KAISER PERMANENTE®

Group Name: HORIZON COMMUNITY CHURCH
Region: Northwest
Contract Period: 09/01/2026 to 08/31/2027
Summary of Benefits

DED PLAN J 4000/40/30%/7500

Accumulation Details

The accumulation period is calendar year, and the accumulation type is Embedded.

Deductible(s) and Out-of-Pocket Maximum(s) Details

Cost Share amounts that count toward the Deductible are shown below.

For services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Deductible(s)	**Participating Providers**
Self-only Deductible per year (for a Family of one Member)	$4000
Individual Family Member Deductible per year (for each Member in a Family of two or more Members)	$4000
Family Deductible per year (for an entire Family)	$8000

Out-of-Pocket Maximum(s)[1]	**Participating Providers**
Self-only Out-of-Pocket Maximum per year (for a Family of one Member)	$7500
Individual Family Member Out-of-Pocket Maximum per year (for each Member in a Family of two or more Members)	$7500
Family Out-of-Pocket Maximum per year (for an entire Family)	$15000

Professional Services	**Participating Providers**
Primary care office visit[2]	$5 for first 3 visits, then $40 for additional visits in the same year
Specialty care office visit	$40 per visit
Telehealth[2]	$0
Routine physical maintenance exams, including well-woman exams	No Charge

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Professional Services	Participating Providers
Well-child preventive exams (through age 23 months)	No Charge
Physical, occupational, and speech therapy	$40 (20 visits per therapy per year)

Outpatient Services	Participating Providers
Outpatient surgery visits and certain other outpatient procedures	30% Coinsurance After Deductible
Diagnostic X-rays	30% Coinsurance After Deductible
Laboratory services	30% Coinsurance After Deductible
Preventive X-rays, screenings, and laboratory tests	No Charge
Advanced imaging (CT / MRI / PET)	30% Coinsurance After Deductible
Chemotherapy/radiation therapy visit	$40 per visit After Deductible

Hospitalization and Emergency Services	Participating Providers
Urgent care	$40 per visit
Hospital room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance After Deductible
Ambulance services	20% Coinsurance After Deductible
Emergency department visits	$300 After Deductible (Waived if Admitted)

Medication Coverage	Participating Providers
Retail Pharmacy (up to a 30-day supply)	Kaiser Permanente Pharmacy: Generic: $10 Brand: $20 Non Preferred: $40 Specialty: $200
Mail order prescriptions (up to a 90-day supply)	Kaiser Permanente Pharmacy: Two copayments at retail cost share
Administered medications, including injections (all outpatient settings)	30% Coinsurance After Deductible
Allergy injections	$10 per visit
Immunizations	No Charge

Maternity Care	Participating Providers
Scheduled prenatal care exams and postpartum visit	No Charge
Laboratory	30% Coinsurance After Deductible
X-Ray, imaging, and special diagnostic procedures	30% Coinsurance After Deductible
Labor and Delivery Hospital Services	30% Coinsurance After Deductible

Durable Medical Equipment (DME)	Participating Providers
Durable medical equipment	30% Coinsurance After Deductible
Prosthetic and orthotic devices	30% Coinsurance After Deductible

Mental Health Services	Participating Providers
Inpatient psychiatric care	30% Coinsurance After Deductible
Outpatient individual therapy visits[2]	$5 for first 3 visits, then $40 for additional visits in the same year

Substance Use Disorder Treatment	Participating Providers
Inpatient detoxification	30% Coinsurance After Deductible
Outpatient individual therapy visits[2]	$5 for first 3 visits, then $40 for additional visits in the same year

Home Health Services	Participating Providers
Home health care	30% Coinsurance After Deductible (up to 130 visits per Year)

Alternative Care	Participating Providers
Benefit maximum	Not Applicable
Acupuncture care	$25 per visit up to 12 visits per calendar year
Chiropractic care	$25 per visit up to 20 visits per calendar year
Massage therapy	$25 per visit up to 12 visits per calendar year
Naturopathic medicine[2]	$5 for first 3 visits, then $40 for additional visits in the same year

Other Professional Services	Participating Providers
Skilled nursing facility	30% Coinsurance After Deductible (up to 100 days per Year)
Hospice care	No Charge
Fertility diagnosis	50% Coinsurance After Deductible
Fertility lab	50% Coinsurance After Deductible
Fertility treatment	Treatment Not Covered
Bariatric care	Covered
Adult hearing aid(s)	Not Covered
Pediatric hearing aid(s)	30% Coinsurance (1 per Ear / 36 months)

Vision Services	Participating Providers
Pediatric Vision exam	$40 per visit
Adult Vision exam	$40 per visit
Pediatric optical eyewear	Not Covered
Adult optical eyewear	Not Covered

1. Refer to your Evidence of Coverage (EOC) for benefits that may not apply to Out-of-Pocket Maximum.
2. First 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 from all contracted providers combined.