2024 PEBB Summary of Benefits

Mandatory Open Enrollment October 1–31

pebb
Public Employees' Benefit Board

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

2024 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, except the first new patient preventive visit for members who have not previously seen a participating provider.

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	See Frames, and Lenses
Frames	• $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	• Single vision, lined bifocal and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in prescription glasses	Each calendar year
Lens enhancements	• 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)	• $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	• $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 Standard progressive lenses	Each covered in full after $20 copay $0	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
Please note, Kaiser Permanente vision benefits are included in the medical coverage and can be found on the medical summary comparison.			

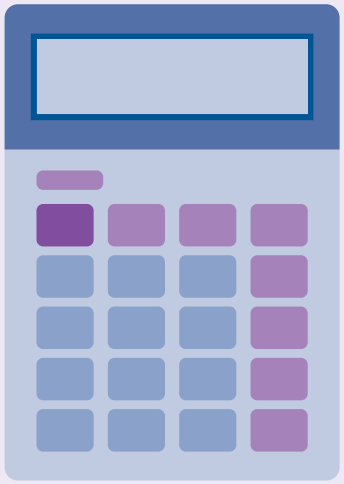
What do I contribute in monthly premiums?

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)

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

PEBBPremiumEstimator.com



Full-time and part-time medical plans

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Standard deductible[2]	$250/individual, $750/family	$0	$250/individual, $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family
Additional non-HEM participant deductible applies to all services unless otherwise noted	$100/individual, $300/family	$100/individual, $300/family	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$600/individual, $1,200/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family	$1,900/individual, $5,700 family	$4,800/individual, $14,400/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family
Primary care visit	$5, deductible waived	$5	$10[13] first four visits, deductible waived	30%	15% or 10%[3] first four visits, deductible waived	30%	$10 first four visits, deductible waived	30%
Chronic care visit[4]	$5, deductible waived	$5	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Specialty care visit	$5 with referral, deductible waived	$5 with referral	$10	30%	15%	30%	$10	30%

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Outpatient mental health care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10 deductible waived	30%
Substance Use Disorder Treatment	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Maternity prenatal and postnatal services	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Delivery facility charges	Included with maternity services and professional delivery	Included with maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges
Fertility services	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Lab and X-ray	$15, deductible waived	$0	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Inpatient hospital per admission[11]	$50/day up to $250 max	$50/day, up to $250 max	$50/day, up to $250 max	$500 + 40%	15%	$500 + 40%	$50/day, up to $250 max	$500 + 40%
Outpatient surgery in a hospital setting[11]	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25
Emergency department[5]	$150	$150	$150	$150	$150 + 15%	$150 + 15%	$150	$150
Durable medical equipment	15%, deductible waived	$0	15%	30%	15%	30%	15%	30%
Insulin, diabetic supplies	$0, deductible waved	$0	$0, deductible waived[14]	$0, deductible waived[14]	0%, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[6] copay/$500[7] copay – does not apply to Kaiser)	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	$100[6]/$500[7]	$100[6] + 30%/ $500[7] + 30%	$100[6] + 15%/ $500[7] + 15%	$100[6] + 30%/ $500[7] + 30%	$100[6]/$500[7]	$100[6] + 30%/ $500[7] + 30%

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Spinal manipulation and acupuncture[11]	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	30%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	15%, up to 60 services/year max combined. Not applied to out-of-pocket max	30%, up to 60 services/year max combined. Not applied to out-of-pocket max	$10; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max	30%; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max
Massage therapy services[11,12]	$25, deductible waived; 12 visits/ year max	N/A	$10, up to $1,000/ year max	30%, up to $1,000/year max	15%, up to $1,000/ year max. Not applied to out-of-pocket max	30%, up to $1,000/year max. Not applied to out-of-pocket max	$10, up to $1000/ year max. Not applied to out-of-pocket max	30%, up to $1,000/ year max. Not applied to out-of-pocket max
Routine vision exam	$5, deductible waived	$5	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance	$200/year	$200/year	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs All plans have formularies that list which drugs are covered. Contact your vendor for a copy of their formulary or to find out if a drug is covered.	• No deductible • Copays accumulate to out-of-pocket max • $5 generic • $25 brand • 50%, up to $100 max non-formulary brand • $50 specialty • Mail order: 1 copay for up to 90-day supply, $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• No deductible • Copays accumulate to out-of-pocket max • $1 generic • $15 brand • $50 specialty • Mail order: 1 copay for up to 90-day supply, $1 generic, $15 brand	• $50/individual, $150/family deductible[8] • $1,000/individual, out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 preferred brand • Copay x 2.5 for 90-day • $10 generic specialty • $100 brand specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[10] • $10 generic • $30 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[8] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[8] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $20 generic specialty • $100 brand specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount

Part-time only medical plans

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Part-time only		Part-time only		Part-time only		Part-time only	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Standard deductible[2]	$250/individual, $750/family	$0	$500/individual, $1,500/family	$1,000/individual, $3,000/family	$500/individual, $1,500/family	$1,000/individual, $3,000/family	$500/individual, $1,500/family	$1,000/individual, $3,000/family
Additional non-HEM participant deductible applies to all services unless otherwise noted	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$1,500/individual, $3,000/family	$2,500/individual, $7,500/family	$6,000/individual, $18,000/family	$3,200/individual, $9,600/family	$7,500/individual, $22,500/family	$2,500/individual, $7,500/family	$6,000/individual, $18,000/family
Primary care visit	$30, deductible waived	$30	$40[13] first four visits, deductible waived	50%	20% or 15% first four visits, deductible waived	50%	$40 first four visits, deductible waived	50%
Chronic care visit[4]	$30, deductible waived	$30	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Specialty care visit	$30 with referral, deductible waived	$30 with referral	$40	50%	20%	50%	$40	50%
Outpatient mental health care	$30, deductible waived	$30	$40, deductible waived	50%	20%, deductible waived	50%	$40, deductible waived	50%
Substance Use Disorder Treatment	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Maternity prenatal and postnatal services	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges		$0, deductible waived	50%	20%	50%	$0, deductible waived	50%
Delivery facility charges	Included with maternity services and professional delivery		Inpatient delivery subject to inpatient hospital charges		Inpatient delivery subject to inpatient hospital charges		Inpatient delivery subject to inpatient hospital charges	
Fertility services	Refer to Member Handbook		Refer to Member Handbook		Refer to Member Handbook		Refer to Member Handbook	
Preventive	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Lab and X-ray	$20, deductible waived	$10	Quest labs - $0, other providers 20%	50%	20%	50%	20%, deductible applies	50%
Inpatient hospital per admission[11]	$500	$500	$500	$500 + 50%	20%	$500 + 50%	$500	$500 + 50%
Outpatient surgery in a hospital setting[11]	20%	$30	$40/visit	$100 + 50%	20%	$100 + 50%	$40/visit	$100 + 50%
Urgent care	$50	$30	$30	30%	20%	20%	$40	$40

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Part-time only		Part-time only		Part-time only		Part-time only	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Emergency department[5]	$150	$150	$150	$150	$150 + 20%	$150 + 20%	$150	$150
Durable medical equipment	50%, deductible waived	50%	20%	50%	20%	50%	20%	50%
Insulin, diabetic supplies	$0, deductible waved	$0	$0, deductible waived[14]	$0, deductible waived[14]	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[6] copay/$500[7] copay – does not apply to Kaiser)	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	$100[6]/$500[7]	$100[6] + 50%/ $500[7] + 50%	$100[6] + 20%/ $500[7] + 20%	$100[6] + 50%/ $500[7] + 50%	$100[6]/$500[7]	$100[6] + 50%/ $500[7] + 50%
Spinal manipulation and acupuncture[11]	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	N/A	$40; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	50%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	20%, up to 60 visits/year max combined. Not applied to out-of-pocket max	50%, up to 60 visits/year max combined. Not applied to out-of-pocket max	$40; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	50%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit
Massage therapy services[11,12]	$25, deductible waived; 12 visits/ year max	N/A	$40, up to $1,000/ year max	50%, up to $1,000/ year max	20%, up to $1,000/year max. Not applied to out-of-pocket max	50%, up to $1,000/year max. Not applied to out-of-pocket max	$40/visit, up to $1,000/year max. Not applied to out-of-pocket max	50%, up to $1,000/year max. Not applied to out-of-pocket max
Routine vision exam	$30	$30	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs All plans have formularies that list which drugs are covered. Contact your vendor for a copy of their formulary or to find out if a drug is covered.	• No deductible • Copays accumulate to out-of-pocket max • $10 generic • $25 brand • $50 specialty • Mail order: 2 copays for up to 90-day supply	• No deductible • Copays accumulate to out-of-pocket max • $10 generic • $25 brand • $50 specialty • Mail order: 2 copays for up to 90-day supply	• $50/individual, $150/family deductible[8] • $1,000/individual, out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $20 generic specialty • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount	• $50/individual $150/family deductible[8] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • 40% preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[8] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in network rate and billed amount

N/A= Not applicable

1. To receive in-network benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from in-network specialists. Otherwise, benefits typically have higher costs or may not be covered. See the list of medical homes on the plan's website.
2. All medical plans have a standard plan deductible (except Kaiser Traditional). On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.
3. Providence Statewide plan members whose in-network provider has been recognized by the Oregon Health Authority as a patient-centered primary care home will have the lower coinsurance.
4. These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible in network.
5. Copay amounts for use of a hospital emergency department are waived if the member is admitted directly to the hospital for inpatient treatment. This does not include admittance for observation. Copay does not apply to out-of-pocket max except in Kaiser plans. In plan deductible applies.
6. These procedures are MRI, CT, PET and SPECT scans; sleep studies; spinal injections; upper endoscopy; bunionectomy; surgery for hammertoe and Morton's neuroma. Copay does not apply to out-of-pocket max. Not applied to cancer-related procedures. These procedures may be overused compared with their risks and benefits. One copay will be applied for each service billed. Multiple copays may apply if more than one service is done in a visit.
7. These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Copay does not apply to out-of-pocket max. Not applied to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.
8. The prescription drug deductible is $50 per person or $150 for families with three or more members. It applies separately from the medical deductible.
9. The prescription drug out-of-pocket max is $1,000 per person, with a family max of $3,000. It accrues separately from the medical out-of-pocket max.
10. All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions.
11. Copays and coinsurance do not apply to out-of-pocket max except for Kaiser.
12. Moda and Providence out-of-network providers may bill you for any amount over the max plan allowance.
13. Members must choose a PCP 360 with Moda and must see their chosen PCP 360 for all primary care services to be covered in network.
14. Insulin pumps/supplies does not apply. This benefit is covered under the Durable Medical Equipment.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your Member Handbook/Evidence of Coverage for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the Member Handbook/Evidence of Coverage will prevail.

pebb
Public Employees' Benefit Board

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact PEBB at 503-373-1102 (voice/text) or email pebb.benefits@odhsoha.oregon.gov. We accept all relay calls.

200-254952_MSC 5564 2024 (10/2023)