pebb
Public Employees' Benefit Board

2027

PEBB Summary of Benefits

Medical Plans (Available to All Members)

The following plans are available to both full-time and part-time members regardless of hours worked. This information provides a high-level summary. See plan documents for details.

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to full-time and part-time members**		**Available to full-time and part-time members**		**Available to full-time and part-time members**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**Out of network[1]**
Standard deductible[2]	$250/individual, $750/family	$0	$250/individual $750/family	$500/individual, $1,500/family	$500/individual $1,500/family	$500/individual, $1,500/family
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$800/individual, $1,600/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	15% or 10%[3] first four visits, per calendar year, deductible waived	30%	$10[1] first four visits, per calendar year, deductible waived	30%
Chronic care visit[4]	$5, deductible waived	$5	0%, deductible waived	30%	$0, deductible waived	30%
Specialty care visit	$5 with referral, deductible waived	$5 with referral	15%	30%	$25	30%
Outpatient mental health care	$5, deductible waived	$5	15%, deductible waived	30%	$10, deductible waived	30%
Substance Use Disorder Treatment	$0, deductible waived	$0	0%, deductible waived	30%	$0, deductible waived	30%
Maternity prenatal and postnatal services	$0, deductible waived	$0	0%, deductible waived prenatal, 15% postnatal	30%	$0, deductible waived	30%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	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

Medical Plans (Available to All Members) — Continued

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to full-time and part-time members**		**Available to full-time and part-time members**		**Available to full-time and part-time members**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**Out of network[1]**
Doula services	$0, deductible waived; 24-hour limit for prenatal/postnatal visits/year, plus 1 labor and delivery visit	$0; 24-hour limit for prenatal/postnatal visits/year, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/ pregnancy, plus 1 labor and delivery visit
Fertility services	Refer to Evidence of Coverage document	Refer to Evidence of Coverage document	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%
Lab and X-ray	$15, deductible waived	$0	15%	30%	$0, deductible waived	30%
Inpatient hospital per admission	$50/day up to $250 max	$50/day, up to $250 max	15%	$500 + 40%	$50/day, up to $250 max	$500 + 40%[11]
Outpatient surgery in a hospital setting	15%	$5	15%	$100 + 40%	$10	$100 + 40%[11]
Urgent care	$25, deductible waived	$5	15%	15%	$25	$25
Emergency department[5]	$150	$150	$150 + 15%	$150 + 15%	$150	$150
Durable medical equipment	15%, deductible waived	$0	15%	30%	15%	30%
Insulin, diabetic supplies	$0, deductible waived	$0	Administered by Judi Rx: 0%, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]
Spinal manipulation and acupuncture[12]	$10; Spinal manipulation: 30 visit annual limit, Acupuncture: 24 visit annual limit	$10; 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%[11]; Spinal manipulation: 20 visit annual limit, Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max

Medical Plans (Available to All Members) — Continued

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to full-time and part-time members**		**Available to full-time and part-time members**		**Available to full-time and part-time members**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**Out of network[1]**
Massage therapy services[12]	$25, deductible waived; 12 visits/year max	N/A	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%[11], up to $1,000/year max. Not applied to out-of-pocket max
Other specialty services and procedures	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	Additional cost tier: $100 copay[6] + 15% or $500 copay[7] + 15%	Additional cost tier: $100 copay[6] + 30% or $500 copay[7] + 30%	Additional cost tier: $100 copay[6] or $500 copay[7]	Additional cost tier: $100 copay[6] + 30%/ $500[7] + 30%
Routine vision exam	$5, deductible waived	$5	N/A	N/A	N/A	N/A
Vision hardware allowance	$250/year	$200/year	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 • $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	Administered by Judi Rx • $50/individual, $150/family deductible[8] • $1,000/individual or $3,000/family out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Specialty: $10 generic, $100 brand • Mandatory mail order or retail: Copay x 2.5 for 90-day[14]	Administered by Judi Rx • 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	Administered by Judi Rx • $50/individual, $150/family deductible[8] • $1,000/individual or $3,000/family out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Specialty: $10 generic, $100 brand • Mandatory mail order or retail: Copay x 2.5 for 90-day[14]	Administered by Judi Rx • 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

Medical Plans (Available to Part-Time Members Only)

The following plans are available to part-time members only. This information provides a high-level summary. See plan documents for details.

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to part-time members only**		**Available to part-time members only**		**Available to part-time members only**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**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
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$1,500/individual, $3,000/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	20% or 15%[3] first four visits, per calendar year, deductible waived	50%	$40 first four visits, per calendar year, deductible waived	50%
Chronic care visit[4]	$30, deductible waived	$30	0%, deductible waived	50%	$0, deductible waived	50%
Specialty care visit	$30 with referral, deductible waived	$30 with referral	20%	50%	$40	50%
Outpatient mental health care	$30, deductible waived	$30	20%, deductible waived	50%	$40, deductible waived	50%
Substance Use Disorder Treatment	$0, deductible waived	$0	0%, deductible waived	50%	$0, deductible waived	50%
Maternity prenatal and postnatal services	$0, deductible waived	$0	0%, deductible waived prenatal, 20% postnatal	50%	$0, deductible waived	50%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	20%	50%	$0, deductible waived	50%
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

Medical Plans (Available to Part-Time Members Only) — Continued

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to part-time members only**		**Available to part-time members only**		**Available to part-time members only**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**Out of network[1]**
Doula services	$0, deductible waived; 24-hour limit for prenatal/postnatal visits/year, plus 1 labor and delivery visit	$0; 24-hour limit for prenatal/postnatal visits/year, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/year, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/year, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/year, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal/ postnatal visits/year, plus 1 labor and delivery visit
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
Preventive	$0, deductible waived	$0	0%, deductible waived	50%	$0, deductible waived	50%
Lab and X-ray	$20, deductible waived	$10	20%	50%	20%	50%
Inpatient hospital per admission	$500	$500	20%	$500 + 50%	$500	$500 + 50%[11]
Outpatient surgery in a hospital setting	20%	$30	20%	$100 + 50%	$40/visit	$100 + 50%[11]
Urgent care	$50, deductible waived	$30	20%	20%	$30	$30
Emergency department[5]	$150	$150	$150 + 20%	$150 + 20%	$150	$150
Durable medical equipment	50%, deductible waived	50%	20%	50%	20%	50%
Insulin, diabetic supplies	$0, deductible waived	$0	Administered by Judi Rx: $0, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]	Administered by Judi Rx: $0, deductible waived[13]
Spinal manipulation and acupuncture[12]	$10; Spinal manipulation: 20 visit annual limit, Acupuncture: 12 visit annual limit	N/A	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%[11]; Spinal manipulation: 20 visit annual limit, Acupuncture: 12 visit annual limit

Medical Plans (Available to Part-Time Members Only) — Continued

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Health PPO		Moda Health Coordinated Care	
Work status	**Available to part-time members only**		**Available to part-time members only**		**Available to part-time members only**	
Network	**Kaiser network**	**Kaiser network**	**In network**	**Out of network**	**PCP 360**	**Out of network[1]**
Massage therapy services[12]	$25, deductible waived; 12 visits/year max	N/A	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%[11], up to $1,000/year max. Not applied to out-of-pocket max
Other specialty services and procedures	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	Additional cost tier: $100 copay[6] + 20% or $500 copay[7] + 20%	Additional cost tier: $100 copay[6] + 50% or $500 copay[7] + 50%	Additional cost tier: $100 copay[6] or $500 copay[7]	Additional cost tier: $100 copay[6] + 50%/ $500[7] + 50%
Routine vision exam	$30	$30	N/A	N/A	N/A	N/A
Vision hardware allowance	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	Administered by Judi Rx • $50/individual $150/ family deductible[8] • $1,000/individual or $3,000/family out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • 40% brand • Specialty: $20 generic, $100 brand • Mandatory mail order or retail: Copay x 2.5 for 90-day[14]	Administered by Judi Rx • 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	Administered by Judi Rx • $50/individual, $150/ family deductible[8] • $1,000/individual or $3,000/family out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • $50 brand • Specialty: $20 generic, $100 brand • Mandatory mail order or retail: Copay x 2.5 for 90-day[14]	Administered by Judi Rx • 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, each member must use a PCP 360 at a PCP 360 facility for primary care services.
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 Evidence of Coverage document for additional details.
3. Moda Health PPO 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 maximum 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 maximum. 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 maximum. 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 maximum is $1,000 per person, with a family maximum of $3,000. It accrues separately from the medical out-of-pocket maximum.
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 maximum except for Kaiser.
12. Moda Health out-of-network providers may bill you for any amount over the maximum plan allowance.
13. Insulin pumps/supplies does not apply. This benefit is covered under the Durable Medical Equipment.
14. Mandatory 90-day fill: PEBB members who are currently taking a maintenance drug medication will need to fill a 90-day supply through mail order or at 90-day supply participating retail pharmacies. For more details, refer to the Member Handbook.

Dental Plans

The following plans are available to full-time and/or part-time members. Your ability to enroll in a dental plan below is based on your full-time or part-time work status. Some plans are only available to full-time or part-time members. This information gives a high-level summary only. See plan documents for details.

Vendor Dental Plan	Willamette Dental[7]	Kaiser Dental	Delta Dental PPO		Delta Dental Premier[1]	Kaiser Dental	Delta Dental Premier[1]
Work status	**Available to full-time and part-time members**	**Available to full-time and part-time members**	**Available to full-time members only**		**Available to full-time members only**	**Available to part-time members only**	**Available to part-time members only**
Network	**Willamette Dental P.C. dentists**	**Kaiser network**	**In network**	**Out of network**	**Participating providers**	**Kaiser network**	**Participating providers**
Deductible: individual/ family	None	None	$50/$150	$50/$150	$50/$150	None	$50
Annual max coverage	No annual max[6]	$1,750	$1,750	$1,750	$1,750	$1,250	$1,250
Diagnostic and preventive services	Covered with office visit copay	$0[2]	0%[2], no deductible	10%[2], no deductible	0%[2], no deductible	$0[2]	0%[2]
Basic and maintenance services	$20 copay for fillings, other basic services covered with office visit copay	$5 copay + 20%	20%-year 1[4] 10%-year 2[4] 0%-year 3[4]	30%	20%	$5 copay + 50%	50%
Crowns	$250 copay	$5 copay + 25%	50%	50%	50%	$5 copay + 50%	50%
Implants	$1,500/year[5]	$5 copay + 50%	50%	50%	50%	Not covered	Not covered
Dentures	$290 copay	$5 copay + 50%	50%	50%	50%	$5 copay + 50%	50%
Orthodontia	$2,500 copay	$5 copay + 50%, up to $2,500 lifetime[3]	50%, up to $1,800 lifetime	50%, up to $1,800 lifetime[3]	50%, up to $1,800 lifetime[3]	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 maximum plan allowance.
2. Preventive services will not accrue toward the plan maximum.
3. The $2,500 (Kaiser) and $1,800 (Delta Dental) lifetime maximum coverage is separate from the $1,750 annual maximum 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 maximum.
7. $10 office visit copay applies to each office visit.

Vision Plan

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

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

	VSP Basic Plan	VSP Plus Plan
Well Vision Exam (every calendar year)	• Focuses on your eyes and overall wellness: $10 copay • Routine retinal screening: Up to $39 copay	• Focuses on your eyes and overall wellness: $10 copay • Routine retinal screening: Up to $10 copay
Essential Medical Eye Care (available as needed)	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more; $20 per exam • Coordination with your medical coverage may apply. Ask your VSP network doctor for details • Available as needed	
Prescription Glasses		
Frame[1] (every calendar year)	• $25 copay for prescription glasses (frames and lenses) • Featured Frame Brands allowance[2]: $170 • Frame allowance: $150 • Walmart/Sam's Club frame allowance: $150 • Costco frame allowance: $80 • 20% savings on the amount over your allowance	• $25 copay for prescription glasses (frames and lenses) • Featured Frame Brands allowance[2]: $245 • Frame allowance: $225 • Walmart/Sam's Club frame allowance: $225 • Costco frame allowance: $125 • 20% savings on the amount over your allowance
Lenses (every calendar year)	• Copay included in prescription glasses • Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	
Lens Enhancements (every calendar year)	• Standard progressive lenses: $0 • Premium progressive lenses: $80–$90 • Custom progressive lenses: $120–$160 • Average savings of 40% on other lens enhancements[3]	• Standard progressive lenses: $0 • Premium progressive lenses: $20 • Custom progressive lenses: $20 • Anti-glare coating: $20 • Average savings of 40% on other lens enhancements[3]

	VSP Basic Plan	VSP Plus Plan
Contacts (instead of glasses)		
Contacts (instead of glasses; every calendar year)	• Contacts: $200 allowance; copay does not apply • Contact lens exam (fitting and evaluation): up to $60 • 15% savings on a contact lens exam (fitting and evaluation)	• Contacts: $225 allowance; copay does not apply • Contact lens exam (fitting and evaluation): up to $60 • 15% savings on a contact lens exam (fitting and evaluation)
Other Services and Savings		
VSP Lightcare™[1] (every calendar year)	• $25 copay • Ready-made non-prescription sunglasses or blue light filtering glasses (instead of prescription glasses or contacts): $150 allowance	• $25 copay • Ready-made non-prescription sunglasses or blue light filtering glasses (instead of prescription glasses or contacts): $225 allowance
Vision Therapy	• You get a fully covered evaluation and 75% off approved therapy sessions up to $750 annually • Sessions cover diagnosis and treatment of turned eye, eye teaming, lazy eye, eye focusing, and general eye movement availability • Check with your doctor to see if you qualif	
Glasses and Sunglasses	• Discover all current eyewear offers and savings at vsp.com/offers • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam; or get 20% savings from a VSP provider within 12 months of your last WellVision Exa	
Laser Vision Correction	• Average of 15% off the regular price; discounts available at contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	
Exclusive Member Extras	• Save up to 60% on digital hearing aids with TruHearing®; visit vsp.com/offers/special-offers/hearing-aids for details • Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers • Everyday savings on entertainment, health and wellness, travel, and more with VSP Simple Values	

1. Coverage with a retail chain may be different or not apply.
2. Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
3. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

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.

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.

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