Clackamas County - Peace Officers 2025	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	$0	$50/$150 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$1000/$2000	$1000/$3000	$2000/$6000 Common Maximum	
PREVENTIVE HEALTH SERVICES				
Periodic health exams	Covered in full	Covered in full	Covered in full	20%*
Well baby care, routine immunizations	Covered in full	Covered in full	Covered in full	20%*
Gynecology exams/tests	Covered in full	Covered in full	Covered in full	20%*
Mammograms	Covered in full	Covered in full	Covered in full	20%
PHYSICIAN/PROVIDER SERVICES				
Primary Care/Naturopath Office visits	$10 (First 3 visits $5)	$15 (First 3 visits $5)	$10* (First 3 visits $5)	20%*
Allergy shots	Covered in full	$15	Covered in full	20%
Pre-natal & post-natal visits; delivery	Covered in full	$150/pregnancy	$50*/pregnancy	20%
HOSPITAL SERVICES				
Inpatient care & provider visits	Covered in full	Covered in full	Covered in full	20%
Maternity care	Covered in full	Covered in full	Covered in full	20%
Routine newborn nursery care	Covered in full	Covered in full	Covered in full	20%
Surgery & anesthesia	Covered in full	Covered in full	Covered in full	20%
Rehabilitative care (subject to limitations)	Covered in full	Covered in full	Covered in full	20%
Skilled nursing facility (subject to limitations)	Covered in full	Covered in full	Covered in full	20%
DURABLE MEDICAL EQUIPMENT				
Medical & diabetic supplies, appliances and prosthetics	Covered in full	20% (Up to $500 maximum)	20% (Up to $500 maximum)	20% (Up to $500 maximum)
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services	$75	$100	$100*	$100*
Urgent care services	$10	$15	$10*	20%*
Emergency medical transportation	$75	$50	$50	$50
OTHER COVERED SERVICES				
X-ray & lab services	Covered in full	Covered in full	Covered in full	20%
Outpatient rehabilitative services	$10/visit (20 visits per calendar year)	$15/visit (30 visits per calendar year)	$10/Visit (30 visits per calendar year)	20% (30 visits per calendar year)
Outpatient surgery	$10	Covered in full	$10	20%
Chemotherapy & radiation	$10	Covered in full	$10	Not covered
Home health care	Covered in full (up to 130 visits per year)	Covered in full	Covered in full	20%
Hospice care	Covered in full	Covered in full	Covered in full	Covered in full
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	$10 co pay*	$10 co pay*	Up to Limits - see VSP summary
Kaiser Adult Vision Frequency - Every 24 months Providence VSP Vision Frequency - Every 12 months	$200 for lenses and frames	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
HEARING AID ALLOWANCE				
Children	One hearing aid per ear every 4 years	20% (One per ear every 3 years)	20% (One per ear every 3 years)	20% (One per ear every 3 years)
ALTERNATIVE CARE				
Office visits	$10 for chiropractic and acupuncture[1] $25 massage. Chiropractic - 20 visit annual limit Acupuncture and Massage - 12 visit annual limit	$10* for chiropractic, massage, acupuncture; 30 visit annual limit each	$10* for chiropractic, massage, acupuncture; 30 visit annual limit each	N/A
PRESCRIPTION DRUGS				
Generic/Brand copay at pharmacy	$10/$20	$10/$15	$10*/$15*	N/A
Generic/Brand copay for 90-day mail (maintenance drugs)	$20/$40	$10/$15	$10*/$15*	N/A
	[1]Physician-referred acupuncture is restricted to 12 visits per calendar year		*Deductible does not apply	