Milton-Freewater Unified School District #7
OEBB Plans for 2025-2026--*effective October 1, 2025*

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	$1,955.33	$700.00	$800.00	$1,100.00	
	MODA Medical Plan 2	$1,813.86	$1,100.00	$1,200.00	$1,900.00	
	MODA Medical Plan 3	$1,701.74	$1,500.00	$1,600.00	$2,700.00	
	MODA Medical Plan 4	$1,606.85	$1,900.00	$2,000.00	$3,500.00	
	MODA Medical Plan 5	$1,484.31	$2,300.00	$2,400.00	$4,300.00	
	**MODA Medical Plan 6 ** **	$1,514.06	$1,900.00	$2,000.00	$3,500.00	
	**MODA Medical Plan 7 ** **	$1,413.06	$2,300.00	$2,400.00	$4,300.00	

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	Deductible	Place an "X" next to plan choice Select only one
	DELTA DENTAL Plan 1	$168.93	Yes	$2,200.00	$50.00	
	DELTA DENTAL Plan 5	$149.20	Yes	$1,700.00	$50.00	
	DELTA DENTAL Plan 6	$107.68	No	$1,200.00	$50.00	
	Delta Dental	$146.43	Yes	$2,300.00	$50.00	
	Delta Dental	$98.69	Yes	$1,500.00	$50.00	
	WILLAMETTE Dental	$123.59	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	$49.80	$600.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	MODA Pearl	$40.71	$400.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	MODA Quartz	$28.74	$250.00	0-16 1x/year 17+ 1x/2 years	1x/plan year	
	VSP Choice Plus	$33.97	varies	1x/plan year	1x/plan year	
	VSP Choice	$16.51	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

				Place an "X"
	4-4.9 worked daily hrs Cap	**$1,062.00**	60% of CAP	
	5-5.9 worked daily hrs Cap	**$1,239.00**	70% of CAP	
	6-6.9 worked daily hrs Cap	**$1,416.00**	80% of CAP	
	7-8.0 worked daily hrs Cap	**$1,770.00**	100% of CAP	
$0.00	**Subtotal of CAP**			

CAP updated for 25/26 school year

$0.00	***Approximate* Out of pocket cost/month**

Positive number (in red) = your approximate out of pocket cost

Negative number = no out of pocket cost

Subtotal COST minus Subtotal Cap equals (=) out of pocket cost