

OREGON
2026

PLAN UPDATES

What's new for Oregon small business group plans with coverage effective on or after January 1, 2026



This booklet contains a summary of important information you will want to know about our 2026 small group plans. For more details on plan design, refer to the Medical Plans Overview for Oregon Small Businesses.

business.kp.org



Plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest.
500 NE Multnomah St., Suite 100, Portland, OR 97232.

Your partner in good health

At Kaiser Permanente, we offer a fully integrated health care delivery system with providers, hospitals, pharmacies, and labs working together to provide coordinated care for our members.

WHAT'S NEW AT KAISER PERMANENTE



Center for Black Health and Wellness

Our new Center for Black Health and Wellness is led by a team of clinicians who have experience in providing exceptional culturally responsive care to Black patients and their families. The team is passionate about improving the health of our Black members and elevating their care experience. Learn more at kpcenterforblackhealth.org.



Increasing access in Clark County

We're committed to helping members get timely care in SW Washington. We've increased primary care capacity at all medical offices in Clark County including Battle Ground, Salmon Creek, Orchards, and Cascade Park for more convenient access to appointments. Find a provider and location near you: kp.org/locations.



Ticket pass¹ offers more ways to find appointment availability

Members can now "opt in" to be notified of newly added scheduling appointments on kp.org. If there aren't any openings for the appointment ticket they receive, they can select their preferred days and times, and we will notify them as soon as a time slot opens based on their set preferences.



Kaiser Permanente Dental: Integrated care to support total health

Our highly integrated care team approach has been helping our members smile for more than 50 years, with dental care seamlessly connected to their medical care. Our dental and medical teams collaborate to help prevent illness and manage chronic conditions, like diabetes, with personalized prevention and treatment plans. Plus, our dental team can see if members are due for a screening, lab test, or follow-up appointment – and can even help them get it scheduled, saving valuable time.² Learn more at kp.org/dental.

¹Ticket pass works for most in-person appointment types. ²When appropriate and available. These features apply to care you get at Kaiser Permanente medical and dental facilities.

2026 medical plan portfolio

Our plan portfolio offers choice and flexibility with multiple plans to choose from in all 4 metal levels (platinum, gold, silver, and bronze). For 2026, we're adding a new gold HSA-eligible plan to our portfolio. This plan features a \$1,800 aggregate accumulation deductible, which differs from our other HSA-eligible plan deductible accumulation structures.

We have a variety of products to fit your needs, whether it be plans with no deductible, plans with a deductible, or plans that can pair with a health savings account (HSA).

Kaiser Permanente Plus™ provides comprehensive care from Kaiser Permanente doctors and facilities and affiliated providers. Plus, employees have the option to see any licensed out-of-network provider for a limited number of services each year.

Added Choice® Point-of-Service plans offer employees autonomy when choosing care and coverage. They can access Kaiser Permanente's integrated care model and highly trained doctors, as well as seek covered services from thousands of licensed providers across the country.

Lastly, for your employees (and their dependents) who reside outside of our service area, we offer our Added Choice Point-of-Service Out-of-Area product to seek care, no matter which state they live in.

As a reminder, all plans include the first 3 combined visits for primary care or primary care-related services at \$5. First 3 visits are any combination of in-person or virtual services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. Telehealth will remain at \$0; however, it is included in the 3 combined visits.

We have two buy-up options available on most medical plans: adult vision hardware or adult vision hardware and massage. Groups may choose to add these buy-up options during their renewal process. See more information in the bundle options below.

We have made necessary cost-sharing changes to keep plans within their respective metal levels. New plan names and specific cost-sharing changes for each plan are provided in the 2026 Medical Plan Changes section of this document. Groups may choose to renew with their current plan or select any other plan within our portfolio. Refer to the Medical Plans Overview for additional details.

NEW: Pediatric dental coverage will now be included in your medical plan

We will be adding pediatric dental benefits for members under the age of 19 to all Oregon small business medical plans, except for the Oregon Standard Plans.

Members can seek pediatric dental services from Kaiser Permanente dental providers or more than 200,000 participating providers in the Dental Choice PPO network.

If you're enrolling in an Oregon Standard Plan and employees would like to obtain certified pediatric dental coverage, you may offer a family dental plan. Employees must enroll in a Kaiser Permanente family dental plan in order for their dependents to enroll.

Please refer to the 2026 Medical Plan Changes section for more details.

2026 dental plan portfolio

Continuing Coverage:

Our dental plan portfolio offers a wide range of plans, offering benefit maximums from \$1,000 to \$3,000 – including options with implant and cosmetic orthodontia coverage as well as Voluntary plan options.

We will continue to offer family dental plans that provide coverage for both adults and pediatric dependents together on one plan. Plans include medically necessary orthodontia for members under 19 years of age and an annual out-of-pocket maximum for in-network services.

On our family dental plans, the annual out-of-pocket maximum for in-network services has increased from \$425 to \$450 for an individual under 19 years of age and from \$850 to \$900 for a family (with 2 or more pediatric members enrolled).

Discontinued Coverage:

We are discontinuing our stand-alone pediatric dental plans in 2026. All membership on these plans will be discontinued and not be mapped to a new plan. If the member is enrolled in a Kaiser Permanente medical plan (excluding Oregon Standard Plans), pediatric dental benefits will be provided. If the member is **not** enrolled in a medical plan, pediatric dental coverage will end on the last day of the month, prior to the 2026 group renewal effective date.

New Pediatric Dental Coverage:

As noted in the 2026 Medical Plan Portfolio section, ACA-compliant pediatric dental benefits for members 18 and younger will now be included in all medical plans (excluding Oregon Standard Plans). Some important details below:

- **Effective upon renewal:**

Members aged 18 and younger enrolled in a medical plan will automatically gain access to pediatric dental benefits included in their plan at renewal.

- **Orthodontia coverage:**

In 2026, pediatric dental coverage included in the medical plan does not include cosmetic orthodontia or implant benefits. To maintain this coverage, members must be enrolled in a family dental plan that offers this coverage, and the **subscriber must also be enrolled**.

- **Coverage differences:**

Updated dental benefits may differ from current plan coverage. Please review the medical plan Summary of Benefits for specific details.

- **Optional disenrollment:**

Members aged 18 and younger may choose to disenroll from family dental coverage to reduce premiums. Action is required via online account services via business.kp.org or by submitting a 2026 Oregon enrollment/change form.

- **Enrollment mapping:**

No automatic enrollment changes will occur, except for the termination of stand-alone pediatric dental plans. All other existing enrollments will remain unless action is taken.

- **Dual enrollment:**

Members may continue to enroll in both medical and family dental plans to maintain comprehensive dental coverage.

View the 2026 Medical Plan Changes and 2026 Dental Plan Changes sections for more information.

Voluntary dental plan options

Voluntary family dental plan options are available to small employer groups and their employees. Traditional and Dental Choice PPO plan options range from a \$1,000 to \$2,000 benefit maximum with \$50 deductible. See the Dental Product Portfolio brochure for additional details. The following rules apply:

- **Employee** contributes 51% to 100% of premium.
- Group participation minimum of 5 employees or 25%, whichever is greater.
- **Employer** sets up payroll deductions and submits premiums on behalf of employees.
- Standard open enrollment and qualifying life event change rules apply.
- Voluntary dental plans **may not** be elected in combination with nonvoluntary plans.

Automatic renewals

For your renewal in 2026, we will automatically provide you with coverage from one of the plans that best matches the plan or plans your business offers today. But you can choose from any of our other plans available to small employers if you prefer. Please indicate on the Renewal Changes forms if you would like to make changes.

Bundle options

As you consider alternatives to help lower your health care costs, consider offering employees a plan with 1 or 2 buy-up alternatives. These bundle plan options are provided at no additional charge and allow you to tailor your plan offerings, giving employees more choice and more control over their monthly premium cost.

You contribute the same amount toward each plan (no less than 50% of the lowest premium plan) and let your employees decide if they want to pay more for a buy-up option. For more details, refer to the Medical Plans Overview.

Prescription drug coverage is automatically covered on all medical plans

All our plans come with built-in coverage for outpatient prescription drugs. All prescription drug plans have a 4-tiered benefit design with different cost-sharing amounts for generic, preferred brand, non-preferred brand, and specialty drugs.

Your employees can save time and money by ordering prescription refills online or by phone. Members can get a 90-day supply for only 2 times the 30-day supply copay when using Kaiser Permanente mail-order pharmacy. We can mail most prescription medications to you within 3 to 5 days, and you don't pay any extra for standard U.S. postage.

Alternative care benefits

Chiropractic and acupuncture services are essential health benefits and covered on all plans (without a referral). Cost shares for these 2 services will apply to the out-of-pocket maximum.

- Chiropractic: 20 self-referred visits per year.
- Acupuncture: 12 self-referred visits per year.
- Naturopathic: Unlimited self-referred visits.

Refer to plan-specific Summary of Benefits for chiropractic, acupuncture, and naturopathic cost-sharing details.

Visit herayahealth.com for a list of providers. For members enrolled under Added Choice plans, these benefits may be used at Heraya Health, PPO, and other nonparticipating providers and facilities.

For alternative care, members can choose a PPO provider from First Choice Health in Oregon and Washington or First Health Network in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington, D.C. The Cigna HealthcareSM PPO Network¹ can be accessed for PPO network care outside states where Kaiser Permanente operates.²

For members enrolled under KP Plus plans, benefits may be used in-network with Heraya Health providers and any licensed out-of-network provider.

Massage, routine vision eye exam, and hardware benefits

All our medical plans (except the Oregon Standard plans) may be purchased with additional coverage to meet your needs. The 2 buy-up options include medical plans with adult vision hardware and routine eye exam and medical plans with self-referred massage, vision hardware, and routine eye exam. The massage benefit includes a 12-visit limit per calendar year. Refer to plan-specific summaries for cost-sharing details in PPO providers/in-network and nonparticipating/out-of-network provider networks. Members can access this massage benefit through the Heraya Health network of providers. Visit herayahealth.com for a list of providers.

As a reminder, plans purchased without the vision hardware benefit do not provide coverage for adult routine eye exams. Go to kp2020.org/nw for more information, including our optical locations.

¹The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.

²Kaiser Permanente operates in the states of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and Washington, D.C.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Healthcare Intellectual Property, Inc.

Pediatric vision coverage on all medical plans

All our plans cover pediatric vision exams and one pair of standard frames with lenses or conventional or disposable contact lenses in lieu of eyeglasses (limited to one pair per year for conventional lenses or up to a 6-month supply of disposable contact lenses per year) at no additional charge. Go to kp2020.org/nw for more information, including our optical locations.

Standard plans

Our plan portfolio includes standard plans that have been designed by the state of Oregon, and all carriers are required to offer these particular plans. Because they were not designed by Kaiser Permanente, the coverage may differ slightly from our typical plans. Differences include benefits such as pediatric dental coverage, hospice, fertility, temporomandibular joint (TMJ) coverage, and dependent out of area. Please refer to your Sales Summary of Benefits for details.

Benefits that accrue to the medical out-of-pocket maximum

Most benefits, including copays and coinsurance for services not subject to deductible, as well as the deductible itself, accrue to the medical out-of-pocket maximum. Copays and coinsurance that accrue to the out-of-pocket maximum are waived once an individual or family has reached that maximum.

For KP Plus plans, deductibles and out-of-pocket maximums do not apply to out-of-network services.

Underwriting guidelines

Please be sure to review the Rating and Underwriting Assumptions Policy effective January 1, 2026, for Oregon small employers with 50 or fewer employees.

2026 MEDICAL PLAN CHANGES

YEAR	2025	2026
PLAN NAME	All Oregon medical plans, except Oregon Standard plans	
ANNUAL OUT-OF-POCKET MAXIMUM	N/A	Applies to the medical out-of-pocket maximum.
BENEFIT	Member pays	
PEDIATRIC DENTAL	N/A	Included in all medical plans, except Oregon Standard plans.
PREVENTIVE AND DIAGNOSTIC SERVICES Oral exam, X-rays, teeth cleaning, fluoride treatments	N/A	\$0
BASIC RESTORATIVE SERVICES Routine fillings, basic crowns, simple extractions	N/A	50%*
MAJOR RESTORATIVE SERVICES Gold or porcelain crowns, inlays, bridge abutments, pontics	N/A	50%*

YEAR	2025	2026
PLAN NAME	KP OR Platinum 0	
BENEFIT	Member pays	
OUTPATIENT SURGERY	\$150	\$200
EMERGENCY DEPARTMENT VISIT	\$150	\$200

YEAR	2025	2026
PLAN NAME	KP OR Gold 0	
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	\$8,800 per individual; \$17,600 per family
BENEFIT	Member pays	
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$40	\$50
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	50%

YEAR	2025	2026
PLAN NAME	KP OR Platinum 250	
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,300 per individual; \$6,600 per family	\$3,500 per individual; \$7,000 per family
BENEFIT	Member pays	
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$15	\$25

*Pediatric dental services are subject to deductible, up to the maximum out-of-pocket, on HSA-qualified plans.

YEAR	2025	2026
PLAN NAME	KP OR Platinum 500	
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
SPECIALTY CARE	\$30	\$35
NATUROPATHIC SERVICES	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
OUTPATIENT THERAPIES ²	\$30	\$35
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Outpatient	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$5	\$10
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$15	\$25

YEAR	2025	2026
PLAN NAME	KP OR Gold 1000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	\$8,900 per individual; \$17,800 per family
BENEFIT	Member pays	
PRIMARY CARE OFFICE VISIT	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
SPECIALTY CARE	\$40	\$45
NATUROPATHIC SERVICES	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
OUTPATIENT THERAPIES ²	\$40	\$45
X-RAY/DIAGNOSTIC TEST	\$20	\$40
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Outpatient	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$25 ¹
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$10	\$15
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$40	\$50

¹First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. ²Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025	2026
PLAN NAME	KP OR Gold 1500	
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	\$8,900 per individual; \$17,800 per family
BENEFIT	Member pays	
SPECIALTY CARE	\$45	\$55
OUTPATIENT THERAPIES ¹	\$45	\$55
OUTPATIENT SURGERY	25%*	30%*
INPATIENT HOSPITAL CARE CARE	25%*	30%*
EMERGENCY DEPARTMENT VISIT	25%*	30%*
AMBULANCE SERVICES	25%*	30%*
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	25%*	30%*
DURABLE MEDICAL EQUIPMENT	25%*	30%*
GENERIC OUTPATIENT PRESCRIPTION DRUGS PRESCRIPTION DRUGS	\$10	\$15
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$30	\$50
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	\$75
OUTPATIENT ADMINISTERED MEDICATIONS	25%*	30%*
MATERNITY CARE Inpatient	25%*	30%*
SKILLED NURSING	25%*	30%*

*Subject to annual medical deductible. ¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025	2026
PLAN NAME	KP OR Gold 2000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	\$8,900 per individual; \$17,800 per family
BENEFIT	Member pays	
SPECIALTY CARE	\$45	\$60
OUTPATIENT THERAPIES ¹	\$45	\$60
OUTPATIENT SURGERY	25%*	30%*
X-RAY/DIAGNOSTIC TEST	\$35	\$45
INPATIENT HOSPITAL CARE	25%*	30%*
EMERGENCY DEPARTMENT VISIT	25%*	30%*
AMBULANCE SERVICES	25%*	30%*
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	25%*	30%*
DURABLE MEDICAL EQUIPMENT	25%*	30%*
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$45	\$50
OUTPATIENT ADMINISTERED MEDICATIONS	25%*	30%*
MATERNITY CARE Inpatient	25%*	30%*
SKILLED NURSING	25%*	30%*

YEAR	2025	2026
PLAN NAME	KP OR Silver 3000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	\$9,600 per individual; \$19,200 per family
BENEFIT	Member pays	
SPECIALTY CARE	\$55	\$60
OUTPATIENT THERAPIES ¹	\$55	\$60
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	\$65

*Subject to annual medical deductible. ¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025	2026
PLAN NAME	KP OR Silver 4000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,600 per individual; \$19,200 per family
BENEFIT	Member pays	
LAB	\$45	\$40
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	50%	50%*

YEAR	2025	2026
PLAN NAME	KP OR Silver 5000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,600 per individual; \$19,200 per family
BENEFIT	Member pays	
X-RAY/DIAGNOSTIC TEST	\$50	\$50*

YEAR	2025	2026
PLAN NAME	KP OR Silver 6000	
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,200 per individual; \$18,400 per family	\$9,800 per individual; \$19,600 per family
BENEFIT	Member pays	
X-RAY/DIAGNOSTIC TEST	\$75	40%*

YEAR	2025	2026
PLAN NAME	KP OR Bronze 9200	
BENEFIT	Member pays	
FERTILITY SERVICES (diagnosis)	50%*	0%*

*Subject to annual medical deductible.

New 2026 HSA-Qualified HDHP Plan

YEAR	2026
PLAN NAME	KP OR Gold HSA 1800
ACCUMULATION TYPE	Aggregate
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,800 per individual; \$3,600 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$5,500 per individual; \$10,150 per family
BENEFIT	
PRIMARY CARE OFFICE VISIT	\$5* for the first 3 visits; then 20%* ⁵
URGENT CARE VISIT	20%*
SPECIALTY CARE	20%*
PRENATAL CARE	\$0
ALLERGY SHOTS AND OTHER INJECTIONS	20%*
TELEHEALTH (PHONE/VIDEO)	0%* for the first 3 visits ⁵
SELF-REFERRED ALTERNATIVE CARE Acupuncture services ¹	\$25*
Chiropractic care ²	\$25*
Naturopathic services	\$5* for the first 3 visits; then 20%* ⁵
OUTPATIENT THERAPIES ³	20%*
OUTPATIENT SURGERY	20%*
LAB AND X-RAY/DIAGNOSTIC TEST	20%*
CT, MRI, AND PET SCANS	20%*
INPATIENT HOSPITAL CARE	20%*
EMERGENCY DEPARTMENT VISIT	20%*
AMBULANCE SERVICES	20%*
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Inpatient psychiatric and residential treatment	20%*
Outpatient	\$5* for the first 3 visits; then 20%* ⁵
DURABLE MEDICAL EQUIPMENT	20%*
FERTILITY SERVICES (diagnosis)	50%*
DEPENDENT OUT-OF-AREA ⁴	20%*
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$20*
BRAND OUTPATIENT PRESCRIPTION DRUGS	20%*
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	50%*
SPECIALTY OUTPATIENT PRESCRIPTION DRUGS	50%*
OUTPATIENT ADMINISTERED MEDICATIONS	20%*
MATERNITY CARE Inpatient	20%*
SKILLED NURSING	20%*

*Subject to annual medical deductible. ¹Limited to 12 visits per year. ²Limited to 20 visits per year. ³Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies. ⁴Limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. ⁵First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

YEAR	2025	2026
PLAN NAME	KP OR Silver HSA 3500	KP OR Silver HSA 3600
BENEFIT	Member pays	
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$3,500 per individual; \$7,000 per family	\$3,600 per individual; \$7,200 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,000 per individual; \$14,000 per family	\$7,800 per individual; \$15,600 per family

YEAR	2025		2026	
PLAN NAME	KP OR Platinum KP Plus 0			
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
BENEFITS ¹	Member pays			
OUTPATIENT SURGERY	\$150	Not covered	\$200	No change
EMERGENCY DEPARTMENT VISIT	\$150	Covered at the in-network cost share ²	\$200	No change

¹These plans include a dependent out-of-area (OOA) benefit, which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. ²The limit of 10 covered services does not apply.

YEAR	2025		2026	
PLAN NAME	KP OR Gold KP Plus 1000			
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	N/A	\$8,900 per individual; \$17,800 per family	No change
BENEFITS ¹	Member pays			
PRIMARY CARE OFFICE VISIT	\$5 for the first 3 visits; then \$20 ²	\$40	\$5 for the first 3 visits; then \$25 ²	\$45
SPECIALTY CARE	\$40	\$60	\$45	\$65
TELEHEALTH (PHONE/VIDEO)	\$0 ²	\$40	No change	\$45
SELF-REFERRED ALTERNATIVE CARE Naturopathic services	\$5 for the first 3 visits; then \$20 ²	\$40	\$5 for the first 3 visits; then \$25 ²	\$45
OUTPATIENT THERAPIES	\$40 ³	\$60	\$45 ³	\$65
X-RAY/DIAGNOSTIC TEST	\$20	\$40	\$40	\$60
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Outpatient	\$5 for the first 3 visits; then \$20 ²	\$40	\$5 for the first 3 visits; then \$25 ²	\$45
PHARMACY NETWORK	Kaiser Permanente pharmacies	Out-of-network pharmacies	Kaiser Permanente pharmacies	Out-of-network pharmacies
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$10	\$30	\$15	\$35
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$40	\$60	\$50	\$70

¹These plans include a dependent out-of-area (OOA) benefit, which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. ²First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. ³Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025		2026	
PLAN NAME	KP OR Silver KP Plus 3000			
NETWORK	In-network	Out-of-network (limited to 10 covered services per year, combined)	In-network	Out-of-network (limited to 10 covered services per year, combined)
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,900 per individual; \$17,800 per family	N/A	\$9,600 per individual; \$19,200 per family	No change
BENEFITS ¹	Member pays			
SPECIALTY CARE	\$55	\$75	\$60	\$80
OUTPATIENT THERAPIES	\$55 ²	\$75	\$60 ²	\$80
PHARMACY NETWORK	Kaiser Permanente pharmacies	Out-of-network pharmacies	Kaiser Permanente pharmacies	Out-of-network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	\$80	\$65	\$85

¹These plans include a dependent out-of-area (OOA) benefit, which provides limited coverage for dependent children outside the Kaiser Foundation Health Plan of the Northwest service area. For covered services, the member pays 20% of the billed charges. Services are limited to 10 office visits, 10 diagnostic labs or X-rays, and 10 prescription drug fills. This out-of-area benefit cannot be combined with any other benefit to exceed the benefit limit. Refer to your *Evidence of Coverage (EOC)* for details. ²Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025			2026		
PLAN NAME	KP OR Platinum Added Choice 250					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,200 per individual; \$6,400 per family	\$4,500 per individual; \$9,000 per family	\$7,000 per individual; \$14,000 per family	\$3,500 per individual; \$7,000 per family	\$5,000 per individual; \$10,000 per family	No change
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$20	Not covered	\$30	\$25	No change	\$35

YEAR	2025			2026		
PLAN NAME	KP OR Gold Added Choice 500					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,200 per individual; \$12,400 per family	\$8,200 per individual; \$16,400 per family	\$10,200 per individual; \$20,400 per family	\$7,000 per individual; \$14,000 per family	\$9,200 per individual; \$18,400 per family	\$10,500 per individual; \$21,000 per family
BENEFIT	Member pays					
X-RAY/DIAGNOSTIC TEST	\$35	40%*	50%*	\$45	No change	No change
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$20	Not covered	\$75	\$25	No change	No change

*Subject to annual medical deductible.

YEAR	2025			2026		
PLAN NAME	KP OR Gold Added Choice 1000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,000 per individual; \$14,000 per family	\$9,000 per individual; \$18,000 per family	\$11,000 per individual; \$22,000 per family	\$7,500 per individual; \$15,000 per family	\$9,500 per individual; \$19,000 per family	No change
BENEFIT	Member pays					
PRIMARY CARE OFFICE VISIT	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	50%*	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$45 ¹	No change
SPECIALTY CARE	\$40	\$60	50%*	\$45	\$65	No change
ALLERGY SHOTS AND OTHER INJECTIONS	\$10	\$40	50%*	No change	\$45	No change
SELF-REFERRED ALTERNATIVE CARE Naturopathic services	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	50%*	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$45 ¹	No change
OUTPATIENT THERAPIES ²	\$40	\$60	50%*	\$45	\$65	No change
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES Outpatient	\$5 for the first 3 visits; then \$20 ¹	\$5 for the first 3 visits; then \$40 ¹	50%*	\$5 for the first 3 visits; then \$25 ¹	\$5 for the first 3 visits; then \$45 ¹	No change
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$10	Not covered	\$25	\$15	No change	\$30
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$30	Not covered	\$75	\$50	No change	No change

*Subject to annual medical deductible. ¹First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services. ²Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025			2026		
PLAN NAME	KP OR Silver Added Choice 3000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$8,700 per individual; \$17,400 per family	\$9,000 per individual; \$18,000 per family	\$14,000 per individual; \$28,000 per family	\$9,200 per individual; \$18,400 per family	\$9,800 per individual; \$19,600 per family	No change
BENEFIT	Member pays					
SPECIALTY CARE	\$55	\$70	50%*	\$60	\$75	No change
OUTPATIENT THERAPIES ¹	\$55	\$70	50%*	\$60	\$75	No change
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	Not covered	\$70	\$65	No change	\$75

YEAR	2025			2026		
PLAN NAME	KP OR Silver Added Choice 4000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	50%	Not covered	50%	50%*	No change	50%*

*Subject to annual medical deductible. ¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025			2026		
PLAN NAME	KP OR Platinum Added Choice OOA 250					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$3,200 per individual; \$6,400 per family	\$3,200 per individual; \$6,400 per family	\$7,000 per individual; \$14,000 per family	\$3,600 per individual; \$7,200 per family	\$3,600 per individual; \$7,200 per family	No change
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$20	Not covered	\$20	\$25	No change	\$25

YEAR	2025			2026		
PLAN NAME	KP OR Gold Added Choice OOA 500					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$6,900 per individual; \$13,800 per family	\$6,900 per individual; \$13,800 per family	\$10,000 per individual; \$20,000 per family	\$7,500 per individual; \$15,000 per family	\$7,500 per individual; \$15,000 per family	No change
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$10	Not covered	\$10	\$15	No change	\$15

YEAR	2025			2026		
PLAN NAME	KP OR Gold Added Choice OOA 1000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,000 per individual; \$14,000 per family	\$7,000 per individual; \$14,000 per family	\$11,000 per individual; \$22,000 per family	\$7,500 per individual; \$15,000 per family	\$7,500 per individual; \$15,000 per family	No change
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
GENERIC OUTPATIENT PRESCRIPTION DRUGS	\$10	Not covered	\$10	\$15	No change	\$15
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$20	Not covered	\$20	\$30	No change	\$30

YEAR	2025			2026		
PLAN NAME	KP OR Silver Added Choice OOA 3000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
ANNUAL OUT-OF-POCKET MAXIMUM	\$9,000 per individual; \$18,000 per family	\$9,000 per individual; \$18,000 per family	\$14,000 per individual; \$28,000 per family	\$9,600 per individual; \$19,200 per family	\$9,600 per individual; \$19,200 per family	No change
BENEFIT	Member pays					
SPECIALTY CARE	\$55	\$55	50%*	\$60	\$60	No change
OUTPATIENT THERAPIES ¹	\$55	\$55	50%*	\$60	\$60	No change
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
BRAND OUTPATIENT PRESCRIPTION DRUGS	\$60	Not covered	\$60	\$75	No change	\$75

YEAR	2025			2026		
PLAN NAME	KP OR Silver Added Choice OOA 4000					
NETWORK	KP Select Providers	PPO Providers	Nonparticipating Providers	KP Select Providers	PPO Providers	Nonparticipating Providers
BENEFIT	Member pays					
PHARMACY NETWORK	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies	Kaiser Permanente pharmacies	N/A	MedImpact network pharmacies
NON-PREFERRED BRAND OUTPATIENT PRESCRIPTION DRUGS	50%	Not covered	50%	50%*	No change	50%*

*Subject to annual medical deductible. ¹Rehabilitative and habilitative therapies have limits of 30 visits each per year. Neurodevelopmental conditions have an additional 30 visits per year for both rehabilitative and habilitative therapies.

YEAR	2025	2026
PLAN NAME	KP OR Standard Gold ¹	
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$1,500 per individual; \$3,000 per family	\$1,800 per individual; \$3,600 per family
ANNUAL OUT-OF-POCKET MAXIMUM	\$7,000 per individual; \$14,000 per family	\$8,150 per individual; \$16,300 per family
BENEFIT	Member pays	
TELEHEALTH PRIMARY CARE (PHONE/VIDEO)	\$0	\$5 for the first 3 visits; then \$20 ²
TELEHEALTH SPECIALTY CARE (PHONE/VIDEO)	\$0	\$40
TELEHEALTH URGENT CARE (PHONE/VIDEO)	\$0	\$60

YEAR	2025	2026
PLAN NAME	KP OR Standard Silver ¹	
ANNUAL MEDICAL DEDUCTIBLE (PER CALENDAR YEAR)	\$5,500 per individual; \$11,000 per family	\$6,100 per individual; \$12,200 per family
BENEFIT	Member pays	
SPECIALTY CARE	\$80	\$100
TELEHEALTH PRIMARY CARE (PHONE/VIDEO)	\$0	\$5 for the first 3 visits; then \$40 ²
TELEHEALTH SPECIALTY CARE (PHONE/VIDEO)	\$0	\$100
TELEHEALTH URGENT CARE (PHONE/VIDEO)	\$0	\$70

YEAR	2025	2026
PLAN NAME	KP OR Standard Bronze ¹	
TELEHEALTH PRIMARY CARE (PHONE/VIDEO)	\$0	\$5 for the first 3 visits; then \$50 ²
TELEHEALTH SPECIALTY CARE (PHONE/VIDEO)	\$0	\$150
TELEHEALTH URGENT CARE (PHONE/VIDEO)	\$0	\$100

¹These plans may not be sold with additional coverage such as adult vision hardware and eye exam and massage. Only medically necessary eye exams are covered. These plans exclude the following benefits: pediatric dental benefits, dependent out of area, and fertility diagnosis. ²First 3 visits are any combination of in-person or telemedicine services for primary care non-specialty medical services, mental health outpatient services, naturopathic medicine, or substance use disorder outpatient services.

YEAR	2025	2026
PLAN NAME	Plan with Group Senior Advantage	
BENEFIT	Member pays	
OUTPATIENT PRESCRIPTION DRUGS	\$2,000 prescription (Part D) maximum out-of-pocket	\$2,100 prescription (Part D) maximum out-of-pocket

2026 DENTAL PLAN CHANGES

YEAR	2025	2026
PLAN NAME	All Family Traditional dental plans	
ANNUAL OUT-OF-POCKET MAXIMUM	\$425 per individual; \$850 per family	\$450 per individual; \$900; per family
BENEFIT	Member pays	
NITROUS OXIDE* Members age 12 and younger	\$0	\$25

YEAR	2025	2026
PLAN NAME	All Traditional dental plans	
BENEFIT	Member pays	
EMERGENCY TREATMENT	For out-of-network: all charges over \$100.	For out-of-network: the cost shares that normally apply for nonemergency dental care services, plus amounts that exceed usual and customary charges for qualifying claims.

YEAR	2025		2026	
PLAN NAME	All Family Choice dental plans			
NETWORK	In-network	Out-of-network	In-network	Out-of-network
ANNUAL OUT-OF-POCKET MAXIMUM	\$425 per individual; \$850 per family	N/A	\$450 per individual; \$900 per family	No change

*Nitrous oxide services do not apply to the deductible nor count toward the annual benefit maximum.

SUMMARY OF 2026 PLAN CHANGES

The following changes will be made to small group plans, effective at renewal on or after January 1, 2026, unless stated otherwise.

This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the Group Agreement. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other group-specific or product-specific plan design changes (including changes to copayment or coinsurance amounts) may apply, such as moving to standard benefits. Refer to the previous pages in this Plan Updates document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your Group Agreement, the information contained in the Group Agreement shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your group renews in 2026. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Medical plan benefit changes and clarifications

Benefit	Summary of changes	Reason for change
Allergy serum	An "Allergy serum" row will be added to the Benefit Summary under the "Outpatient Services" section. The serum cost share will be in addition to any applicable office visit cost share.	To clarify that allergy serums will be subject to cost sharing.
Doula coverage	The "Maternity and Newborn Care" section of the <i>Evidence of Coverage (EOC)</i> and Benefit Summary will be revised to reflect coverage for both inpatient and outpatient doula services.	To align with Oregon Senate Bill 692.
Live/work policy	The live/work policy will be updated to require that subscribers live or work inside the Kaiser Permanente service area, applicable to their coverage, when they enroll. This change will be reflected in the <i>EOC</i> . Previously, it was required that subscribers live or work in the service area at least 50% of the time to be eligible for enrollment.	Policy alignment across Kaiser Permanente regions.
Pediatric dental coverage	PPO Pediatric dental coverage will be included in all Oregon Small Group medical plans, with the exception of the Oregon Standard Plans.	For ease of administration.
Preventive breast exams	Language in the "Preventive Care Services" and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" sections of the <i>EOC</i> will be updated to indicate that preventive breast screenings include any imaging done prior to a breast cancer diagnosis. Diagnostic and supplemental breast imaging includes imaging that follows a breast cancer diagnosis.	Alignment with the Washington state Office of the Insurance Commissioner's guidance.

Medical plan benefit changes and clarifications *(continued)*

Benefit	Summary of changes	Reason for change
<p>Prior authorization requirements</p>	<p>The “Prior Authorization Review Requirements” section of the <i>EOC</i> will be updated to clarify that prior authorization is not required when a provider determines, during a previously authorized surgery, that an additional procedure is medically necessary.</p>	<p>To comply with Oregon House Bill 3134.</p>
<p>Prosthetics and Orthotics additional coverage</p>	<p>The <i>EOC</i>’s “External Prosthetic and Orthotic Devices” section will be updated to reflect that Kaiser Permanente covers medically necessary devices for physical activities such as running, biking, swimming, and strength training.</p>	<p>Benefit enhancement to align with Oregon Senate Bill 699.</p>
<p>The CHP Group</p>	<p>The CHP Group, our contracted provider network for alternative care services, has changed its name to Heraya Health. We will make edits throughout relevant <i>EOC</i> documents to reflect the new name and website URL. As part of this transition, the CHP Active and Healthy program will be discontinued.</p>	<p>Administrative change to reflect the updated name.</p>

Dental benefit plan changes

Benefit	Summary of changes	Reason for change
Annual out-of-pocket maximum	Annual out-of-pocket maximum will be applied until the end of the month in which the member turns 19 years of age.	To comply with Centers for Medicare and Medicaid Services (CMS) final guidance.
Composite fillings	The buy-up cost for composite fillings on posterior teeth will be removed.	Removing the buy-up cost for composite fillings on posterior teeth will provide members with cost savings and allows them to choose non-metal, mercury-free fillings without an extra cost.
Emergency dental coverage	Emergency dental coverage for members on Traditional dental plans who receive dental emergency care from a nonparticipating provider outside the service area will change. Members will incur the cost share that normally applies for nonemergency dental care services.	To align the emergency dental benefit for Oregon and Washington members.
Nitrous oxide	The cost share for nitrous oxide for members aged 0 to 12 on Oregon plans will increase from \$0 to \$25 to match the cost share for members aged 13 and older. All members will incur a cost share with no distinction between ages.	To align the cost share for members of all ages. This same change was made for Washington in 2025.
Oregon Small Group Pediatric-only plans	Oregon Small Group Pediatric-only plans will be discontinued.	Stand-alone pediatric dental plans in Oregon will be discontinued as pediatric dental coverage will be included in medical plans beginning in 2026.
PPO Prior Authorization	PPO Prior Authorization requirements will change from requiring all procedures over \$500 to be submitted for prior authorization to a set list of procedural codes to be required for prior authorization.	By focusing on specific procedures instead of costs, both providers and members will experience more transparency, consistency, and potentially quicker access to necessary care, all while being protected against unnecessary costs and treatments.

Senior Advantage benefit plan changes

Benefit	Summary of changes	Reason for change
<p>Prescription formulary exceptions</p>	<p>If a formulary exception is approved, brand prescription medications will apply a tier 5 cost share, which was previously tier 4.</p>	<p>Market alignment. Please note cost share may not differ for all groups.</p>
<p>Prescription maximum out-of-pocket</p>	<p>Medicare will have a \$2,100 prescription (Part D) maximum out-of-pocket.</p>	<p>CMS annually adjusts the maximum out-of-pocket as part of the Inflation Reduction Act (IRA).</p>
<p>Prescriptions – insulin products</p>	<p>The cost share will change from \$35 per month or applicable tier cost share to 25% (up to \$35 max per month) or applicable tier cost share.</p>	<p>CMS-driven change to help manage the cost of insulin products.</p>

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Information in this brochure was accurate at the time of production.
Details may have changed since publication.

