



**Moda Health 2025-26 Plan Year**  
**Special Monthly Rate Category for Some Local Governments**  
**(Effective October 1, 2025)**



Medical & Pharmacy				
OEBB Plan	Tier-Rated Groups			
Moda Medical Plans	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Moda Medical Plan 1	\$961.25	\$2,114.72	\$1,826.41	\$2,979.91
Moda Medical Plan 2	\$891.70	\$1,961.74	\$1,694.27	\$2,764.33
Moda Medical Plan 3	\$836.57	\$1,840.46	\$1,589.53	\$2,593.44
Moda Medical Plan 4	\$789.94	\$1,737.82	\$1,500.87	\$2,448.82
Moda Medical Plan 5	\$729.69	\$1,605.33	\$1,386.46	\$2,262.09
Moda Medical Plan 6*	\$744.31	\$1,637.48	\$1,414.21	\$2,307.40
Moda Medical Plan 7*	\$694.66	\$1,528.24	\$1,319.90	\$2,153.51

\* 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	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Opal Plan	\$21.83	\$47.99	\$41.40	\$67.60
Pearl Plan	\$17.81	\$39.24	\$33.87	\$55.26
Quartz Plan	\$12.58	\$27.71	\$23.91	\$38.99



**Moda Health/Delta Dental 2025-26 Plan Year**  
**Special Monthly Rate Category for Some Local Governments**  
**(Effective October 1, 2025)**



Dental and Orthodontia				
OEBB Plan	Tier-Rated Groups			
Provider network noted in plan name below	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Premier Plan 1 - Delta Dental Premier Network	\$69.45	\$137.60	\$153.00	\$226.59
Premier Plan 5 - Delta Dental Premier Network	\$61.35	\$121.52	\$135.13	\$200.13
Premier Plan 6* - Delta Dental Premier Network	\$46.84	\$92.72	\$94.12	\$143.79
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	\$60.21	\$119.27	\$132.63	\$196.41
Exclusive PPO Plan** - Delta Dental PPO Network	\$40.58	\$80.37	\$89.38	\$132.38

\* 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.



**Kaiser Permanente 2025-26 Plan Year**  
**Special Monthly Rate Category for Some Local Governments**  
(Effective October 1, 2025)



Medical and Pharmacy				
OEBB Plan	Tier-Rated Groups			
Must use Kaiser Permanente facilities and providers for all non-emergency services	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Kaiser Medical Plan 1	\$855.17	\$1,881.39	\$1,624.84	\$2,651.05
Kaiser Medical Plan 2A	\$746.61	\$1,643.60	\$1,418.49	\$2,315.63
Kaiser Medical Plan 2B	\$728.90	\$1,604.59	\$1,384.83	\$2,260.68
Kaiser Medical Plan 3*	\$565.20	\$1,244.19	\$1,073.44	\$1,752.46

\* 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	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Kaiser Dental Plan	\$75.76	\$166.70	\$143.97	\$234.88

Vision				
OEBB Plan	Tier-Rated Groups			
Must use Kaiser Permanente facilities and providers for all non-emergency services	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Kaiser Vision Plan	\$8.49	\$18.67	\$16.12	\$26.31



**Willamette Dental Group 2025-26 Plan Year**  
**Special Monthly Rate Category for Some Local Governments**  
**(Effective October 1, 2025)**



Dental and Orthodontia				
OEBB Plan	Tier-Rated Groups			
Must use Willamette Dental Group facilities and providers for all non-emergency services	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
Willamette Dental Plan	\$48.17	\$96.34	\$102.62	\$153.93



**VSP Vision 2025-26 Plan Year**  
**Special Monthly Rate Category for Some Local Governments**  
**(Effective October 1, 2025)**



Vision				
OEBB Plan	Tier-Rated Groups			
Vision plans using the VSP Choice network	Employee Only	Employee + Spouse or Domestic Partner	Employee + Child(ren)	Employee + Spouse or Domestic Partner + Child(ren)
VSP Choice Plus Plan	\$14.15	\$31.14	\$26.90	\$43.87
VSP Choice Plan	\$6.89	\$15.14	\$13.08	\$21.33