Your Benefit Summary

SAIF Corporation

Active Plan - January 1, 2026

Providence Health Plan | POWERED BY Collective Health

Office Visit Copay	Hospital Coinsurance	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$25/$35	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$2,350 per person $4,700 per family (2 or more)	$4,700 per person $9,400 per family (2 or more)	$400 per person $800 per family (2 or more)	$800 per person $1,600 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, http://my.collectivehealth.com

- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- Some services and penalties do not apply to out-of-pocket maximums.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- To get the most out of your benefits, use the providers within the EPO network. View a list of network providers and pharmacies at http://join.collectivehealth.com/saif-php
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Prior authorization is required for some services.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible, then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Providence ExpressCare Retail Health Clinic visits	Covered in full✓	Not applicable
• Providence ExpressCare Virtual	Covered in full✓	Not applicable
Preventive Health and Wellness Services		
• Periodic health exams and well baby care	Covered in full✓	40%✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%✓
• Mammogram	Covered in full✓	40%✓
• Prostate screening exam (calendar year)	Covered in full✓	40%✓
• Colorectal exam	Covered in full✓	40%✓
• Colorectal cancer screening: sigmoidoscopy, colonoscopy	Covered in full✓	40%
• The following tests (when received with your health maintenance exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full✓	40%✓
• The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet	Covered in full✓	40%✓
• Pneumococcal vaccine	Covered in full✓	40%✓
• Flu vaccine	Covered in full✓	40%✓
• Routine immunizations/shots	Covered in full✓	40%✓
• Nutritional counseling	Covered in full✓	40%✓
• Hearing screenings	Covered in full✓	40%✓
• Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and over the counter. Medications must be purchased at a participating pharmacy.	Covered in full✓	Not covered

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Physician / Provider Services		
• Office visits to Primary Care Provider or Naturopath (In-person) (First 3 in-network in-person visits to a Primary Care Provider or Naturopath: $5, deductible waived, then cost-share applies)	$25 / visit✓	40%✓
• Office visits to Primary Care Provider or Naturopath (Virtually)	Covered in full✓	Not covered
• Office visits to Specialist (In-person)	$35 / visit✓	40%✓
• Office visits to Specialist (Virtually)	Covered in full✓	Not covered
• Office visits to Alternative Care Provider (in-person)	$25 / visit✓	$25 / visit✓
• Office visits to Alternative Care Provider (virtually)	Covered in full✓	Not covered
• Allergy shots, serums, infusions and injectable medications	$25 / visit	40%
• Inpatient hospital visits	$25 / visit	40%
• Surgery; anesthesia at provider's office	$25 / provider	40%
• Surgery; anesthesia at facility	$100 / provider	40%
Diagnostic Services		
• Lab and testing services (includes ultrasound)	20%	40%
• X-ray services	20% per provider, per day	40%
• High-tech imaging services (such as PET, CT or MRI)	20% per provider, per day	40%
• Diagnostic and supplemental breast exam	Covered in full✓	40%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$150	$150**
• Urgent care services (for non-life threatening illness/minor injury)	$35 / visit✓	$35 / visit✓
• Emergency medical transportation (air and/or ground)	$150	$150**
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (30 days per calendar year)	20%	40%
• Skilled nursing facility (60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Bariatric surgery	20%	40%
Outpatient Services		
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	20%	40%
• Bariatric surgery for morbid obesity	20%	40%
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	Covered in full✓	40%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime) (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	20%	40%
• Chiropractic manipulation (Limited to 30 visits per calendar year)	$25 / visit✓	$25 / visit✓
• Acupuncture (Limited to 24 visits per calendar year)	$25 / visit✓	$25 / visit✓
• Massage therapy (Limited to 24 visits per calendar year)	$25 / visit✓	$25 / visit✓
Maternity Services		
• Prenatal care	Covered in full✓	40%
• Delivery and postnatal services	$250 / delivery✓	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%✓	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies	20%✓	40%
• Diabetes supplies (such as lancets, test strips and needles)	Covered in full✓	40%
• Removable custom shoe orthotics	20%✓	40%✓
• Hearing aids (one per ear every three calendar years; in-network deductible applies)	20%✓	40%

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Mental Health / Substance Use Disorder		
Services except outpatient provider office visits may require prior authorization.		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	20%**
• Outpatient provider office visits (In-person) (First 3 in-network in-person visits: $5, deductible waived, then cost-share applies)	$25 / visit✓	40%✓
• Outpatient provider office visits (Virtually)	Covered in full✓	Not covered
Home Health and Hospice		
• Home health care	Covered in full✓	40%
• Hospice care	Covered in full✓	Covered in full✓
• Respite Care (Limited to 5 consecutive days; 30 days per lifetime)	Covered in full✓	40%
Fertility Services		
• Fertility treatments are administered through Progyny. Please call (833) 233-0843 to activate benefit. Infertility diagnosis is not required. (Limited to 2 Progyny Smart Cycles per lifetime, with option to restart the cycle if the first is unsuccessful)	20%*	Not covered (call Progyny to find a provider)

*Cost share does not apply to out-of-pocket maximums.
**In-network deductible applies.

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:
- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible.

Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Office Visits Virtually
Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

Out-of-Network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to http://join.collectivehealth.com/saif-php

Out-of-Pocket Maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

Personal Physician/Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Providence ExpressCare Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries.

Providence ExpressCare Virtual
Sevices for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments.

Prior authorization
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

(844) 945-4148

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: http://join.collectivehealth.com/saif-php