Clackamas County - General County 2019 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	$1000/$3000	$1000/$2000 Common Deductible	$750/$1500 Common Deductible		$1000/$2000 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$1000/$2000	$3000/$9000	$3000/$6000 Common Maximum	$2500/$5000 Common Maximum		$2000/$4000 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							
Office visits	$10*	$25* primary care; 20% specialty care	$25*	$20*	30%*	$15*	50%*
Allergy shots	Covered in full	$5*	$25*	10%	30%	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	$150/pregnancy*	$150*/pregnancy	30%	$150*/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 & diabetic supplies, appliances and prosthetics	Covered in full (diabetic testing supplies treated as prescription drug items)	20%* (diabetic testing supplies treated as prescription drug items)	20%**[1]	10%**[1]	30%	30%**[1]	50%
EMERGENCY/URGENT & AMBULANCE SERVICES							
Emergency services	$75*	20%	$100*	$100*	$100*	$100*	$100*
Urgent care services	$10*	$25*	$25*	$20*	30%*	$15*	50%*
Emergency medical transportation	$75*	20%*	20%	10%	10%	30%	30%
OTHER COVERED SERVICES							
X-ray & lab services	Covered in full	20%	10%*	Covered in full	30%	30%*	50%
Outpatient rehabilitative services	$10/visit* (limited to 20 visits per therapy per year)	20% (After deductible, limited to 20 visits per therapy per year)	$25/visit*	$20/visit*	30%	30%	50%
Outpatient surgery	$10*	20%	20%	10%	30%	30%	50%
Chemotherapy & radiation	$10*	20%	20% (co-pays for self-administered)	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	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%	50%
Adults	$1500 every 3 years for each ear	$1500 every 3 years for each ear	20%* (One hearing aid per ear every 4 years)	10%* (One hearing aid per ear every 4 years)		30%	50%
VISION							
Children Vision	$10 /exam + no charge for standard lenses and frames or six months supply of contact lenses	$25/exam + no charge for standard lenses and frames or six months supply of contact lenses	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 12 months	$200 for lenses and frames or contact lenses every 24 months	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $130 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 $130 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*/visit for chiropractic, acupuncture, naturopath[2] $25* massage (12 hour limit), $1500 combined annual max		$25*/chiropractic, acupuncture, massage; $2000 annual max ***	$20/chiropractic, acupuncture, massage; $2000 annual max . ***	N/A	$15 co pay for Spinal Manipulation/Acupuncture up to $500 annual max	Discount available
PRESCRIPTION DRUGS							
Generic/Brand at pharmacy	$10/$20*	$15/$30	$10*/50% ($200 per script max)*	$15*/$30*	N/A	$10*/50%*	N/A
Generic/Brand for 90-day mail (maint. drugs)	$20/$40*	$30/$60	$20*/50% ($400 per script max)*	$30*/$60*	N/A	$30*/50%*	N/A
	[2]Physician-referred acupuncture visits is limited to 12 visits per calendar year		***Deductible does not apply**			****Deductible does not apply to diabetic supplies**	
	*****Participants may be responsible for more than 1 co-pay depending on how their provider bills Providence for their services. Eligible naturopathic services are billed as physician/provider services.**					**[1]Deductible does not apply to removable custom shoe orthotics**	