Clackamas County - Peace Officers 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	$0	$0	$50/$150 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$600/$1200	$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				
Office visits	$10	$15	$10*	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%[1]	20%**[1]	20%
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/calendar year)	$10/Visit (30 visits/calendar year)	20% (30 visits/calendar year)
Outpatient surgery	$10	Covered in full	$10	20%
Chemotherapy & radiation	$10	Covered in full	$10	20%
Home health care	Covered in full (up to 130 visits per year)	$15/visit	Covered in full	20%
Hospice care	Covered in full	Covered in full	Covered in full	Covered in full
VISION				
Children Vision	$10/exam + no charge for standard lenses and frames or six months supply of contact lenses every 24 months	Covered in full (up to limits)	Covered in full (up to limits)	Up to Limits - see VSP summary
Vision Examinations - every 12 months	$10	$10 co pay	$10 co pay	Up to Limits - see VSP summary
Benefit every 24 months	$200 for lenses and frames	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $130	Lenses covered in full (up to limits); Frames or Contact lenses covered up to $130	Up to Limits - see VSP summary
HEARING AID ALLOWANCE				
Children	One hearing aid per ear every 4 years	20%	20%	20%
ALTERNATIVE CARE				
Office visits	$10 for chiropractic, acupuncture, naturopath, $25 massage, $1500 combined annual max	$10/chiropractic, $1500 annual max	$10*/chiropractic, $1500 annual max	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
	[2]Physician-referred acupuncture is restricted to 12 visits per calendar year	*Deductible does not apply [1]Deductible does not apply to removable custom shoe orthotics	**Deductible does not apply to purchase of diabetic supplies.	