

Clackamas County 2026	Kaiser	Providence
Medicare Retirees	Senior Advantage	Medicare Align
Medicare Advantage plans require Medicare Parts A and B Enrollment	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY
DEDUCTIBLE/OUT-OF-POCKET MAXIMUM		
Deductible: Individual/Family Maximum	\$0	\$0
Annual Out-of-Pocket Maximum: Individual	\$600	\$1,500
PREVENTIVE HEALTH SERVICES		
Periodic health exams (maximum once per year)	\$0	\$0
Preventive screening test (colon, pap smears, prostate, etc.)	Covered in full within limits set by Medicare	Covered in full within limits set by Medicare
Mammograms		
OUTPATIENT OFFICE VISITS		
Primary Care Physician	\$10	\$15
Specialty Care		\$20
Mental Health and Chemical Dependency		\$20
Urgent Care		\$25
INPATIENT HOSPITAL SERVICES		
Inpatient care (per Medicare benefit period)	No charge	\$100 per day/\$500 maximum per admission
Inpatient Provider visits		
Inpatient Surgery and Anesthesia		
Inpatient Mental Health and Chemical Dependency		
Inpatient Rehabilitative care		
Skilled nursing facility	Covered in full (100 days per benefit period)	Covered in full (100 days per benefit period)
EMERGENCY/AMBULANCE SERVICES		
Emergency services (waived if admitted)	\$50	\$50
Ambulance services	\$50	\$50
DURABLE MEDICAL EQUIPMENT		
Medical & diabetic supplies, appliances and prosthetics	No charge except Part B drugs covered under prescription drug benefit	20% Coinsurance for Medicare-Approved equipment
Hearing aids	\$1,500 hearing aid allowance per ear every 3 yrs	\$0 exam copay; Member pays \$299 per ear for Advanced hearing aid or \$599 per ear for Premium hearing aid (annual benefit)
OTHER COVERED SERVICES		
Imaging services (Includes X-Ray, CT, MRI and PET Scans)	Covered in full	10%
Lab services	Covered in full	Covered in full
Outpatient rehabilitative services	\$10	\$20
Outpatient surgery		\$75 per surgery
Chemotherapy & radiation		20% for chemotherapy drugs or other Part B Drugs
Home health care (Medicare-covered)	Covered in full for Medicare-approved charges (Up to 100 days per benefit period)	Covered in full for Medicare-approved charges (Up to 100 days per benefit period)
Hospice (Medicare-certified hospice)	Covered in full for Medicare-approved charges	Covered in full for Medicare-approved charges
VISION		
Eye examinations	\$10	\$60 exam allowance per year
Lenses & frames	\$200 eyewear allowance every 2 calendar years	\$300 allowance per calendar year for eye glasses, frames and contacts
ALTERNATIVE CARE		
Office visits	\$10 for chiropractic & acupuncture; \$25 massage Annual visit limits: 20 chiropractic, 12 acupuncture, 12 massage Naturopath billed as primary care (no visit limit)	\$20 for each Medicare-covered chiropractic visit
PRESCRIPTION DRUGS		
Generic Copay (up to 30-day supply)	\$10	\$10
Brand Name and Specialty Drug Copay (up to 30-day supply)	\$20	50%
Mail Order Maintenance Drugs (90-day supply)	2 co pays Avail. only in Or. & Wash.	3 copays
Annual Out-of-Pocket Maximum for Prescription Drugs	\$2000 per person	\$1000 per person