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

Moda Health 2024-25 Plan Year

Plans and Monthly Imputed Income Amounts

Special Rate Category for Some Local Governments

(Effective October 1, 2024)

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	$1,113.83	$835.42	$1,949.28
Moda Medical Plan 2	$1,033.25	$774.98	$1,808.25
Moda Medical Plan 3	$969.38	$727.08	$1,696.48
Moda Medical Plan 4	$915.31	$686.50	$1,601.86
Moda Medical Plan 5	$845.53	$634.19	$1,479.72
Moda Medical Plan 6*	$862.47	$646.87	$1,509.36
Moda Medical Plan 7*	$804.92	$603.74	$1,408.69

* 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	$26.16	$19.57	$45.77
Pearl Plan	$21.43	$16.06	$37.45
Quartz Plan	$15.13	$11.33	$26.41

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Moda Health/ODS 2024-25 Plan Year

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(Effective October 1, 2024)

DELTA DENTAL

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	$66.26	$81.24	$152.79
Premier Plan 5 - Delta Dental Premier Network	$58.51	$71.75	$134.94
Premier Plan 6* - Delta Dental Premier Network	$44.62	$45.97	$94.27
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	$57.43	$70.42	$132.44
Exclusive PPO Plan** - Delta Dental PPO Network	$38.69	$47.45	$89.26

* 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 Imputed Income Amounts

Special Rate Category for Some Local Governments

(Effective October 1, 2024)

Medical and Pharmacy

OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	**Domestic Partner**	**Domestic Partner Child(ren) Only**	**Domestic Partner + Domestic Partner Child(ren)**
Kaiser Medical Plan 1	$1,013.21	$759.91	$1,773.11
Kaiser Medical Plan 2A	$836.88	$626.86	$1,463.87
Kaiser Medical Plan 2B	$810.31	$606.95	$1,417.41
Kaiser Medical Plan 3*	$618.07	$462.65	$1,080.77

* 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 Child(ren) Only**	**Domestic Partner + Domestic Partner Child(ren)**
Kaiser Dental Plan	$88.20	$66.15	$154.33

Vision

OEBB Plan	Tier-Rated Groups		
Must use Kaiser Permanente facilities and providers for all non-emergency services	**Domestic Partner**	**Domestic Partner Child(ren) Only**	**Domestic Partner + Domestic Partner Child(ren)**
Kaiser Vision Plan	$10.18	$7.63	$17.82

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Williamette Dental Group 2024-25 Plan Year

Plans and Monthly Imputed Income Amounts

Special Rate Category for Some Local Governments

(Effective October 1, 2024)

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 Child(ren) Only**	**Domestic Partner + Domestic Partner Child(ren)**
Willamette Dental Plan	$47.00	$53.12	$103.19

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VSP Vision 2024-25 Plan Year
Plans and Monthly Imputed Income Amounts
Special Rate Category for Some Local Governments
(Effective October 1, 2024)

Vision			
OEBB Plan	**Tier-Rated Groups**		
Vision plans using the VSP Choice network	**Domestic Partner**	**Domestic Partner Child(ren) Only**	**Domestic Partner + Domestic Partner Child(ren)**
VSP Choice Plus Plan	$16.99	$12.75	$29.72
VSP Choice Plan	$8.25	$6.19	$14.44