

What do I contribute in monthly premiums?

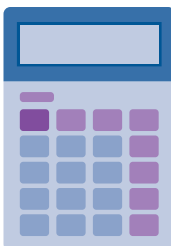
Your employer pays a large portion of the monthly premium costs for your core benefits (medical, dental, vision). Many employees only pay 1% to 5% of those monthly costs, depending on:

- your agency or university employer
- the plan you choose
- where you live
- your work status (full-time or part-time)

Note: Part-time employees may pay more depending on hours worked. Contact your payroll office for a more accurate estimate.

Use the Premium Estimator Tool to see what you may pay each month.

<https://pebbpremiumestimator.com>



This information gives a high-level summary only. See plan documents for details.

2025 PEBB dental plans summary comparison							
Vendor Dental Plan	Kaiser Dental	Delta Dental PPO		Delta Dental Premier ¹	Willamette Dental Group ⁷	Kaiser Dental	Delta Dental Premier ¹
Work status	Full-time and part-time	Full-time and part-time		Full-time and part-time	Full-time and part-time	Part-time only	Part-time only
Network	Kaiser network	In network	Out of network	Participating providers	Willamette Dental Group dentists	Kaiser network	Participating providers
Deductible: individual/family	None	\$50/\$150	\$50/\$150	\$50/\$150	None	None	\$50
Annual max coverage	\$1,750	\$1,750	\$1,750	\$1,750	No annual max ⁶	\$1,250	\$1,250
Diagnostic and preventive services	\$0 ²	0% ² , no deductible	10% ² , no deductible	0% ² , no deductible	Covered with office visit copay	\$0 ²	0% ²
Basic and maintenance services	\$5 copay + 20%	20%-year 1 ⁴ 10%-year 2 ⁴ 0%-year 3 ⁴	30%	20%	\$20 copay for fillings, other basic services covered with office visit copay	\$5 copay + 50%	50%
Crowns	\$5 copay + 25%	50%	50%	50%	\$250 copay	\$5 copay + 50%	50%
Implants	\$5 copay + 50%	50%	50%	50%	\$1,500/year ⁵	Not covered	Not covered
Dentures	\$5 copay + 50%	50%	50%	50%	\$290 copay	\$5 copay + 50%	50%
Orthodontia	\$5 copay + 50%, up to \$1,500 lifetime ³	50%, up to \$1,800 lifetime ³	50%, up to \$1,800 lifetime ³	50%, up to \$1,800 lifetime ³	\$2,500 copay	Not covered	Not covered

¹ Members can utilize any licensed providers on the Premier plans and receive in-network benefit level. However, the out-of-network providers may bill you for any amount above the max plan allowance.
² Preventive services will not accrue toward the plan max.
³ The \$1,500 (Kaiser) and \$1,800 (Delta Dental) lifetime max coverage is separate from the \$1,750 annual max coverage.
⁴ Benefits payments increase by 10% each plan year provided the member has visited a Delta Dental PPO provider at least once during the plan year.
⁵ For implant surgery only.
⁶ Benefits for implant surgery have a benefit max.
⁷ A \$10 office visit copay applies to each office visit.



Vision Services Plan (VSP) Basic Plan

Benefit	Description	Copay	Frequency
Well vision exam	Focuses on your eyes and overall wellness	\$10	Each calendar year
Prescription glasses		\$25	Each calendar year
Frames	<ul style="list-style-type: none"> • \$150 allowance for a wide selection of frames • \$170 allowance for featured frame brands • 20% savings on the amount over your allowance • \$150 Walmart®/Sam's Club® frame allowance • \$80 Costco® frame allowance 	Included in prescription glasses	Each calendar year
Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal and lined trifocal lenses • Impact-resistant lenses for dependent children 	Included in prescription glasses	Each calendar year
Lens enhancements	<ul style="list-style-type: none"> • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements 	\$0 \$80-\$90 \$120-\$160	Each calendar year
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) 	Up to \$60	Each calendar year
Lightcare	• \$150 allowance for ready-made non-prescription sunglasses or blue light filtering glasses instead of prescription glasses or contacts	\$25	Each calendar year
Vision Therapy	• Fully covered evaluation. 75% off approved therapy sessions up to \$750 annually	25% of approved therapy sessions	Every 12 months

VSP Plus Plan (includes Basic Plan coverage)

Benefit	Description	Copay	Frequency
Frames	<ul style="list-style-type: none"> • \$225 allowance for a wide selection of frames • \$245 allowance for featured frame brands • 20% savings on the amount over your allowance • \$225 Walmart®/Sam's Club® frame allowance • \$125 Costco® frame allowance 	Included in prescription glasses	Each calendar year
Lenses	Anti-reflective coatings and premium & custom progressive lenses	Each covered in full after \$20 copay	Each calendar year
	Standard progressive lenses	\$0	
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$225 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • 15% savings on contact lens (fitting and evaluation) 	Up to \$60	Each calendar year
Lightcare	• \$225 allowance for ready-made non-prescription sunglasses or blue light filtering glasses instead of prescription glasses or contacts	\$25	Each calendar year
Retinal Screening	High-resolution imaging systems take pictures of the inside of the eye	\$10	Each calendar year

Note: Kaiser Permanente medical plan coverage includes vision benefits. See the medical plan summary comparison for details.



2025 Summary of Benefits



Public Employees' Benefit Board

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2025 PEBB Summary of Benefits



**Open Enrollment
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