County of Fresno
Group ID 604334 - Low Plan
Member Services 1-800-464-4000

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/25—12/31/25)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member	$1,000 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$25 per visit
Urgent care consultations, evaluations, and treatment	$25 per visit
Physical, occupational, and speech therapy	$25 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission
Emergency Services	**You Pay**
Emergency department visits	$75 per visit
Ambulance and Transportation Services	**You Pay**
Ambulance Services	$100 per trip
Other transportation Services when provided by our designated transportation provider as described in this *EOC*	No charge for up to 24 one-way trips (50 miles per trip) per calendar year
Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,000 in 2025. (If you spend $2,000, you move on to the catastrophic coverage stage):	
Generic drugs at a pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

continued

Prescription Drug Coverage	You Pay
Brand-name drugs at a pharmacy	$25 for up to a 30-day supply, $50 for a 31- to 60-day supply, or $75 for a 61- to 100-day supply
Brand-name refills through our mail-order service	$25 for up to a 30-day supply or $50 for a 31- to 100-day supply
Catastrophic coverage stage	No charge
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	20 percent Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance for each ear
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog	No charge for a quarterly benefit limit of $70
Fitness benefit – One Pass™ (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

Summary of Benefits booklet

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.