Your Benefit Summary

Option Advantage Premium

Bend Chamber of Commerce - Premier Plan

Providence Health Plan

Copay	What You Pay In-Network	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 Common Deductible
$25/$50	20% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$6,000 per person $12,000 per family (2 or more)	$6,000 per person $12,000 per family (2 or more)	$1,000 per person $2,000 per family (2 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 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.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Accident Benefit: The first $1,000 of covered services within 90 days of an accident is covered up to the maximum benefit available and not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. If date of injury occurred prior to being enrolled on this plan, the benefit will not apply. The balance is covered as shown below. See your member handbook for further details.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network plus OHSU. View a list of in-network providers and pharmacies at ProvidenceHealthPlan.com/findaprovider
- 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.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.
- Learn more about covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare .

Option Advantage Premium Benefit Highlights ✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), 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 Virtual	Covered in full ✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full ✓	Not applicable
Preventive Care		
• Periodic health exams and well-baby care	Covered in full ✓	50%
• Routine immunizations; shots	Covered in full ✓	50%
• Colonoscopy (Age 45+)	Covered in full ✓	50%
• Gynecological exam (calendar year) and PAP test	Covered in full ✓	50%
• Mammograms	Covered in full ✓	50%
• Nutritional counseling	Covered in full ✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
• Diabetes self management education	Covered in full ✓	Covered in full ✓

Option Advantage Premium 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 and virtual visits: covered in full, deductible waived, then copay.)	$25 / visit✓	50%
• Office visits to Primary Care Provider or Naturopath (Virtually) (First 3 in-network in-person and virtual visits: covered in full, deductible waived.)	Covered in full✓	50%
• Office visits to Specialists/Other Providers (In-person & Virtually)	$50 / visit✓	50%
• Office visits to an Alternative Care Provider (In-person and Virtually)	$25 / visit✓	50%
• Chiropractic Manipulations (limited to 20 visits per calendar year)	$25 / visit✓	$25 / visit✓
• Acupuncture (limited to 12 visits per calendar year)	$25 / visit✓	$25 / visit✓
• Allergy shots and serums	$5✓	50%
• Infusions and injectable medications	20%	50%
• Surgery; anesthesia in an office or facility	20%	50%
• Inpatient hospital visits	20%	50%
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%✓	50%
• High-tech imaging services (such as PET, CT or MRI)	20%	50%
• Diagnostic and supplemental breast exam	Covered in full✓	50%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250 + 20%✓	$250 + 20%✓
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit✓	50%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health or Substance Use Disorder Services.)	20%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health or Substance Use Disorder Services.)	20%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	50%
• 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, infusion, dialysis, chemotherapy, radiation therapy, osteopathic manipulation, pain management (multi-disciplinary) program	20%	50%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	50%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	50%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	50%
• Outpatient rehabilitative physical therapy, occupational, and speech therapy. (Limited to 30 visits per calendar year. Limits do not apply to Mental Health/Substance Use Disorder Services.)	20%✓	50%
• Outpatient habilitative physical therapy, occupational, and speech therapy. (Limited to 30 visits per calendar year. Limits do not apply to Mental Health/Substance Use Disorder Services.)	20%✓	50%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	20%	50%
• Biofeedback for specified diagnosis (limited to 10 visits per lifetime, limits do not apply to Mental Health/Substance Use Disorder Services)	20%	50%
• Vision therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	20%✓	50%
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	20%	50%
• Inpatient hospital/facility services	20%	50%
• Routine newborn nursery care	20%✓	50%

Option Advantage Premium Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years, in-network deductible waived)	20%	50%
• Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors)	20%✓	50%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	20%✓	50%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	50%
Mental Health / Substance Use Disorder		
Services except outpatient provider office visits may require prior authorization.		
• Inpatient and residential services	20%	50%
• Day treatment, intensive outpatient and partial hospitalization services	20%	50%
• Applied behavior analysis	20%	50%
• Outpatient provider office visits (In-person) (First 3 in-network virtual and in-person visits: covered in full, deductible waived, then copay.)	$25 / visit✓	50%
• Outpatient provider office visits (Virtually) (First 3 in-network virtual and in-person visits: covered in full, deductible waived.)	Covered in full✓	50%
Home Health and Hospice		
• Home health care	20%	50%
• Hospice care	Covered in full✓	Covered in full✓

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.

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 ervices 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 ProvidenceHealthPlan.com/findaprovider.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Primary Care 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-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

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.

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status 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
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: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*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

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).

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

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

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

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

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

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

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

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

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

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).

Your Benefit Summary

Prescription Drug Plan

Formulary B: Preventive

Bend Chamber of Commerce

Providence Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at myprovidence.com.

- Medicare Part D creditable.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at ProvidenceHealthPlan.com or call us.
- You have broad access to our network of participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at myprovidence.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty drugs)
1 - Preferred generic drug	$5	$10	N/A
2 - Non-preferred generic drug	$10	$20	
3 - Preferred brand-name drug	$50	$100	
4 - Non-preferred brand-name drug	$75	$150	
5 - Specialty drugs	N/A	N/A	30%

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any participating pharmacy.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you request a brand-name drug when a generic is available, you will be responsible for the difference in cost between the brand-name and generic drug in addition to your brand-name drug copayment/coinsurance, unless your physician indicates "dispense as written" (DAW).
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a greater than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost.
- Approved non-formulary medications will be covered at the non-preferred brand-name drug tier. Approved non-formulary specialty drugs will be covered at the specialty cost sharing tier.
- If you take an eligible specialty medication, the Specialty Pharmacy Variable Copay Program helps lower your out-of-pocket costs to $0. The list of medications eligible for this program is available at http://ProvidenceHealthPlan.com/smartrxassist. Refer to your handbook for more information.
- Your prescription drug benefit includes a $0 co-pay, with no deductible for certain preventive medications. Preventive drugs are taken regularly to help prevent or limit the development of specific diseases or conditions.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using preferred retail or mail order pharmacy after the initial 30-day supply purchase. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and covered under your prescription benefit. Refer to your formulary and Member Handbook for additional details.
- Certain drugs, devices and supplies obtained from your pharmacy may apply toward your medical benefit.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a prior authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to your medical benefit.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website.
- Effective generic drug choices are available to treat most medical conditions. Visit ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.
- Insulin cost share capped at $85 for a 30-day supply. Deductible does not apply.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

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

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary. They are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over-the-counter preventive drugs received from Participating Pharmacies will not be covered in full without a written prescription from your Qualified Practitioner under your ACA preventive drug benefit. Over-the-counter contraceptives do not require a written prescription, as required by ORS 743A.067(2(j)(C) or 743A.067(4).

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

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.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least a month's supply and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition, and are limited to a 30-day supply.

Non-Formulary
An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a prior authorization by the health plan and, if approved, will be covered at either the highest non-specialty or specialty cost sharing tier.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Preferred brand-name drug / Non-preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Non-preferred brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

Preferred generic drug / Non-preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Generally your out-of-pocket costs will be less for Preferred generic drugs.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at www.ProvidenceHealthPlan.com

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Your Benefit Summary

Vision $400 Plan

Bend Chamber of Commerce

Providence Health Plan

Important information about your plan

- Vision care services do not apply to out-of-pocket maximums.
- You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your vision care benefit.
- For the service to be a covered benefit, you must receive all of your vision services and supplies care from a licensed eye care provider.
- Benefits are not administered through VSP.
- Providers can confirm eligibility by calling Providence Health Plan Customer Service. Portland Metro Area: 503-574-7500 All other areas: 800-878-4445

Benefits

Your Providence Health Plan vision benefit provides coverage as follows:

- Adults: up to $400 per calendar year (including exam, prescription lenses, contact lenses and frames)
- Pediatric vision services (covered in full):
  - Pediatric vision exam
  - Frames (Limited to one pair per calendar year)
  - Lenses (Including single vision, lined bifocal, lined trifocal, lenticular lenses, as well as polycarbonate, scratch and UV resistant)
  - Contacts (Instead of glasses. Includes contact lens exam and annual supply of contact lenses)

Using your vision plan benefit

- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.
  Submit claims to:

  Providence Health Plan
  Attn: Claims Dept.
  P.O. Box 3125
  Portland, OR 97208-3125

Exclusions

- Orthoptic or vision training
- Subnormal vision aids, aneseikonic lenses, or Plano (non-prescription lenses) glasses
- Sunglasses
- All materials not listed as covered benefits
- Services and supplies received outside of the United States
- Deluxe frames for pediatrics

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

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Please contact a service representative for assistance.

Customer Service
503-574-7500 or
800-878-4445
M-F, 8 am to 5 pm

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