

2025 SAIF Providence medical plan

	Completes the Wellness Rewards Program requirements*		Does not complete the Wellness Rewards Program requirements*	
Coverage level	SAIF monthly cost	Employee monthly cost	SAIF monthly cost	Employee monthly cost
Employee only	\$775.92	\$0.00	\$725.92	\$50.00
Employee + spouse or domestic partner	\$1,542.63	\$0.00	\$1,442.63	\$75.00
Employee + child(ren)	\$1,441.41	\$0.00	\$1,366.41	\$100.00
Employee + family	\$2,367.55	\$0.00	\$2,217.55	\$150.00
Monthly spouse/domestic partner premium share	Employee monthly cost			
Spouse/partner has no access to other employer-sponsored medical coverage	\$0			
Spouse/partner is enrolling in your SAIF medical plan as a secondary plan	\$150			
Spouse/partner is enrolling in your SAIF medical plan in lieu of their employer’s plan	\$300			
Deductible & out-of-pocket expenses	Copay or coinsurance (in-network)		Copay or coinsurance (out-of-network)	
The Providence plan offers deductible carryover, which means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied towards next year’s deductible(s).				
Annual individual deductible	\$400		\$800	
Annual family deductible (2 or more)	\$800		\$1,600	
Annual individual out-of-pocket maximum	\$2,350		\$4,700	
Annual family out-of-pocket maximum (2 or more)	\$4,700		\$9,400	
On-demand provider visits	Copay or coinsurance (in-network)		Copay or coinsurance (out-of-network)	
Providence ExpressCare retail health clinic	Covered in full ✓		Not applicable	
Providence ExpressCare virtual	Covered in full ✓		Not applicable	
Preventive care services	Copay or coinsurance (in-network)		Copay or coinsurance (out-of-network)	
Gynecological exams (calendar year) and pap tests	Covered in full ✓		40% ✓	
Periodic health exams and well-baby care	Covered in full ✓		40% ✓	
Mammogram	Covered in full ✓		40% ✓	
Prostate screening exam (calendar year)	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% ✓	

Nutritional counseling	Covered in full ✓	40% ✓
Routine immunizations/shots	Covered in full ✓	40% ✓
Colorectal exam	Covered in full ✓	40% ✓
Colorectal cancer screening: sigmoidoscopy, colonoscopy	Covered in full ✓	40%
Hearing screenings	Covered in full ✓	40% ✓
Tobacco cessation; counseling/classes, and deterrent medications (including Rx's and OTC). Medications must be purchased at a participating pharmacy.	Covered in full ✓	Not covered
Professional and outpatient services	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
Office visits to primary care provider or Naturopath (in-person); the first 3 in-network, in-person visits: \$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 ✓	40% ✓
Office visits to specialist (virtually)	Covered in full ✓	Not covered
Alternative care providers (in-person): <ul style="list-style-type: none"> • Chiropractic services (30 visit limit) • Acupuncture (24 visit limit) • Massage therapy (24 visit limit) 	\$25 ✓	\$25 ✓
Alternative care providers (virtually)	Covered in full ✓	Not covered
Allergy shots, serums, infusions and injectable medications	\$25/visit	40% ✓
Physician visit while inpatient hospital	\$25/visit	40% ✓
Surgery: anesthesia at provider's office	\$25/provider	40%
Surgery: anesthesia at facility	\$100/provider	40%
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%
Diagnostic services	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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%
Hospital services	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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) service (inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)	50%	Not covered
Bariatric surgery**	20%	40%
Maternity care	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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%
Fertility services	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
<ul style="list-style-type: none"> Fertility treatments are administered through Progyny. Call (833) 233-0843 to activate your 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. Covers artificial insemination, ART, IVF, GIFT, ZIFT. Click here for more information. Click here for a list of covered providers. 	20%	Not covered (call Progyny to find a covered provider)
Medical, equipment, supplies, devices	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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; click here to order)	20% ✓	40%
Emergency and urgent services	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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
Home health and hospice	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
Home health care	Covered in full ✓	40%
Hospice care	Covered in full ✓	Covered in full ✓
Mental health and substance use disorder	Copay or coinsurance (in-network)	Copay or coinsurance (out-of-network)
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); the 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
Prescription drugs	Copays/coinsurance apply to your medical out-of-pocket maximum	
Participating and preferred retail pharmacies (limited to 30-day supply) <ul style="list-style-type: none">Retail pharmaciesPreferred retail pharmacies		
ACA preventive drugs	Covered in full ✓	
Preferred generic drug	\$10 ✓	
Non-preferred generic drug	\$30 ✓	
Preferred brand-name drug	\$30 ✓	
Non-preferred brand drug	50% up to \$100 max ✓	
Mail-order prescription drugs (up to 90-day supply) from these vendors: <ul style="list-style-type: none">Costco Home DeliveryPostal Prescription Services		
ACA preventive drugs	Covered in full ✓	
Preferred generic drug	\$20 ✓	
Non-preferred generic drug	\$60 ✓	
Preferred brand-name drug	\$60 ✓	
Non-preferred brand drug	50% up to \$200 max ✓	
Participating specialty pharmacies (limited to 30-day supply) from this vendor: <ul style="list-style-type: none">Credena Health		
Specialty drug	50% up to \$100 max ✓	

* **Wellness Rewards Program:** To qualify for the medical plan premium waiver in 2026, you'll need to complete two required activities and two additional activities within the Wellness Rewards Program year—running from October 1, 2024, to September 30, 2025. Spouses/partners are not required to participate in the Wellness Rewards Program requirements. Employees hired between April 1 and September 30 are exempt from the Wellness Rewards Program requirements for this program year but are encouraged to participate. The Wellness Rewards Program requirements include:

1. Complete the **Health Check** survey in Virgin Pulse
2. Complete a **preventive care activity** and document it in Virgin Pulse. The preventive care attestation form can be found under the Benefits tab or My Care Checklist in Virgin Pulse. You do not need to submit documentation from your provider. Preventive care activities can include a biometric screening, annual exam, dental exam, vision exam, cancer screening, mental health counseling or coaching appointment, or any other health exam recommended by your health care provider.
3. Complete **TWO** of the following of your choice:
 - Earn 32,000 points in Virgin Pulse
 - Participate in two corporate challenges in Virgin Pulse
 - Complete two Journeys in Virgin Pulse
 - Join meQuilibrium and complete the initial assessment
 - Complete a meQuilibrium re-assessment

**To locate an approved facility for bariatric surgery, click [here](http://www.providencehealthplan.com/findaprovider). Not all approved facilities are considered in-network. Facilities must be verified by using the Providence provider directory: <http://www.providencehealthplan.com/findaprovider>

***For outpatient rehabilitation services, your provider will make a notification for services through an outside authorizing agent, EviCore. A notification is the initial request submitted to EviCore to inform Providence that you are starting physical therapy and/or occupational therapy services. EviCore determines if the requests are approved or require medical necessity review. For more information, visit our website at ProvidenceHealthPlan.com/OutpatientRehab.

✓ No deductible needs to be met prior to receiving this benefit.

This is not an all-inclusive summary of SAIF's policies with this health care provider and does not fully describe your benefits coverage. For more detailed information on your benefits, please refer to the [online member handbook](#) or call Membership Services.