Administered by PROVIDENCE Health Plan

Your Benefit Summary

SAIF Corporation
Well-Aware and Engaged Plan
January 1, 2020

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 $7,050 per family (3 or more)	$9,400 per person $28,200 per family (3 or more)	$350 per person $1,050 per family (3 or more)	$1,050 per person $3,150 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.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 www.ProvidenceHealthPlan.com/providerdirectory.
- 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		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	Covered in full✓	Not covered
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	$25 / visit✓	40%✓
• Office visits to specialist	$35 / visit✓	40%✓
• Office visits to Alternative Care Provider (such as Naturopath)	$25 / visit✓	$25 / visit✓
• 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 [f](includes ultrasound)[/f8]	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%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$150	$150, in-network deductible applies
• Urgent care services (for non-life threatening illness/minor injury)	$35 / visit✓	$35 / visit✓
• Emergency medical transportation (air and/or ground)	$150	$150, in-network deductible applies
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
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, acupuncture, and massage therapy ($1,500 calendar year maximum combined; does not apply to out-of-pocket maximum)	$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 (Limited to $200 per calendar year)	20%	40%
• Hearing aids (one per ear every three calendar years; in-network deductible applies)	20%	40%
Mental Health and Substance Abuse (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient, and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	20%, in-network deductible applies
• Outpatient provider visits	$25 / visit✓	40%✓
Home Health and Hospice		
• Home health care	Covered in full✓	40%
• Hospice care	Covered in full✓	Covered in full✓

* Please see Summary Plan Description for specific requirements to receive this benefit
** 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.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

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.

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 www.ProvidenceHealthPlan.com/providerdirectory.

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.

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.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)