



When calculating your rates,  
please use the Composite-Rated  
Group for calculation.

Member Services  
1-888-469-6322  
OEBB.Benefits@state.or.us

**Moda Health 2021-22 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2021)



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	\$708.97	\$1,559.72	\$1,347.06	\$2,197.84	\$1,687.32
Moda Medical Plan 2	\$659.56	\$1,451.04	\$1,253.20	\$2,044.69	\$1,569.75
Moda Medical Plan 3	\$620.04	\$1,364.09	\$1,178.11	\$1,922.17	\$1,475.69
Moda Medical Plan 4	\$588.41	\$1,294.50	\$1,118.00	\$1,824.11	\$1,400.41
Moda Medical Plan 5	\$544.07	\$1,196.96	\$1,033.77	\$1,686.67	\$1,294.88
Moda Medical Plan 6*	\$557.18	\$1,225.80	\$1,058.67	\$1,727.30	\$1,326.09
Moda Medical Plan 7*	\$520.02	\$1,144.03	\$988.06	\$1,612.09	\$1,237.63

\* 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	\$23.99	\$52.73	\$45.50	\$74.28	\$54.72
Pearl Plan	\$19.56	\$43.11	\$37.23	\$60.72	\$44.73
Quartz Plan	\$13.82	\$30.44	\$26.27	\$42.85	\$31.58



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**Moda Health/Delta Dental 2021-22 Plan Year**

**Plans and Monthly Rates**

(Effective October 1, 2021)



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	\$65.76	\$130.29	\$144.89	\$214.56	\$159.96
Premier Plan 5 - Delta Dental Premier Network	\$58.04	\$114.99	\$127.87	\$189.36	\$141.17
Premier Plan 6* - Delta Dental Premier Network	\$43.43	\$85.96	\$87.26	\$133.30	\$99.83
Exclusive PPO Incentive Plan** - Delta Dental PPO Network	\$56.76	\$112.44	\$125.03	\$185.17	\$138.05
Exclusive PPO Plan** - Delta Dental PPO Network	\$38.81	\$76.87	\$85.48	\$126.59	\$94.37

\* 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.



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**Kaiser Permanente 2021-22 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2021)



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	\$634.87	\$1,396.71	\$1,206.25	\$1,968.10	\$1,510.22
Kaiser Medical Plan 2A	\$524.73	\$1,155.14	\$996.94	\$1,627.46	\$1,250.85
Kaiser Medical Plan 2B	\$508.01	\$1,118.33	\$965.17	\$1,575.59	\$1,210.67
Kaiser Medical Plan 3*	\$387.23	\$852.41	\$735.43	\$1,200.65	\$921.05

\* 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	\$73.07	\$160.77	\$138.84	\$226.53	\$174.03

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	\$8.02	\$17.66	\$15.25	\$24.88	\$19.11



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**Willamette Dental Group 2021-22 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2021)



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	\$46.60	\$93.20	\$99.27	\$148.91	\$119.53



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**VSP Vision 2021-22 Plan Year**  
**Plans and Monthly Rates**  
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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	\$16.54	\$36.41	\$31.44	\$51.30	\$39.71
VSP Choice Plan	\$8.05	\$17.71	\$15.29	\$24.94	\$19.31