

Milton-Freewater Unified School District #7
OEBB Plans for 2026-2027--effective October 1, 2026

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	\$2,024.36	\$950.00	\$1,050.00	\$1,350.00	
	MODA Medical Plan 2	\$1,877.89	\$1,350.00	\$1,450.00	\$2,150.00	
	MODA Medical Plan 3	\$1,761.81	\$1,750.00	\$1,850.00	\$2,950.00	
	MODA Medical Plan 4	\$1,663.57	\$2,150.00	\$2,250.00	\$3,750.00	
	MODA Medical Plan 5	\$1,536.70	\$2,250.00	\$2,650.00	\$4,550.00	
	MODA Medical Plan 6 **	\$1,567.51	\$2,150.00	\$2,250.00	\$3,750.00	
	MODA Medical Plan 7 **	\$1,462.94	\$2,550.00	\$2,650.00	\$4,550.00	

**to receive in-network coordinated care benefits, you must choose and use a PCP 360
All plan rates are composite which means rates are the same for anyone on the members plan, immediate family only, dependents under 26 only
** Choosing plans 6 or 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	\$173.86	Yes	\$2,200.00	\$50.00	
	DELTA DENTAL Plan 5	\$153.56	Yes	\$1,700.00	\$50.00	
	DELTA DENTAL Plan 6	\$110.82	No	\$1,200.00	\$50.00	
	**Exclusive PPO Incentive Delta Dental	\$150.70	Yes	\$2,300.00	\$50.00	
	**Exclusive PPO Delta Dental	\$101.56	Yes	\$1,500.00	\$50.00	
	WILLAMETTE Dental	\$127.79	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

	4-4.9 worked daily hrs Cap	\$1,098.00
	5-5.9 worked daily hrs Cap	\$1,281.00
	6-6.9 worked daily hrs Cap	\$1,464.00
	7-8.0 worked daily hrs Cap	\$1,830.00
\$0.00	Subtotal of CAP	

60% of CAP
70% of CAP
80% of CAP
100% of CAP

CAP updated for 26/27 school year

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

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

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

Negative number = no out of pocket cost