



COBRA Moda Health 2026-27 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
 (Effective October 1, 2026)



Medical & Pharmacy			
OEBB Plan	Tier-Rated Groups		
Moda Medical Plans	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Moda Medical Plan 1	\$1,218.07	\$913.61	\$2,131.72
Moda Medical Plan 2	\$1,129.95	\$847.52	\$1,977.50
Moda Medical Plan 3	\$1,060.11	\$795.14	\$1,855.27
Moda Medical Plan 4	\$1,000.97	\$750.74	\$1,751.78
Moda Medical Plan 5	\$924.69	\$693.55	\$1,618.22
Moda Medical Plan 6*	\$943.19	\$707.41	\$1,650.63
Moda Medical Plan 7*	\$880.25	\$660.24	\$1,540.54

* This plan MAY be paired with an HSA (Health Savings Account), but the HSA is not required. Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible. Once the deductible is met Rx's are paid at the same level as other covered medical expenses.

Vision			
OEBB Plan	Tier-Rated Groups		
May use any licensed provider	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Opal Plan	\$26.68	\$19.96	\$46.69
Pearl Plan	\$21.86	\$16.38	\$38.20
Quartz Plan	\$15.43	\$11.55	\$26.93



COBRA Moda Health/Delta Dental 2026-27 Plan Year
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Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Provider network noted in plan name below	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Premier Plan 1 - Delta Dental Premier Network	\$71.55	\$87.71	\$164.96
Premier Plan 5 - Delta Dental Premier Network	\$63.16	\$77.46	\$145.68
Premier Plan 6* - Delta Dental Premier Network	\$48.15	\$49.62	\$101.76
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	\$62.00	\$76.02	\$142.97
Exclusive PPO Plan** - Delta Dental PPO Network	\$41.77	\$51.22	\$96.37

* This plan has no orthodontia coverage

** This plan has no out-of-network benefit. Services performed by providers outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and x-rays. All other services are considered non-covered.



**COBRA Kaiser Permanente 2026-27 Plan Year
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Medical and Pharmacy			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Kaiser Medical Plan 1	\$1,082.34	\$811.75	\$1,894.10
Kaiser Medical Plan 2A	\$946.05	\$708.62	\$1,654.83
Kaiser Medical Plan 2B	\$923.59	\$691.81	\$1,615.57
Kaiser Medical Plan 3*	\$716.13	\$536.03	\$1,252.22

* This plan MAY be paired with an HSA (Health Savings Account), but the HSA is not required. Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible. Once the deductible is met Rx's are paid at the same level as other covered medical expenses.

Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Kaiser Dental Plan	\$95.90	\$71.93	\$167.81

Vision			
OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Kaiser Vision Plan	\$10.39	\$7.79	\$18.18



COBRA Willamette Dental Group 2026-27 Plan Year
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Dental and Orthodontia			
OEBB Plan	Tier-Rated Groups		
Must use Willamette Dental Group facilities and providers for all non-emergency services	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
Willamette Dental Plan	\$50.84	\$57.45	\$111.54



COBRA VSP Vision 2026-27 Plan Year
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Vision			
OEBB Plan	Tier-Rated Groups		
Vision plans using the VSP Choice network	Domestic Partner	Domestic Partner's Child(ren) Only	Domestic Partner + Domestic Partner's Child(ren)
VSP Choice Plus Plan	\$17.33	\$13.00	\$30.31
VSP Choice Plan	\$8.42	\$6.32	\$14.73