Multnomah Bar Association

Providence SIGNATURE PPO

	GOLD SIGNATURE PPO	SILVER SIGNATURE PPO	H.S.A. 3500 SIGNATURE PPO	H.S.A. 6650 SIGNATURE PPO
Rates Effective: 4/1/2022 - 3/31/2023	**To Find Providers for the Providence SIGNATURE NETWORK go to: ProvidenceHealthPlan.com/findaprovider (Select Signature PPO)**			
Deductible	$1,000	$2,500	$3,500	$6,650
Family Deductible	$2,000	$5,000	$7,000	$13,300
Out-of-Pocket Maximum	$7,350	$7,350	$6,750	$6,650
Family Out-of-Pocket Maximum	$14,700	$14,700	$13,500	$13,300
Network	Signature PPO	Signature PPO	Signature PPO	Signature PPO
Out of Network Benefit	$2,000 Ded. $14,700 OOPM Deductible, then 40%	$5,000 Ded. $14,700 OOPM Deductible, then 50%	$7,000 Ded, $13,500 OOPM Deductible, then 50%	$13,300 Ded, $13,300 OOPM Deductible, then 0%
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**	**After Deductible**	**After Deductible**
Office Visits (other than Preventive)	$35 Copay* (Virtual $10*)	$35 Copay* (Virtual $10*)	50% Coinsurance	Deductible, then 0%
Specialist Visits	$45 Copay* (Virtual $45*)	$45 Copay* (Virtual $45*)	50% Coinsurance	Deductible, then 0%
Outpatient Mental Health	$35 Copay*	$35 Copay*	50% Coinsurance	Deductible, then 0%
Facility Expenses	**After Deductible**	**After Deductible**	**After Deductible**	**After Deductible**
Inpatient Hospital	20% Coinsurance	30% Coinsurance	50% Coinsurance	Deductible, then 0%
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	30% Coinsurance	50% Coinsurance	Deductible, then 0%
Other Expenses	**After Deductible**	**After Deductible**	**After Deductible**	**After Deductible**
ER	$250 Copay	$250 Copay	50% Coinsurance	Deductible, then 0%
Urgent Care	$45 Copay*	$45 Copay*	50% Coinsurance	Deductible, then 0%
Lab & X-Ray (other than Preventive)	First $500 0%, then 20%	First $500 0%, then 30%	50% Coinsurance	Deductible, then 0%
MRI & CT Scans	20% Coinsurance	30% Coinsurance	50% Coinsurance	Deductible, then 0%
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**	**After Deductible**	**After Deductible**
Tier 1	$0 Copay*	$0 Copay*	50% Coinsurance	Deductible, then 0%
Tier 2	$10 Copay*	$10 Copay*	50% Coinsurance	Deductible, then 0%
Tier 3	$15 Copay*	$15 Copay*	50% Coinsurance	Deductible, then 0%
Tier 4	$45 Copay*	$45 Copay*	50% Coinsurance	Deductible, then 0%
Specialty Drugs	50% Copay ($200 Max Copay)*	50% Copay ($200 Max Copay)*	50% after deductible, up to $200	0% after deductible, up to $200
Alternative Care				
Alternative Care Definition	Chiropractic, Acupuncture	Chiropractic, Acupuncture	Chiropractic, Acupuncture	Chiropractic, Acupuncture
Alternative Care Benefit	$35 Copay*; 20/12 Visit Limit	$35 Copay*; 20/12 Visit Limit	50% after deductible; 20/12 Visit Limit	0% after deductible; 20/12 Visit Limit

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

This summary was designed for comparison purposes only. For detailed benefit summaries go to: https://aldrichadvisors.com/services/employee-benefits/mba/

Aldrich

Multnomah Bar Association

Providence EXTEND PPO

	GOLD EXTEND PPO	SILVER EXTEND PPO
Rates Effective: 4/1/2022 - 3/31/2023	**To Find Providers for the Providence EXTEND NETWORK go to: ProvidenceHealthPlan.com/findaprovider (Select EXTEND PPO)**	
Deductible	$1,000	$2,500
Family Deductible	$2,000	$5,000
Out-of-Pocket Maximum	$7,350	$7,350
Family Out-of-Pocket Maximum	$14,700	$14,700
Network	Extend PPO	Extend PPO
Out of Network Benefit	$2000 Ded. $14,700 OOPM Deductible, then 40%	$5000 Ded. $14,700 OOPM Deductible, then 50%
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**
Office Visits (other than Preventive)	$35 Copay* (Virtual $10*)	$35 Copay* (Virtual $10*)
Specialist Visits	$45 Copay* (Virtual $45*)	$45 Copay* (Virtual $45*)
Outpatient Mental Health	$35 Copay*	$35 Copay*
Facility Expenses	**After Deductible**	**After Deductible**
Inpatient Hospital	20% Coinsurance	30% Coinsurance
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	30% Coinsurance
Other Expenses	**After Deductible**	**After Deductible**
ER	$250 Copay	$250 Copay
Urgent Care	$45 Copay*	$45 Copay*
Lab & X-Ray (other than Preventive)	First $500 0%, then 20%	First $500 0%, then 30%
MRI & CT Scans	20% Coinsurance	30% Coinsurance
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**
Tier 1	$0 Copay*	$0 Copay*
Tier 2	$10 Copay*	$10 Copay*
Tier 3	$15 Copay*	$15 Copay*
Tier 4	$45 Copay*	$45 Copay*
Specialty Drugs	50% Copay ($200 Max Copay)*	50% Copay ($200 Max Copay)*
Alternative Care		
Alternative Care Definition	Chiropractic, Acupuncture	Chiropractic, Acupuncture
Alternative Care Benefit	$35 Copay*; 20/12 Visit Limit	$35 Copay*; 20/12 Visit Limit

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

This summary was designed for comparison purposes only. For detailed benefit summaries go to: https://aldrichadvisors.com/services/employee-benefits/mba/

Aldrich

Multnomah Bar Association

Providence CONNECT
(Portland Metro Area Only)

	PLATINUM CONNECT	GOLD CONNECT
Rates Effective: 4/1/2022 - 3/31/2023	**You must designate a Medical Home from the Providence CONNECT NETWORK: ProvidenceHealthPlan.com/findaprovider (Select CONNECT PPO)**	
Deductible	$500	$1,500
Family Deductible	$1,000	$3,000
Out-of-Pocket Maximum	$5,850	$7,350
Family Out-of-Pocket Maximum	$11,700	$14,700
Network	Connect PPO	Connect PPO
Out of Network Benefit	$1,000 Ded. $11,700 OOPM Deductible, then 50%	$3,000 Ded. $14,700 OOPM Deductible, then 50%
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**
Office Visits (other than Preventive)	$20 Copay* (Virtual $10*)	$35 Copay* (Virtual $10*)
Specialist Visits	$40 Copay* (Virtual $40*)	$70 Copay* (Virtual $70*)
Outpatient Mental Health	$20 Copay*	$35 Copay*
Facility Expenses	**After Deductible**	**After Deductible**
Inpatient Hospital	20% Coinsurance	20% Coinsurance
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	20% Coinsurance
Other Expenses	**After Deductible**	**After Deductible**
ER	$250 Copay	$250 Copay
Urgent Care	$40 Copay*	$70 Copay*
Lab & X-Ray (other than Preventive)	20% Coinsurance*	20% Coinsurance*
MRI & CT Scans	20% Coinsurance	20% Coinsurance
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**
Tier 1	$0 Copay*	$0 Copay*
Tier 2	$10 Copay*	$10 Copay*
Tier 3	$15 Copay*	$15 Copay*
Tier 4	$45 Copay*	$45 Copay*
Specialty Drugs	50% Copay ($200 Max Copay)*	50% Copay ($200 Max Copay)*
Alternative Care		
Alternative Care Definition	Chiropractic, Acupuncture	Chiropractic, Acupuncture
Alternative Care Benefit	$20 Copay*; 20/12 Visit Limit	$35 Copay*; 20/12 Visit Limit

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

This summary was designed for comparison purposes only. For detailed benefit summaries go to: https://aldrichadvisors.com/services/employee-benefits/mba/

Aldrich

Multnomah Bar Association

Providence CHOICE
(Outside Portland Metro Area)

	PLATINUM CHOICE	GOLD CHOICE
Rates Effective: 4/1/2022 - 3/31/2023	**You must designate a Medical Home from the Providence CHOICE NETWORK: ProvidenceHealthPlan.com/findaprovider (Select CHOICE PPO)**	
Deductible	$500	$1,500
Family Deductible	$1,000	$3,000
Out-of-Pocket Maximum	$5,850	$7,350
Family Out-of-Pocket Maximum	$11,700	$14,700
Network	Choice PPO	Choice PPO
Out of Network Benefit	$1,000 Ded. $11,700 OOPM Deductible, then 50%	$3,000 Ded. $14,700 OOPM Deductible, then 50%
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**
Office Visits (other than Preventive)	$20 Copay* (Virtual $10*)	$35 Copay* (Virtual $10*)
Specialist Visits	$40 Copay* (Virtual $40*)	$70 Copay* (Virtual $70*)
Outpatient Mental Health	$20 Copay*	$35 Copay*
Facility Expenses	**After Deductible**	**After Deductible**
Inpatient Hospital	20% Coinsurance	20% Coinsurance
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	20% Coinsurance
Other Expenses	**After Deductible**	**After Deductible**
ER	$250 Copay	$250 Copay
Urgent Care	$40 Copay*	$70 Copay*
Lab & X-Ray (other than Preventive)	20% Coinsurance*	20% Coinsurance*
MRI & CT Scans	20% Coinsurance	20% Coinsurance
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**
Tier 1	$0 Copay*	$0 Copay*
Tier 2	$10 Copay*	$10 Copay*
Tier 3	$15 Copay*	$15 Copay*
Tier 4	$45 Copay*	$45 Copay*
Specialty Drugs	50% Copay ($200 Max Copay)*	50% Copay ($200 Max Copay)*
Alternative Care		
Alternative Care Definition	Chiropractic, Acupuncture	Chiropractic, Acupuncture
Alternative Care Benefit	$20 Copay*; 20/12 Visit Limit	$35 Copay*; 20/12 Visit Limit

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

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Aldrich

Multnomah Bar Association

Kaiser Permanente

Rates Effective: 4/1/2022 - 3/31/2023	KAISER GOLD	KAISER GOLD PPO	KAISER SILVER	KAISER BRONZE	KAISER H.S.A.
Deductible	$1,000	$1,000	$1,500	$3,000	$5,000
Family Deductible	$3,000	$3,000	$4,500	$9,000	$10,000
Out-of-Pocket Maximum	$4,000	$4,000	$4,000	$7,350	$6,750
Family Out-of-Pocket Maximum	$12,000	$8,000	$12,000	$14,700	$13,500
Network	Kaiser Facilities	T1: Kaiser T2: First Choice T3: Non	Kaiser Facilities	Kaiser Facilities	Kaiser Facilities
Out of Network Benefit	Emergency Hospital Only	T2: $2,000 Ded; $6,000 OOPM T3: $3,000 Ded, then 60% to $7,500	Emergency Hospital Only	Emergency Hospital Only	Emergency Hospital Only
Physician Expenses	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**	***Indicates Deductible Waived**
Office Visits (other than Preventive)	$25 Copay* (Virtual $0*)	$25 Copay* (Virtual $0*) (T2: $35*)	$20 Copay* (Virtual $0*)	$30 Copay* (Virtual $0*)	50% Coinsurance
Specialist Visits	$35 Copay* (Virtual $0)	$35 Copay* (T2: $45*)	$20 Copay* (Virtual $0*)	$40 Copay* (Virtual $0*)	50% Coinsurance
Outpatient Mental Health	$25 Copay*	$25 Copay* (T2: $35*)	$20 Copay*	$30 Copay*	50% Coinsurance
Facility Expenses					
Inpatient Hospital	20% Coinsurance	20% Coinsurance (T2: 30%)	30% Coinsurance	20% Coinsurance	50% Coinsurance
Outpatient Hospital / Ambulatory Ce	20% Coinsurance	20% Coinsurance (T2: 30%)	30% Coinsurance	20% Coinsurance	50% Coinsurance
Other Expenses					
ER	20% Coinsurance	$200 Copay	$200 Copay	20% Coinsurance	50% Coinsurance
Urgent Care	$45 Copay*	$45 Copay* (T2: $55*)	$20 Copay* (Virtual $0*)	$50 Copay*	50% Coinsurance
Lab & X-Ray (other than Preventive)	$25 Copay*	$25 Copay* (T2: $35 Copay*)	30% Coinsurance	$30 Copay*	50% Coinsurance
MRI & CT Scans	$100 Copay *	$100 Copay* (T2: 30%)	30% Coinsurance	$100 Copay *	50% Coinsurance
Pharmacy (30 day supply)	**Deductible Waived**	**Deductible Waived**	**Deductible Waived**	**Deductible Waived**	**After Deductible**
Generic	* $20 Copay	* $15 Copay / (T2 *$20 Copay)	* $20 Copay	* $20 Copay	$15 Copay
Formulary Brand Name	* $40 Copay	* $30 Copay / (T2 *$40 Copay)	* $40 Copay	* $40 Copay	$30 Copay
Non Formulary Brand Name	* $60 Copay	* $50 Copay / (T2 *$60 Copay)	* $60 Copay	* $60 Copay	$50 Copay
Vision Exam	$25 Copay*	$25 Copay* (T2: $35 Copay*)	$20 Copay*	$30 Copay*	50% Coinsurance
Vision Lenses & Frames	$150 Allowance	$150 Allowance	$150 Allowance	$150 Allowance	50% Coinsurance
Alternative Care					
Alternative Care Definition	Acupuncture, Chiropractic, Massage	Acupuncture, Chiropractic, Massage	Acupuncture, Chiropractic, Massage	Not Covered	Not Covered
Alternative Care Benefit	$25 Copay*; 12/20/12 Visit Limit	$25 Copay* (T2 20%); 12/20/12 Visit Limit	$25 Copay*; 12/20/12 Visit Limit		

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

This summary was designed for comparison purposes only. For detailed benefit summaries go to: https://aldrichadvisors.com/services/employee-benefits/mba/

Aldrich

Multnomah Bar Association

Dental & Vision Benefits

Rates Effective: 4/1/2022 - 3/31/2023	MODA DENTAL	WILLAMETTE DENTAL	KAISER DENTAL
Calendar Year Deductible	$50 Per Person	No Deductible	No Deductible
Max Calendar Year Benefit	$2,000 Per Person	No Annual Maximum	No Annual Maximum
(Ded Waived for Preventive)	PPO - NON	$10 Copay	$10 Copay
Preventive Treatment	100% - 80%	100%	100%
Restorative	80% - 80%	100%	100%
Oral Surgery	80% - 80%	$80 Copay	100%
Root Canal	80% - 80%	$85 - $140 Copay	50%
Crowns	50% - 50%	$250 Copay	50%
Orthodontia (Adults and Children)	50% - 50% ($2,000 Max)	$1,500 Copay	50%
Implants	50% - 50% ($2,000/Yr Max.)	$1,500 Annual Benefit	Not Covered
Lifetime Max Ortho Benefit	$2,000	None	$2,000
Monthly Premiums	**MODA DENTAL**	**WILLAMETTE DENTAL**	**KAISER DENTAL**
Employee	$61.93	$54.59	$65.89
Employee/Spouse	$110.95	$94.90	$128.54
Employee/Child(ren)	$140.04	$118.20	$127.29
Emplyoee/Family	$178.84	$153.40	$191.18

Any dental plan may be added to any medical plan. MODA dental and Willamette Dental can be purchased with or without VSP coverage.

March open enrollment is the only time a person can enroll in or terminate dental and vision coverage.

	VSP
	With VSP Provider
Copay	$25 per person
Exams 1/12 mos	No Charge **
Lenses 1/12 mos	No Charge **
Frames 1/12 mos	Standard Allowance
Contacts	Up to $60 **
Contacts if Required	
Monthly Premiums	**VSP**
Employee	$7.53
Employee/Spouse	$10.60
Employee/Child(ren)	$10.94
Emplyoee/Family	$17.62

** Retail Frame allowance $200 / Elective Contact Lens allowance $150

A vision benefit is included with the Kaiser medical plan. VSP cannot be purchased alone, but can be added to either MODA or Willamette Dental.

Dental premiums shown include a $3.25 per employee administrative charge, $1.50 of which goes to the MBA.

This summary was designed for comparison purposes only. For detailed benefit summaries go to: https://aldrichadvisors.com/services/employee-benefits/mba/

Aldrich

BROKER COMPENSATION DISCLOSURE FORM

The following constitutes Aldrich Benefits' disclosure of direct and indirect compensation Aldrich Benefits will receive or reasonably expects to receive for the period of April 1, 2022 through March 31, 2023 in connection with the below referenced services it provides to Multnomah Bar Association groups.

For a description of services please see the attached Scope of Services.

Aldrich Benefits does not provide the above-referenced services to Client in the capacity of a plan fiduciary.

Aldrich Benefits reasonably expects to receive direct compensation for the placement of the below lines of coverage in the form of either a per employee per month ("PEPM") fee or a commission paid by the carrier or vendor, in the amount indicated below:

Coverage Line	Carrier/Vendor	PEPM, Standard Commission, Commission Schedule, or Compensation Calculation
Medical	Kaiser	Commission: 3%
Medical	Providence	Commission: 3%
Dental	Moda	Commission: 3%
Dental	Willamette	Commission: 3%
Dental	Kaiser	Commission: 3%
Vision	VSP	Commission: 10%
Medical	Aldrich Benefits, LP	PEPM: $1.75
Dental	Aldrich Benefits, LP	PEPM: $1.75

Other Compensation

Aldrich Benefits may earn additional compensation from any of the above referenced insurers, vendors, or other third parties that cannot be calculated as of the time this disclosure is made to you, or prior to the date Aldrich Benefits' executed, extended, or renewed contract with you is effective. For example, Aldrich Benefits may receive additional compensation contingent upon certain conditions being met, including, but not limited to, profitability, growth, churn/retention, or the volume of services provided. Compensation may be in the form of additional commissions, bonuses or benefits ("compensation"). Furthermore, we may receive corporate sponsorships for webinars, training or other programming we provide for you and other clients, or for our own internal trainings. Whether we receive any of the above referenced compensation, or how much that compensation may be, cannot be discerned at this time.

Should you have any questions about any of the above information or require additional information, please don't hesitate to contact Stephanie Carpentier at 503-716-9334 or scarpentier@aldrichadvisors.com.

The above information is accurate to the best of my knowledge as of the date this disclosure is executed above.

Tracey Davis
Aldrich Benefits, LP

Tracey Davis

Date: 4.1.2022 - 3.31.2023