

Milton-Freewater Unified School District #7
OEBB Plans for 2023-2024--effective October 1, 2023

Medical & Pharmacy Plans

Cost of your plan	Plan Name	Composite rates Cost/month	Deductible for In-network Coordinated Care **with PCP360** Per Person	Deductible for In-network Non-Coordinated Care **without a PCP360** Per Person	Deductible for Any out-of-network service Per Person	Place an "X" next to plan choice Select only one
	MODA Medical Plan 1	\$1,826.03	\$400.00	\$500.00	\$800.00	
	MODA Medical Plan 2	\$1,693.92	\$800.00	\$900.00	\$1,600.00	
	MODA Medical Plan 3	\$1,589.20	\$1,200.00	\$1,300.00	\$2,400.00	
	MODA Medical Plan 4	\$1,500.59	\$1,600.00	\$1,700.00	\$3,200.00	
	MODA Medical Plan 5	\$1,386.16	\$2,000.00	\$2,100.00	\$4,000.00	
	MODA Medical Plan 6 **	\$1,413.94	\$1,600.00	\$1,700.00	\$3,200.00	
	MODA Medical Plan 7 **	\$1,319.62	\$2,000.00	\$2,100.00	\$4,000.00	

Pharmacy coverages differ by plan--check with MODA directly on your specific prescriptions BEFORE you choose plans.
 All plan rates are composite which means rates are the same for anyone on the members plan, immediate family only, dependents under 26 only
 ** Plans 6 & 7 MAY be paired with a H.S.A. (Health Savings Account) if you qualify

Dental Plans

Cost of your plan	Plan Name	Composite rates Cost/month	Ortho Coverage	Benefit Max/year per person	Co-Pay	Place an "X" next to plan choice Select only one
	DELTA DENTAL Plan 1	\$159.58	Yes	\$2200 - preventative & ortho not included	N/A	
	DELTA DENTAL Plan 5	\$140.95	Yes	\$1700 - preventative & ortho not included	N/A	
	DELTA DENTAL Plan 6	\$101.73	No	\$1,200.00	N/A	
	**Exclusive PPO Incentive Delta Dental	\$138.34	Yes	\$2300 - preventative & ortho not included	N/A	
	**Exclusive PPO Delta Dental	\$93.23	Yes	\$1500 - preventative & ortho not included	N/A	
	WILLAMETTE Dental	\$120.55	Yes	N/A	\$20 & up	

All plan rates are composite which means rates are the same for anyone on the members plan, immediate family only, dependents under 26 and qualified only
 **Exclusive Dental plans have no out-of-network coverage, services performed by out-of-network provider will be the full responsibility of the member

Vision Plans

Cost of your plan	Plan Name	Composite rates Cost/month	Benefit Max/year per person	New frames/lenses	Contacts	Place an "X" next to plan choice Select only one
	MODA Opal	\$50.17	\$600.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	MODA Pearl	\$41.02	\$400.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	MODA Quartz	\$28.95	\$250.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	VSP Choice Plus	\$34.95	varies	1x/plan year	1x/plan year	
	VSP Choice	\$16.99	varies	1x/plan year	1x/plan year	

\$0.00	TOTAL Medical Benefit Cost
\$0.00	TOTAL Dental Benefit Cost
\$0.00	TOTAL Visions Benefit Cost
\$0.00	Subtotal of COST

Place an "X" next to your ins. cap - based on your contracted work hrs/day
 Select only one

	4-4.9 worked daily hrs Cap	\$984.00
	5-5.9 worked daily hrs Cap	\$1,148.00
	6-6.9 worked daily hrs Cap	\$1,312.00
	7-8.0 worked daily hrs Cap	\$1,640.00
\$0.00	Subtotal of CAP	

60% of CAP
 70% of CAP
 80% of CAP
 100% of CAP
 CAP updated for 23/24 school year

\$0.00	Approximate Out of pocket cost/month
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Subtotal COST minus Subtotal Cap = out of pocket cost

Positive number (in red) = your approximate out of pocket cost
 Negative number = no out of pocket cost