

www.nwebi.com Password is: MBA (all caps)		PROVIDENCE HEALTH PLANS				
	EPO # 1	EPO # 2	OPEN OPTION # 3	OPEN OPTION # 4	HSA	
Group Numbers	100218-001	100218-002	100218-003	100218-009	100218-007	
Benefits Shown Below With An * Means The Deductible Does Not Apply						
PREVENTIVE & WELLNESS	Providence Only	Providence Only	PPO - NON	PPO - NON	PPO - NON	
Mammogram	* 100% Benefit	* \$15 Copay	* 100% - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
<u>Diabetic Exam</u> Mouth, Teeth, Feet HbA1c, Retinal, Urine Tests	* 100% Benefit	* 80% Benefit	* 100% - 60%	* 90% - 80%	80% - 60%	
<u>Preventive Tests</u> CBC, Urinalysis Glucose, Cholesterol, Fecal Blood	* 100% Benefit	* 80% Benefit	* 100% - 60%	* 90% - 80%	80% - 60%	
Pneumococcal and Flu Vaccine	* 100% Benefit	* \$15 Copay	* 100% - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Routine Immunization Shots	* 100% Benefit	* \$15 Copay	* 100% - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Annual Gynecological Exam	* \$10 Copay	* \$15 Copay	* \$10 Copay - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Annual Prostate Screening Exam	* \$10 Copay	* \$15 Copay	* \$10 Copay - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Periodic Health & Well Baby Exam	* \$10 Copay	* \$15 Copay	* \$10 Copay - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Colorectal Exam & Colonoscopy	* \$10 Copay	80% Benefit	* \$10 Copay - 60%	90% - 80%	80% - 60%	
2 Visits For Weight Loss Counseling	* \$10 Copay	Refer to Handbook	* \$10 Copay - * 60%	Refer to Handbook	80% - 60%	
Smoking Deterrent Program (500 Lifetime Benefit)	* \$10 Copay	80% Benefit	* \$10 Copay - N/A	90% - N/A	80% - N/A	
Deductible Is Based On A Calendar Year						
Per Person	\$750	\$500	\$750	\$750	\$2,600	
Per Family	\$2,250	\$1,500	\$2,250	\$2,250	\$5,200 Aggregate	
Out of Pocket Maximum Is Based On A Calendar Year						
Per Person	\$4,000	\$2,000	\$4,000	\$4,000	\$5,000	
Per Family	\$12,000	\$6,000	\$12,000	\$12,000	\$10,000 Aggregate	
Benefits Shown Below With An * Means The Deductible Does Not Apply						
HOSPITAL CARE	Providence Only	Providence Only	PPO - NON	PPO - NON	PPO - NON	
Inpatient Care	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Rehabilitative Care (30 Days)	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Skilled Nursing Facility (60 Days)	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Emergency Room Hospital	\$125 Copay then 70%	* \$125 Copay	\$125 Copay then 70%	* \$125 Copay	80% - 60%	
Urgent Care Facility	* \$25 Copay	* \$25 Copay	* \$25 Copay	* \$25 Copay	80% - 60%	
PHYSICIAN CARE	Providence Only	Providence Only	PPO - NON	PPO - NON	PPO - NON	
Office Visit	* \$20 Copay	* \$15 Copay	* \$20 Copay - * 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Inpatient Hospital Visits	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Surgery	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Allergy Shots, Inject able Medication	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
LAB, X-RAY & IMAGING	70% Benefit	* 80% Benefit	70% - 60%	* 90% - 80%	80% - 60%	
AMBULANCE SERVICES	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
MATERNITY CARE						
Office Visits and Delivery	* \$200 Copay	* \$150 Copay	* \$200 Copay - 60%	* \$200 Copay - 80%	80% - 60%	
Inpatient Care	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
Except For The HSA Plan Prescription Drug Copays Do Not Apply Towards Out Of Pocket Maximums						
PRESCRIPTION DRUGS						
Value Drugs	* \$5 Copay	* \$5 Copay	* \$5 Copay	* \$5 Copay	80% Benefit	
Generic	* \$15 Copay	* \$15 Copay	* \$15 Copay	* \$15 Copay	80% Benefit	
Formulary Brand Name	* \$40 Copay	* \$40 Copay	* \$40 Copay	* \$40 Copay	80% Benefit	
Non Formulary Brand Name	* 50% Copay	* 50% Copay	* 50% Copay	* 50% Copay	80% Benefit	
Plans # 1 Through # 4 Annual Maximum Out Of Pocket For Non Formulary Drugs Is \$2,000						
DURABLE MEDICAL EQUIPMENT	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
MENTAL HEALTH & CHEMICAL DEPENDENCY						
Outpatient Provider Visi	* \$20 Copay	* \$15 Copay	* \$20 Copay - 60%	* \$20 Copay - * \$20 Copay	80% - 60%	
Inpatient & Residential Carr	70% Benefit	80% Benefit	70% - 60%	90% - 80%	80% - 60%	
MONTHLY PREMIUMS	Providence # 1	Providence # 2	Providence # 3	Providence # 4	Providence HSA	
Employee	\$445.90	\$600.33	\$508.79	\$552.56	\$343.93	
Employee/Spouse	\$936.62	\$1,262.13	\$1,069.16	\$1,161.45	\$721.67	
Employee/Child(ren)	\$866.67	\$1,167.79	\$989.29	\$1,074.67	\$667.83	
Employee/Family	\$1,336.75	\$1,801.76	\$1,526.10	\$1,657.94	\$1,029.67	
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 # 2	Providence # 3	Providence # 4		
Employee	\$450.65	\$605.08	\$513.54	\$557.31	N/A	
Employee/Spouse	\$946.63	\$1,272.14	\$1,079.17	\$1,171.46	N/A	
Employee/Child(ren)	\$875.93	\$1,177.05	\$998.55	\$1,083.93	N/A	
Employee/Family	\$1,351.05	\$1,816.06	\$1,540.40	\$1,672.24	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 mon	No Charge****	Up to \$45 Benefit	
Preventive Treatment	100%	80%	Lenses 1 per 24 mor	No Charge****	Up to \$45 Benefit	
Basic Treatment	80%	80%	Frames 1 per 24 mor	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	(Orthodontia Benefits Are Not Covered)		**** Subject to VSP standard allowance for frames up to \$15!			
DENTAL AND VISION PREMIUMS			Employee	\$55.64		
			Employee/Spouse	\$98.82		
			Employee/Child(ren)	\$114.55		
			Employee/Family	\$152.37		
Secure Horizons Supplement to Parts A & B of Medicare \$343.74 (OR), \$315.11 (WA) <i>PacificCare Medicare rates Plan Year 1/1/10 - 12/31/10</i>						
Providence Health Plan Supplement to Parts A & B of Medicare \$266.77 (OR) <i>Providence Medicare Rates Calendar Year 1/01/10 - 12/31/10</i>						

KAISER Medical, Dental and Vision *MULTNOMAH BAR ASSOCIATION* Rates Effective 4/1/2010 - 3/31/2011

	KAISER # 1	KAISER # 2	KAISER # 3	KAISER # 1	KAISER # 2	KAISER # 3
<i>Group #'s Medical Only:</i>	1568-080	1568-100	1568-140	<u>With Vision</u>	<u>With Vision</u>	<u>With Vision</u>
<i>Group #'s Medical with Dental:</i>	1568-120	1568-130	1568-160	1568-090	1568-110	1568-150
CALENDAR YEAR	Kaiser - PPO - Other			Kaiser - PPO - Other		
DEDUCTIBLE	\$750	\$500	\$250 - \$500 - \$500	\$750	\$500	\$250 - \$500 - \$500
<i>Per Person and Family</i>	\$2,250	\$1,500	\$750 - \$1,500 - \$1,500	\$2,250	\$1,500	\$750 - \$1,500 - \$1,500
CALENDAR YEAR	Kaiser - PPO - Other			Kaiser - PPO - Other		
MAX COINSURANCE	\$2,500	\$2,500	\$1,000-\$2,000-\$3,500	\$2,500	\$2,500	\$1,000-\$2,000-\$3,500
<i>Per Person and Family</i>	\$7,500	\$7,500	\$3,000-\$6,000-\$10,500	\$7,500	\$7,500	\$3,000-\$6,000-\$10,500
Copays shown below with an * means deductible does not apply						
HOSPITAL CARE	Kaiser - PPO - Other			Kaiser - PPO - Other		
Room (Semi-private)	80% Benefit	90% Benefit	90% - 80% - 65%	80% Benefit	90% Benefit	90% - 80% - 65%
Emergency Hospital Services	80% Benefit	90% Benefit	\$100 Copay	80% Benefit	90% Benefit	\$100 Copay
PHYSICIAN CARE	Kaiser - PPO - Other			Kaiser - PPO - Other		
Office Calls	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Office Calls Specialist	80% after Ded.	* \$25 Copay	* \$20 - \$30 - 65%	80% after Ded.	* \$25 Copay	* \$20 - \$30 - 65%
Surgery Inpatient	80% Benefit	90% Benefit	90% - 80% - 65%	80% Benefit	90% Benefit	90% - 80% - 65%
LAB & X-RAY, DIAG. PROC. IN MEDICAL OFFICE	* \$20 Copay	* \$10 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$10 Copay	* \$20 - \$30 - 65%
MATERNITY CARE	Kaiser - PPO - Other			Kaiser - PPO - Other		
Prenatal Care	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Hospital Care	80% Benefit	90% Benefit	90% - 80% - 65%	80% Benefit	90% Benefit	90% - 80% - 65%
PREVENTIVE CARE	Kaiser - PPO - Other			Kaiser - PPO - Other		
Health Exams - Adults and Child	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Routine Immunizations	No Copay	No Copay	* \$0 - \$30 - 65%	No Copay	No Copay	* \$0 - \$30 - 65%
Gynecological Exams (OB-GYN)	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Allergy Shots & Injections	* \$5 Copay	* \$5 Copay	* \$10 - \$30 - 65%	* \$5 Copay	* \$5 Copay	* \$5 - \$30 - 65%
			(Non Kaiser \$300 Max)			
PRESCRIPTION DRUG COPAY	Kaiser - PBM			Kaiser - PBM		
Generic	* \$20 Copay	* \$15 Copay	* \$15 CP - * \$30 CP	* \$20 Copay	* \$15 Copay	* \$15 CP - * \$30 CP
Brand Name	* \$40 Copay	* \$30 Copay	* \$30 CP - * \$30 CP	* \$40 Copay	* \$30 Copay	* \$30 CP - * \$30 CP
Prescription Drug Copays Do Not Apply Towards The Out Of Pocket Maximum						
DURABLE MEDICAL EQUIP	Kaiser - PPO - Other			Kaiser - PPO - Other		
<i>No Annual Limit</i>	* 80% Benefit	* 80% Benefit	* 90% - 70% - 65%	* 80% Benefit	* 80% Benefit	* 80% - 80% - 65%
AMBULANCE	80% Benefit	90% Benefit	* \$100 - * \$100 - 65%	80% Benefit	90% Benefit	90% - 80% - 65%
CHEMICAL DEP. & MENTAL HEALTH	Kaiser - PPO - Other			Kaiser - PPO - Other		
Outpatient Visit & Day Treatment	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Inpatient & Residential Care	80% Benefit	90% Benefit	90% - 80% - 65%	80% Benefit	90% Benefit	90% - 80% - 65%
ALTERNATIVE PROVIDER	Alternative Provider Benefit Has A \$1,500 Calendar Year Maximum Benefit					
Office Visit	* \$20 Copay	* \$25 Copay	* \$10 - \$10 - \$10	* \$20 Copay	* \$25 Copay	* \$20 - \$20 - \$20
Massage Therapy (12 Visit Max)	* \$25 Copay	* \$25 Copay	* \$25 Copay	* \$25 Copay	* \$25 Copay	* \$25 Copay
VISION (Only at Kaiser Facilities - All Plans)	Kaiser - PPO - Other			Kaiser - PPO - Other		
Calendar Year Deductible	None	None	None	None	None	None
Exams (No Limit)	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%	* \$20 Copay	* \$15 Copay	* \$20 - \$30 - 65%
Lenses & Frames once per 2 yr	Not Covered	Not Covered	Not Covered	\$150 Allowance	\$150 Allowance	\$150 Allowance
Contacts (in lieu lenses/frames)	Not Covered	Not Covered	Not Covered	\$150 Allowance	\$150 Allowance	\$150 Allowance
MONTHLY PREMIUMS	Plan # 1	Plan # 2	Plan # 3	Plan # 1	Plan # 2	Plan # 3
	Medical Only			Medical & Vision Only		
Employee	\$394.00	\$505.21	\$513.11	\$399.37	\$510.96	\$517.98
Employee/Spouse	\$784.99	\$1,007.42	\$1,023.22	\$795.73	\$1,018.92	\$1,032.96
Employee/Child(ren)	\$777.17	\$997.38	\$1,013.02	\$787.80	\$1,008.76	\$1,022.66
Employee/Family	\$1,175.99	\$1,509.64	\$1,533.34	\$1,192.09	\$1,526.88	\$1,547.94
DENTAL (Only at Kaiser Facilities)	Kaiser - PPO - Other			Kaiser - PPO - Other		
Calendar Year Deductible	None			None		
Office Visits (Including Restorative Services)	\$10 Copay			None		
Prosthetic Devices, Periodontics & Endodontics	50%			None		
Max Annual Benefit	Unlimited			None		
Orthodontics	Not Covered			None		
Annual Maximum Benefit	None			None		
KAISER DENTAL ONLY PREMIUMS (Group # 1568-173)						
Kaiser dental coverage can be added to any medical plan						
Add these premiums to medical rates above or on other side						
			Employee	\$48.94		
			Employee/Spouse	\$97.89		
			Employee/Child(ren)	\$96.91		
			Employee/Family	\$146.83		

Premiums shown above include a \$3.00 per employee administrative charge, \$1.25 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.



MULTNOMAH BAR ASSOCIATION
EST 1906

GROUP INSURANCE SUMMARY BROCHURE
Rates Effective 4/1/2010 - 3/31/2011

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Portland, Oregon 97213
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