



**USE THE COMPOSITE-RATED GROUPS  
WHEN CALCULATING PLAN COSTS**

**Moda Health 2026-27 Plan Year**

**Plans and Monthly Rates**  
(Effective October 1, 2026)



| 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  | \$850.58          | \$1,871.25                            | \$1,616.13            | \$2,636.85                                         | \$2,024.36             |
| Moda Medical Plan 2  | \$789.05          | \$1,735.89                            | \$1,499.21            | \$2,446.07                                         | \$1,877.89             |
| Moda Medical Plan 3  | \$740.25          | \$1,628.57                            | \$1,406.52            | \$2,294.85                                         | \$1,761.81             |
| Moda Medical Plan 4  | \$698.98          | \$1,537.75                            | \$1,328.07            | \$2,166.88                                         | \$1,663.57             |
| Moda Medical Plan 5  | \$645.68          | \$1,420.51                            | \$1,226.82            | \$2,001.67                                         | \$1,536.70             |
| Moda Medical Plan 6* | \$658.62          | \$1,448.96                            | \$1,251.41            | \$2,041.75                                         | \$1,567.51             |
| Moda Medical Plan 7* | \$614.69          | \$1,352.31                            | \$1,167.94            | \$1,905.57                                         | \$1,462.94             |

\* 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                     | \$21.83           | \$47.99                               | \$41.40               | \$67.60                                            | \$49.80                |
| Pearl Plan                    | \$17.81           | \$39.24                               | \$33.87               | \$55.26                                            | \$40.71                |
| Quartz Plan                   | \$12.58           | \$27.71                               | \$23.91               | \$38.99                                            | \$28.74                |



**USE THE COMPOSITE-RATED GROUPS  
WHEN CALCULATING PLAN COSTS**

**Moda Health/Delta Dental 2026-27 Plan Year**

**Plans and Monthly Rates**

(Effective October 1, 2026)



| 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             | \$71.48           | \$141.62                              | \$157.47              | \$233.20                                           | \$173.86               |
| Premier Plan 5 - Delta Dental Premier Network             | \$63.14           | \$125.06                              | \$139.08              | \$205.97                                           | \$153.56               |
| Premier Plan 6* - Delta Dental Premier Network            | \$48.21           | \$95.42                               | \$96.86               | \$147.98                                           | \$110.82               |
| Exclusive PPO Incentive Plan** - Delta Dental PPO Network | \$61.98           | \$122.76                              | \$136.50              | \$202.14                                           | \$150.70               |
| Exclusive PPO Plan** - Delta Dental PPO Network           | \$41.77           | \$82.72                               | \$91.99               | \$136.25                                           | \$101.56               |

\* 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.



**USE THE COMPOSITE-RATED GROUPS  
WHEN CALCULATING PLAN COSTS**

**Kaiser Permanente 2026-27 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2026)



| 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                                                              | \$755.79          | \$1,662.73                            | \$1,435.99            | \$2,342.94                                         | \$1,796.37             |
| Kaiser Medical Plan 2A                                                             | \$659.84          | \$1,452.57                            | \$1,253.63            | \$2,046.49                                         | \$1,577.79             |
| Kaiser Medical Plan 2B                                                             | \$644.19          | \$1,418.11                            | \$1,223.89            | \$1,997.94                                         | \$1,544.71             |
| Kaiser Medical Plan 3*                                                             | \$499.51          | \$1,099.58                            | \$948.67              | \$1,548.80                                         | \$1,198.09             |

\* 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.

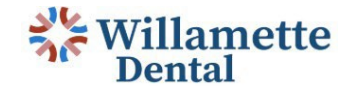
| Dental and Orthodontia                                                             |                   |                                       |                       |                                                    |                        |
|------------------------------------------------------------------------------------|-------------------|---------------------------------------|-----------------------|----------------------------------------------------|------------------------|
| 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                                                                 | \$78.34           | \$172.36                              | \$148.86              | \$242.86                                           | \$186.42               |

| 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                                                                 | \$8.49            | \$18.67                               | \$16.12               | \$26.31                                            | \$20.19                |



**USE THE COMPOSITE-RATED GROUPS  
WHEN CALCULATING PLAN COSTS**

**Willamette Dental Group 2026-27 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2026)



| 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                                                                   | \$49.79           | \$99.63                               | \$106.11              | \$159.14                                           | \$127.79               |



**USE THE COMPOSITE-RATED GROUPS  
WHEN CALCULATING PLAN COSTS**

**VSP Vision 2026-27 Plan Year**  
**Plans and Monthly Rates**  
(Effective October 1, 2026)



| 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                      | \$14.15           | \$31.14                               | \$26.90               | \$43.87                                            | \$33.97                |
| VSP Choice Plan                           | \$6.89            | \$15.14                               | \$13.08               | \$21.33                                            | \$16.51                |