

Medical Group #'s:	KAISER # 1 1568-165	KAISER # 2 1568-167	KAISER # 3 1568-167	KAISER # 4	KAISER H.S.A
PREVENTIVE & WELLNESS	Kaiser Only	Kaiser Only	Kaiser - PPO - Other	NEW Kaiser Only	NEW Kaiser Only
All Preventive Services As Prescribed By Federal Law	* 100% Benefit	*100% Benefit	* 100% - * \$30 - 65%	*100% Benefit	* 100%
Visit Web Site For List					
ANNUAL DEDUCTIBLE					
Per Person	\$750	\$500	\$250 - \$500 - \$500	\$2,000	\$2,000
Per Family	\$2,250	\$1,500	\$750 - \$1,500 - \$1,500	\$6,000	\$4,000 Aggregate
OUT OF POCKET MAXIMUM					
Per Person	\$4,500	\$4,000	\$1,000-\$2,000-\$3,500	\$4,000	\$5,000
Per Family	\$13,500	\$12,000	\$3,000-\$6,000-\$10,500	\$12,000	\$10,000 Aggregate
HOSPITAL CARE	Copays shown below with an * means deductible does not apply				
	Kaiser Only	Kaiser Only	Kaiser - PPO - Other	Kaiser Only	Kaiser Only
Inpatient Care	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
Rehabilitative Care	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
Skilled Nursing Facility (100 Day)	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
Emergency Room Hospital	70% Benefit	80% Benefit	\$100 Copay (after ded)	80% Benefit	80% Benefit
Urgent Care	* \$40 Copay	* \$35 Copay	* \$40 - * \$50 - 65%	80% Benefit	80% Benefit
PHYSICIAN CARE					
Office Visit - Primary Care	* \$20 Copay	* \$20 Copay	* \$20 - * \$30 - 65%	* \$35 Copay	80% Benefit
Office Visit Specialist	80% Benefit (after ded)	* \$25 Copay	* \$30 - * \$40 - 65%	* \$50 Copay	80% Benefit
Surgery	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
Allergy Shots, Inject able Medica	* \$5 Copay	* \$5 Copay	* \$10 - * \$30 - 65%	* \$10 Copay	\$10 Copay (After Deductible)
LAB, X-RAY & IMAGING	* \$20 Copay	* \$10 Copay	* \$20 - * \$30 - 65% (MRI, CT, PET 80% After Ded.)	* \$25 Copay	80% Benefit
AMBULANCE SERVICES	* 70% Benefit	* 80% Benefit	90%	* 80% Benefit	* 80% Benefit
MATERNITY CARE					
Office Visits	* 100% Benefit	* 100% Benefit	* 100% - * \$30 - 65%	* 100% Benefit	* 100% Benefit
Inpatient Care Including Delivery	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
PRESCRIPTION DRUGS	Kaiser Pharmacy	Kaiser Pharmacy	Kaiser - PBM	Kaiser Pharmacy	Kaiser Pharmacy
Generic	* \$20 Copay	* \$20 Copay	*\$15 CP - *\$20 CP	* \$20 Copay	\$15 Copay After Ded
Formulary Brand Name	* \$40 Copay	* \$40 Copay	*\$30 CP - *\$40 CP	* \$40 Copay	\$30 Copay After Ded
Non Preferred Brand Name	N/A	* \$60 Copay	N/A - *\$60 CP	N/A	N/A
Prescription Drug Copays For Plans #1, #2, #3 & #4 Do Not Apply Towards The Out Of Pocket Maximum					
DURABLE MEDICAL EQUIPMENT	* 70% Benefit	* 80% Benefit	80% - 70% - 65%	80% Benefit	80% Benefit
MENTAL HEALTH & CHEMICAL DEPENDENCY					
Outpatient Provider Visit	* \$20 Copay	* \$25 Copay	* \$20 - * \$30 - 65%	* \$35 Copay	80% Benefit
Inpatient & Residential Care	70% Benefit	80% Benefit	90% - 80% - 65%	80% Benefit	80% Benefit
ALTERNATIVE PROVIDER	Alternative Provider Benefit Has A \$1,500 Calendar Year Maximum Benefit				
Office Visit	* \$20 Copay	* \$20 Copay	* \$20 Copay	N/A	N/A
Massage Therapy	* \$25 Copay	* \$25 Copay	* \$25 Copay	N/A	N/A
VISION BENEFIT					
Exam	* \$20 Copay	* \$20 Copay	* \$20 - * \$30 - 65%	* \$25 Copay	80% After Ded
Lens & Frames 1 Per 24 Mos	\$150 Allowance	\$150 Allowance	\$150 Allowance	\$150 Allowance	\$150 Allowance
Contacts In Lieu of lenses/frame	\$150 Allowance	\$150 Allowance	\$150 Allowance	\$150 Allowance	\$150 Allowance
PREMIUMS WITH VISION	Plan # 1	Plan # 2	Plan # 3	Plan # 4	H.S.A
Employee	\$480.58	\$574.98	\$657.31	\$435.80	\$327.07
Employee/Spouse	\$957.91	\$1,146.71	\$1,311.37	\$868.35	\$650.89
Employee/Child(ren)	\$948.36	\$1,135.27	\$1,298.28	\$859.70	\$644.41
Employee/Family	\$1,435.24	\$1,718.44	\$1,965.43	\$1,300.90	\$974.71
DENTAL (Only at Kaiser Facilities)	KAISER DENTAL ONLY PREMIUMS (Group # 1568-173)				
Calendar Year Deductible	None		Kaiser dental coverage can be added to any medical plan		
Office Visits (Including Restorative Services)	\$10 Copay		Add these premiums to medical rates above or on other side		
Prosthetic Devices, Periodontics & Endodontics	50%		Employee \$56.53		
Max Annual Benefit	Unlimited		Employee/Spouse \$113.07		
Orthodontics - \$2,000 Lifetime Max. Benefit	50%		Employee/Child(ren) \$111.94		
Annual Maximum Benefit	None		Employee/Family \$169.60		

Premiums shown above include a \$3.25 per employee administrative charge, \$1.50 of which goes to the MBA

This summary is for comparative purposes only. Refer to the insurance carriers benefit summaries for detailed explanation of benefits.



GROUP INSURANCE SUMMARY BROCHURE

Rates Effective 4/1/2012 - 3/31/2013

Northwest Employee Benefits, Inc.
4300 N.E. Fremont, Suite 260
Portland, Oregon 97213
1-503-284-1331 or 1-800-284-1331 toll free

Check web site at www.nwebi.com click on "Multnomah Bar Association". Password is: MBA (all caps)

PROVIDENCE HEALTH PLANS

www.nwebi.com Password is: MBA (all caps) Group Numbers	NEW PLAN				
	EPO # 1	OPEN OPTION # 3	OPEN OPTION # 4	OPEN OPTION # 6	HSA
	100218-001	100218-003	100218-009		100218-007
Benefits Shown Below With An * Means The Deductible Does Not Apply					
PREVENTIVE & WELLNESS All Preventive Services As Required By Federal Law Visit Web Site For List	Providence Only	PPO - NON	PPO - NON	PPO - NON	PPO - NON
	* 100% Benefit	* 100% - * 60%	* 100% - * \$25 Copay	* 100% - * 50%	* 100% - 60%
	** Colonoscopies are covered at 100% only for members over age 50				
ANNUAL DEDUCTIBLE	Deductible Is Based On A Calendar Year Deductible Does Not Apply To Benefits With *				
Per Person	\$750	\$1,000	\$750	\$2,500	\$2,600
Per Family	\$2,250	\$3,000	\$2,250	\$7,500	\$5,150 Aggregate
OUT OF POCKET MAXIMUM	Out of Pocket Maximum Is Based On A Calendar Year				
Per Person	\$5,000	\$5,000	\$5,000	\$5,000	\$5,000
Per Family	\$15,000	\$15,000	\$15,000	\$15,000	\$10,000 Aggregate
HOSPITAL CARE	Providence Only	PPO - NON	PPO - NON	PPO - NON	PPO - NON
Inpatient Care	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
Rehabilitative Care (30 Days)	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
Skilled Nursing Facility (60 Days)	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
Emergency Room Hospital	\$250 Copay After Ded.	\$250 Copay After Ded.	* \$250 Copay	\$250 Copay After Ded	80% - 60%
Urgent Care Facility	* \$25 Copay	* \$25 Copay - * 60%	* \$25 Copay - * 80%	* \$35 Copay - 50%	80% - 60%
PHYSICIAN CARE	Providence Only	PPO - NON	PPO - NON	PPO - NON	PPO - NON
Office Visit	* \$25 Copay	* \$25 Copay - * 60%	* \$25 Copay - * \$25 Copay	* \$35 Copay - * 50%	80% - 60%
Specialist	* \$25 Copay	* \$25 Copay - * 60%	* \$25 Copay - * \$25 Copay	* \$50 Copay - * 50%	80% - 60%
Surgery	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
Allergy Shots, Inject able Medication	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
LAB, X-RAY & IMAGING	70% Benefit	70% - 60%	* 80% - 80%	70% - 50%	80% - 60%
AMBULANCE SERVICES	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
MATERNITY CARE					
Office Visits and Delivery	* \$250 Copay	* \$250 Copay - 60%	* \$250 Copay - 80%	* \$50 / 70% - 50%	80% - 60%
Inpatient Care	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
PRESCRIPTION DRUGS	Except For The HSA Plan Prescription Drug Copays Do Not Apply Towards Out Of Pocket Maximums				
Value Drugs	* \$5 Copay	* \$5 Copay	* \$5 Copay	N/A	80% Benefit
Generic	* \$15 Copay	* \$15 Copay	* \$15 Copay	* \$15 Copay	80% Benefit
Formulary Brand Name	* \$50 Copay	* \$50 Copay	* \$50 Copay	* \$45 Copay	80% Benefit
Non Formulary Brand Name	* 50% Copay	* 50% Copay	* 50% Copay	* \$45 Copay	80% Benefit
Max Out Of Pocket Non Formulary	\$2,000	\$2,000	\$2,000	(\$250 Ded. On Brand Name drugs)	
DURABLE MEDICAL EQUIPMENT	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
MENTAL HEALTH & CHEMICAL DEPENDENCY					
Outpatient Provider Visit	* \$25 Copay	* \$25 Copay - * 60%	* \$25 Copay - * \$25 Copay	* \$35 Copay - * 50%	80% - 60%
Inpatient & Residential Care	70% Benefit	70% - 60%	80% - 80%	70% - 50%	80% - 60%
MONTHLY PREMIUMS	Providence # 1	Providence # 3	Providence # 4	Providence # 6	Providence HSA
Employee	\$527.14	\$590.41	\$638.31	\$454.53	\$416.62
Employee/Spouse	\$1,107.60	\$1,240.96	\$1,341.96	\$954.53	\$874.64
Employee/Child(ren)	\$1,024.85	\$1,148.22	\$1,241.65	\$883.26	\$809.35
Employee/Family	\$1,580.88	\$1,771.41	\$1,915.69	\$1,362.23	\$1,248.09
PROVIDENCE PREMIUMS INCLUDING ALTERNATIVE PROVIDER BENEFIT					
Each employer group can elect to add this benefit to ALL Providence covered employees and dependents. Must use only Providence contracted providers.					
Alternative Provider Benefits: \$15 Office Visit Copay, \$1,500 Calendar Year Maximum Benefit, Covers Chiropractic, Naturopathy and Acupuncture					
MONTHLY PREMIUMS	Providence # 1	Providence # 3	Providence # 4	Providence # 6	Providence HSA
Employee	\$533.25	\$596.52	\$644.42	\$460.64	N/A
Employee/Spouse	\$1,120.48	\$1,253.84	\$1,354.84	\$967.41	N/A
Employee/Child(ren)	\$1,036.76	\$1,160.13	\$1,253.56	\$895.17	N/A
Employee/Family	\$1,599.28	\$1,789.81	\$1,934.09	\$1,380.63	N/A

ODS & VSP DENTAL AND VISION BENEFITS

DENTAL benefits by ODS (Oregon Dental Service)		Group # 10001777	Vision benefits by VSP (Vision Service Plan)		Group # 3356975
Calendar Year Deductible	\$50 Per Person		VSP Provider		Non VSP Providers
Max Calendar Year Benefit	\$1,500 Per Person		Calendar Year Copay	\$25 per person	\$25 per person
(Ded Waived for Preventive)	PPO	NON PPO	Exams 1 per 12 months	No Charge ****	Up to \$45 Benefit
Preventive Treatment	100%	80%	Lenses 1 per 24 months	No Charge ****	Up to \$45 Benefit
Basic Treatment	80%	80%	Frames 1 per 24 months	Standard Allowance	Up to \$47 Benefit
Restorative, Oral Surgery, Periodontics			Contacts - Required	No Charge ****	Up to \$210 Benefit
Major Treatment	50%	50%	Contacts - Elective	Up to \$120 Benefit	Up to \$105 Benefit
Crowns, Bridge Work, Dentures			**** Subject to VSP standard allowance for frames up to \$150		
Orthodontia	50%	50%			
Adults and Children	Lifetime Maximum Benefit \$2,000				
DENTAL AND VISION PREMIUMS		Employee	\$61.42		
		Employee/Spouse	\$109.62		
		Employee/Child(ren)	\$137.50		
		Employee/Family	\$179.60		

Secure Horizons Supplement to Parts A & B of Medicare: \$394.92 (OR), \$361.99 (WA) PacifiCare Medicare rates Plan Year 1/1/12 - 12/31/12
Providence Health Plan Supplement to Parts A & B of Medicare: \$301.87 (OR) Providence Medicare Rates Calendar Year 1/1/12 - 12/31/12

Medical premiums shown above include a \$3.25 per employee administrative charge, \$1.50 of which goes to the MBA