Member Services
1-888-469-6322
OEBB.Benefits@odhsoha.oregon.gov

Moda Health 2024-25 Plan Year

Plans and Monthly Rates

(Effective October 1, 2024)

Medical & Pharmacy					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
Moda Medical Plans	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Moda Medical Plan 1	$793.33	$1,745.32	$1,507.36	$2,459.39	$1,888.12
Moda Medical Plan 2	$735.94	$1,619.06	$1,398.31	$2,281.45	$1,751.51
Moda Medical Plan 3	$690.43	$1,518.96	$1,311.87	$2,140.41	$1,643.24
Moda Medical Plan 4	$651.94	$1,434.27	$1,238.70	$2,021.05	$1,551.61
Moda Medical Plan 5	$602.23	$1,324.91	$1,144.26	$1,866.96	$1,433.28
Moda Medical Plan 6*	$614.29	$1,351.45	$1,167.19	$1,904.35	$1,462.01
Moda Medical Plan 7*	$573.32	$1,261.30	$1,089.34	$1,777.33	$1,364.49

* 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**				**Composite-Rated Groups**
May use any licensed provider	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Opal Plan	$21.83	$47.99	$41.40	$67.60	$49.80
Pearl Plan	$17.81	$39.24	$33.87	$55.26	$40.71
Quartz Plan	$12.58	$27.71	$23.91	$38.99	$28.74

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Moda Health/Delta Dental 2024-25 Plan Year

Plans and Monthly Rates

(Effective October 1, 2024)

DELTA DENTAL

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-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)**	**Unit**
Premier Plan 1 - Delta Dental Premier Network	$67.54	$133.80	$148.78	$220.33	$164.26
Premier Plan 5 - Delta Dental Premier Network	$59.66	$118.17	$131.41	$194.60	$145.08
Premier Plan 6* - Delta Dental Premier Network	$45.54	$90.16	$91.51	$139.81	$104.70
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	$58.55	$115.98	$128.97	$190.99	$142.39
Exclusive PPO Plan** - Delta Dental PPO Network	$39.46	$78.15	$86.91	$128.72	$95.96

* 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.

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Kaiser Permanente 2024-25 Plan Year

Plans and Monthly Rates

(Effective October 1, 2024)

Medical and Pharmacy

OEBB Plan	Tier-Rated Groups				Composite-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)	Unit
Kaiser Medical Plan 1	$721.66	$1,587.65	$1,371.16	$2,237.15	$1,714.80
Kaiser Medical Plan 2A	$595.37	$1,310.65	$1,131.15	$1,846.54	$1,424.44
Kaiser Medical Plan 2B	$576.47	$1,269.05	$1,095.24	$1,787.92	$1,383.06
Kaiser Medical Plan 3*	$439.75	$968.02	$835.18	$1,363.49	$1,055.35

* 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				Composite-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)	Unit
Kaiser Dental Plan	$73.48	$161.68	$139.63	$227.81	$175.02

Vision

OEBB Plan	Tier-Rated Groups				Composite-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)	Unit
Kaiser Vision Plan	$8.49	$18.67	$16.12	$26.31	$20.19

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Willamette Dental Group 2024-25 Plan Year

Plans and Monthly Rates

(Effective October 1, 2024)

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-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)**	**Unit**
Willamette Dental Plan	$46.99	$93.99	$100.11	$150.18	$120.55

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VSP Vision 2024-25 Plan Year
Plans and Monthly Rates
(Effective October 1, 2024)

Vision					
OEBB Plan	**Tier-Rated Groups**				**Composite-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)**	**Unit**
VSP Choice Plus Plan	$14.15	$31.14	$26.90	$43.87	$33.97
VSP Choice Plan	$6.89	$15.14	$13.08	$21.33	$16.51