Multnomah Bar Association

# Providence SIGNATURE PPO

## *MBA Health Plans*

| | GOLD SIGNATURE PPO | SILVER SIGNATURE PPO | H.S.A. 3500 SIGNATURE PPO | H.S.A. 6650 SIGNATURE PPO |
|---|---|---|---|---|
| **Rates Effective: 4/1/2024 - 3/31/2025** | **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) | 1st 3 Visits $5*, then $35 Copay* | 1st 3 Visits $5*, then $35 Copay* | 3 @ $0, then 50% | 3 @ $0, then 0% |
| Specialist Visits | $45 Copay* | $45 Copay* | 50% Coinsurance | Deductible, then 0% |
| Outpatient Mental Health | 1st 3 Visits $5*, then $35 Copay* | 1st 3 Visits $5*, then $35 Copay* | 3 @ $0, then 50% | 3 @ $0, 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 | Deductible, then 0% |
| **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 |

**This summary was designed for comparison purposes only.**

Multnomah Bar Association

# Providence EXTEND PPO

## *MBA Health Plans*

| | GOLD EXTEND PPO | SILVER EXTEND PPO |
|---|---|---|
| **Rates Effective: 4/1/2024 - 3/31/2025** | **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) | 1st 3 Visits $5*, then $35 Copay* | 1st 3 Visits $5*, then $35 Copay* |
| Specialist Visits | $45 Copay* | $45 Copay* |
| Outpatient Mental Health | 1st 3 Visits $5*, then $35 Copay* | 1st 3 Visits $5*, then $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 |

**This summary was designed for comparison purposes only.**

Multnomah Bar Association

# Providence CONNECT (Portland Metro Area Only)

## *MBA Health Plans*

| | PLATINUM CONNECT | GOLD CONNECT |
|---|---|---|
| **Rates Effective: 4/1/2024 - 3/31/2025** | **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) | 1st 3 Visits $5*, then $20 Copay* | 1st 3 Visits $5*, then $35 Copay* |
| Specialist Visits | $40 Copay* | $70 Copay* |
| Outpatient Mental Health | 1st 3 Visits $5*, then $20 Copay* | 1st 3 Visits $5*, then $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 |

**This summary was designed for comparison purposes only.**

Multnomah Bar Association

# Providence CHOICE
## (Outside Portland Metro Area)
### *MBA Health Plans*

| | PLATINUM CHOICE | GOLD CHOICE |
|---|---|---|
| **Rates Effective: 4/1/2024 - 3/31/2025** | **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) | 1st 3 Visits $5*, then $20 Copay* | 1st 3 Visits $5*, then $35 Copay* |
| Specialist Visits | $40 Copay* | $70 Copay* |
| Outpatient Mental Health | 1st 3 Visits $5*, then $20 Copay* | 1st 3 Visits $5*, then $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 |

**This summary was designed for comparison purposes only.**

Multnomah Bar Association

# Kaiser Permanente

## *MBA Health Plans*

| Rates Effective: 4/1/2024 - 3/31/2025 | 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<br>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) | 3 @ $5* (shared) then $25 Copay* | First 3 Primary and MH Visits at $5*<br>$25 Copay* (Virtual $0*) (T2: $35*) | 3 @ $5* (shared) then $20 Copay* | 3 @ $5* (shared) then $30 Copay* | 3 @ $5 (shared) then 50% |
| Specialist Visits | $35 Copay* | $35 Copay* (T2: $45*) | $20 Copay* | $40 Copay* | 50% Coinsurance |
| Outpatient Mental Health | 3 @ $5* (shared) then $25 Copay* | $25 Copay* (T2: $35*) | 3 @ $5* (shared) then $20 Copay* | 3 @ $5* (shared) then $30 Copay* | 3 @ $5 (shared) then 50% |
| **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 | $150 Allowance |
| **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 | | |

**This summary was designed for comparison purposes only.**

Multnomah Bar Association

# Dental & Vision Benefits

| Rates Effective: 4/1/2024 - 3/31/2025 | 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% | $1,500 Copay | 50% |
| Implants | 50% - 50% | $1,500 Annual Benefit | Not Covered |
| Lifetime Max Ortho Benefit | $2,000 | None | $2,000 |

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

**Open enrollment is the only time a person can enroll unless there is a qualifying event.**

| | 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 | |

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

**A vision benefit is included with the Kaiser medical plan. VSP cannot be purchased as a stand alone benefit, but can be added to either MODA or Willamette Dental. This summary was designed for comparison purposes only.**

# BROKER COMPENSATION DISCLOSURE FORM

The following constitutes Alliant Insurance Services, Inc. disclosure of direct and indirect compensation Alliant Insurance Services, Inc. will receive or reasonably expects to receive for the period of April 1, 2024 through March 31, 2025 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.**

Alliant Insurance Services, Inc. does not provide the above-referenced services to Client in the capacity of a plan fiduciary. Alliant Insurance Services, Inc. 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 | Alliant Insurance Services, Inc. | PEPM: $1.75 |
| Dental | Alliant Insurance Services, Inc. | PEPM: $1.75 |

**Other Compensation**

Alliant Insurance Services, Inc. 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 Alliant Insurance Services, Inc. executed, extended, or renewed contract with you is effective. For example, Alliant Insurance Services, Inc. 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 stephanie.carpentier@alliant.com.

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

Tracey Davis

Date: April 2024 - March 2025