2021 Summary of Benefits

pebb
Public Employees' Benefit Board
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This information gives a high-level summary only.

2021 PEBB vision plans summary employee premium contribution comparison				
	Employee	Employee & spouse/partner	Employee & children	Employee & family
VSP Basic	$8.54	$17.08	$14.52	$23.06
VSP Plus	$14.95	$29.89	$25.41	$40.35
Kaiser	**The full-time Kaiser HMO and Kaiser Deductible medical plans include coverage for vision exams and hardware.**			

You pay a share of premium if you enroll in the VSP Basic. Your premium share is the same percentage rate as your medical coverage percentage, which includes opt out. VSP Plus has better coverage for frames, coatings and progressive lenses. For this plan, you pay the employee premium share for the Basic plan plus the difference in premium cost between the Basic and Plus plans.

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 • $80 Walmart®/Sam's Club®/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 on other lens enhancements	$0 $80–$90 $120–$160 35%–40%	Each calendar year Each calendar year Each calendar year 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
Suncare	• $150 allowance for ready-made nonprescription sunglasses instead of prescription glasses or contacts	$25	Each calendar year
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 • $125 Walmart®/Sam's Club®/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
Suncare	• $225 allowance for ready-made nonprescription sunglasses instead of prescription glasses or contacts	$25	Each calendar year

Please note, Kaiser Permanente vision benefits are included in the medical coverage and can be found on the medical summary comparison.

2021 Open Enrollment

Summary of Benefits

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KAISER PERMANENTE®

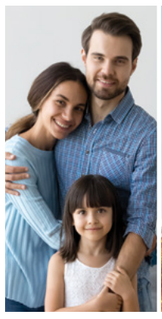
DELTA DENTAL®
Delta Dental of Oregon & Alaska

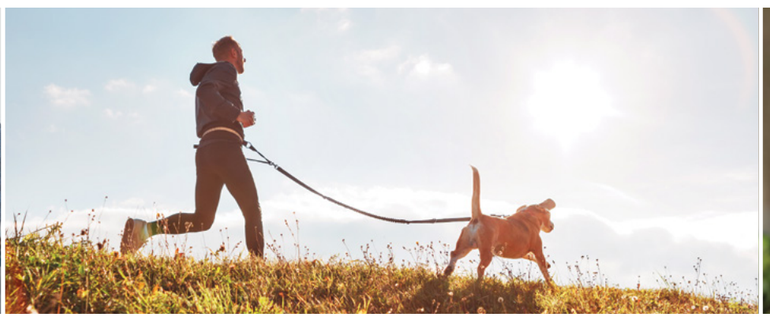
Willamette Dental Group

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

2021 PEBB dental plans summary comparison							
Plan provider status	Kaiser Dental (full-time and part-time)	Delta Dental PPO (full-time and part-time)		Delta Dental Premier[1] (full-time and part-time)	Delta Dental Premier[1] Part-Time (part-time only)	Kaiser Dental (part-time only)	Willamette Dental Group (full-time and part-time)
Benefit plans	Kaiser Network	In network	Out of network	Participating providers	Participating providers	Kaiser Network	Willamette Dental Group dentists
Deductible: individual/family	None	$50/$150	$50/$150	$50/$150	$50	None	None
Annual maximum (max) coverage	$1,750	$1,750	$1,750	$1,750	$1,250	$1,250	No annual maximum[6]
Diagnostic and preventive services	$0 Not subject to or counted toward annual maximum	0%[2], no deductible	10%[2], no deductible	0%[2], no deductible	0%[2]	$0 Not subject to or counted toward annual maximum	Covered with office visit copay
Basic and maintenance services	$5 copay + 20%	20%-year 1 10%-year 2 0%-year 3[4]	30%	20%	50%	$5 copay + 50%	$20 copay for fillings, other basic services covered with office visit copay
Crowns	$5 copay + 25%	50%	50%	50%	50%	$5 copay + 50%	$250 copay
Implants	$5 copay + 50%	50%	50%	50%	Not covered	Not covered	$1,500 per year max[5]
Dentures	$5 copay + 50%	50%	50%	50%	50%	$5 copay + 50%	$290 copay
Orthodontia	$5 copay + 50%, up to $1,500 lifetime[3]	50%, up to $1,500 lifetime[3]	50%, up to $1,500 lifetime[3]	50%, up to $1,500 lifetime[3]	Not covered	Not covered	$2,500 copay

[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 $1,500 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.





Plan provider status	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence PEBB Statewide PPO		Providence Choice (medical home)		Kaiser Deductible part-time	Kaiser Traditional part-time	Moda Synergy Coordinated Care (PCP 360) part-time		Providence PEBB Statewide PPO part-time		Providence Choice part-time (medical home)	
Benefit plans	Kaiser network	Kaiser network	In network	Out of network	In network	Out of network	Medical home	Out of network[1]	Kaiser network	Kaiser network	In network	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	$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		$100/individual, $300/family		$100/individual, $300/family	$100/individual, $300/family	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket maximum (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	$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	$5, deductible waived	$5	$10[14] first four visits, deductible waived	30%	15% or 10%[3] first four visits, deductible waived	30%	$10, first four visits deductible waived	30%	$30, deductible waived	$30	$40[14] 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]	$5, deductible waived	$5	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%	$30, deductible waived	$30	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Specialty care visit	$5 w/referral, deductible waived	$5, with referral	$10	30%	15%	30%	$10, with referral	30%	$30 w/referral, deductible waived	$30, with referral	$40	50%	20%	50%	$40, with referral	50%
Outpatient mental health care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10, deductible waived	30%	$30, deductible waived	$30	$40, deductible waived	50%	20%, deductible waived	50%	$40, deductible waived	50%
Substance abuse treatment	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Maternity services, prenatal	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Maternity services, professional delivery and postnatal services	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	15%	30%	$0, deductible waived	30%	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	20%	50%	$0, deductible waived	50%
Delivery facility 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	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Lab & x-ray	$15, deductible waived	$0	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%	$20, deductible waived	$10	Quest labs - $0, other providers 20%	50%	20%	50%	20%, deductible applies	50%
Inpatient hospital per admission	$50/day up to $250 max	$50/day, up to $250 max	$50/day to $250 max	$500 + 40%	15%	$500 + 40%	$50/day to $250 max	$500 + 40%	$500	$500	$500	$500 + 50%	20%	$500 + 50%	$500	$500 + 50%
Outpatient surgery in a hospital setting	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%	20%	$30	$40/visit	$100 + 50%	20%	$100 + 50%	$40/visit	$100 + 50%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25	$50	$30	$30	30%	20%	20%	$40	$40
Emergency department[5]	$75	$75	$150	$150	$150 + 15%	$150 + 15%	$150	$150	$100	$100	$150	$150	$150 + 20%	$150 + 20%	$150	$150
Durable medical equipment	15%, deductible waived	$0	15%	30%	15%	30%	15%	30%	50%, deductible waived	50%	20%	50%	20%	50%	20%	50%
Insulin, diabetic supplies	$0, deductible waved	$0	$0, deductible waived		0%, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waved	$0	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[6] copay/$500[8] copay – applies to all except Kaiser[7]	$100, deductible waived	$100	$100/$500	$100 + 30%/ $500 + 30%	$100 + 15% $500 + 15%	$100 + 30% $500 + 30%	$100/$500	$100 + 30% $500 + 30%	$100, deductible waived	$100	$100/$500	$100 + 50%/ $500 + 50%"	$100 + 20% $500 + 20%	$100 + 50% $500 + 50%	$100/$500	$100 + 50% $500 + 50%
Alternative care provider visits[12]	$10, deductible waived	$10	$10	30%	15%	30%	$10	30%	$10, deductible waived	$30, with physician's authorization referral	$40	50%	20%	50%	$40	50%
Spinal manipulation, acupuncture and massage therapy[13] services[12]	$10, spinal manipulation and acupuncture; $25, massage therapy; 12 visit limit per year; deductible waived	$10, spinal manipulation and acupuncture; deductible waived; massage therapy not covered	$10 up to $1,000/yr max combined. Not applied to out-of-pocket max.	30% up to $1,000/yr max combined. Not applied to out-of-pocket max. $10 copay applies to max allowance for massage therapy only.	15%, up to 60 services/yr max combined. Not applied to out-of-pocket max.	30%, up to 60 services/yr max combined. Not applied to out-of-pocket max.	$10/visit, up to $1,000/yr max combined. Not applied to out-of-pocket max.	30%, up to $1,000/yr max combined. Not applied to out-of-pocket max.	$30, spinal manipulation and acupuncture; $25, massage therapy; 12 visit limit per year; deductible waived	$30, physician-referred spinal manipulation and acupuncture; deductible waived	$40 up to $1,000/yr max combined. Not applied to out-of-pocket max.	50% up to $1,000/yr max combined. Not applied to out-of-pocket max	20%, up to 60 services/yr max combined. Not applied to out-of-pocket max	50%, up to 60 services/yr max combined. Not applied to out-of-pocket max	$40/visit, up to $1,000/yr max combined. Not applied to out-of-pocket max	50% up to $1,000/yr max combined. Not applied to out-of-pocket max
Routine vision exam	$5	$5	N/A	N/A	N/A	N/A	N/A	N/A	$30	$30	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance yearly benefit	$200	$200	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs	• 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 (31-90 day), $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 (31-90 day), $1 generic, $15 brand	• $50/individual, $150/family deductible[9] • $1,000/ individual, $3,000/family out-of-pocket max[10] • $0 value, not subject to deductible[11] • $10 generic • $30 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[11] • $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[9] • $1,000 out-of-pocket max[10] • $0 value not subject to deductible[11] • $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[9] • $1,000 out-of-pocket max[10] • $0 value, not subject to deductible[11] • $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	• 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[9] • $1,000/ individual, $3,000/family out-of-pocket max[10] • $0 value, not subject to deductible[11] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[11] • $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[10] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[11] • $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[9] • $1,000 out-of-pocket max[10] • $0 value, not subject to deductible[11] • $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

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 providers referred by their medical home. 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 HMO). This is the amount a member must pay for covered services before the plan begins to pay its share for medically necessary covered services. Deductibles apply per individual, or the family deductible will apply when there are three or more individuals within a family, based on the employee's choice of coverage tier. Payments toward the deductible accumulate separately for services in network and out of network. Certain in network services are not subject to the deductible. Examples: first four visits per individual to a primary care provider; insulin and diabetic supplies; visits for care of asthma, diabetes, cardiovascular disease or congestive heart failure; and preventive services. On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.
3. PEBB 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 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; and service not covered in 2021. 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.
7. Applies only to MRI, CT, PET and SPECT scans, and sleep studies in Kaiser plans. Additional copay applies to out-of-pocket max.
8. 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.
9. The prescription drug deductible is $50 per person or $150 for families with three or more members. It applies separately from the medical deductible.
10. 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.
11. All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions.
12. Limited to $1,000/year Providence Choice, Moda and Kaiser. Limited to 60 visits/year in PEBB Statewide plan maximum. Copays and coinsurance do not apply to out-of-pocket max.
13. Moda and Providence out-of-network providers may bill you for any amount over the maximum plan allowance. Massage therapy benefit is only available to Kaiser deductible plan members. Members have access to the CHP Group network only. The benefit is not available to Kaiser Traditional plan members. For Providence members, massage therapy only applies to the Providence Choice plan.
14. 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.

You can get this document in other languages, large print, braille or a format you prefer. Contact PEBB at 503-373-1102 or email inquiries.pebb@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

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