. drugs)	$20/$40*	$40/$80	$20*/50% ($300 per script max)*	$30*/$60*	N/A	$30*/50%*	N/A
	****Physician-referred acupuncture visits is limited to 12 visits per calendar year**		***Deductible does not apply**				
	*****Participants may be responsible for more than 1 co-pay depending on how their provider bills Providence for their services.**						