As of Date

01/16/2026

Member Information

Name:	HODGES,MARVIN W [01201812]		
Number:	xxxx1812	Relationship to subscriber:	Self
Effective date:	1/1/2019	Termination date:	—

Coverage Information

Subscriber name:	HODGES,MARVIN W		
Subscriber number:	xxxx1812	Group number:	9184*2268*11
Payer:	MAS KP-MEDICARE ADVANTAGE [1344]	Benefit plan:	FD AD HIGH OPTION $0 (55166) 0126 [5045063]

Plan Notes

Health Fitness Core Covered, Premium Covered
Ambulance $0 copay/trip;
Transportation for Medical Appointments $0 (24 non-emergency one-way rides by taxi, rideshare, van, and medical transport per calendar year);
Prescription Drug Benefit (FEHB): Part B & Part D Drugs: Dispensing Limit = 30 & 90-day supply

Part D vaccines $0
30 day supply
Prescription Drug Copay Amounts:
KP Pharmacy - $3.5 Generic/$20 Brand;
Network Pharmacy - $8.5 Generic/$22.50 Brand;
90-day supply
KP Mail Order - $7 Generic/$40 Brand
KP Pharmacy - $17 Generic/$45 Brand
KP Par - $7 Generic/ $40 Brand
Pharmacy Benefit Code: EKM
Weight Management: 50% Coins

FD AD HIGH OPTION $0 (55166) 0126 [5045063]:
MOOPs - 5006489 Out-of-Pocket T1

Family Total:	**$4500.00**	**Used:**	**$0.00**	**Remaining:**	**$4500.00**	**Individual Total:**	**$2250.00**	**Used:**	**$0.00**	**Remaining:**	**$2250.00**

Plan Details

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
Alternative Medicine										
Acupuncture Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	**20 Visit**	**20 Visit**	Acupuncture Visits/cal yr
—		—			**2**	—	**Not Covered**	—	—	—
—										

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
Acupuncture - Low Back Pain	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	**20 Visit**	**20 Visit**	Acup Low Back Pain Visits/cal yr
—		—			**2**	—	**Not Covered**	—	—	—
—										
Chiropractic Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	**20 Visit**	**20 Visit**	Chiropratic Visits/cal yr
—		—			**2**	—	**Not Covered**	—	—	—
—										
Ambulance Services										
Ambulance Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Behavioral Health Services										
Mental Health Individual Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Mental Health Group Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Chemical Dependency Individual Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Chemical Dependency Group Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Mental Health, Partial Hospitalization	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Chemical Dependency, Partial Hospitalization	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Dental Services										
Accidental Dental Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Routine Dental Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
DME, Prosthetics, & Orthotics										
Durable Medical Equipment	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
Apnea Monitors	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Bilirubin Lights	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Oxygen & Oxygen Equipment	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
CPAP/BiPAP Equipment & Supplies	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Orthotics	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Diabetic Orthotics	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Prosthetics	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Prosthetic Wigs	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—		—			**Lmt**	—	—	**$350.00**	**$350.00**	KP Prosthetics Wigs $max/cal yr
Nebulizers	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
Peak Flow Meters	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—
UV Light Box	**In Network**	—	Y-I	—	**1**	MOOP	**$0.00 copay**	—	—	—
Blood Glucose Monitor	**In Network**	—	Y-I	—	**1**	MOOP	**20.00% coinsurance**	—	—	—

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
—										
Drugs, Supplies, & Supplements										
Pharmacy - Generic Drugs	**In Network**	—	Y-I	—	**1**	MOOP	**$3.50 copay**	—	—	—
—										
Medical Food Services	**In Network**	—	Y-I	—	**1**	MOOP	**25.00% coinsurance**	—	—	—
—										
Clinically Administered Drugs	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Medicare OTC	**N/A**	—	N	—	**1**	—	**$0.00 copay**	—	—	—
—										
		—			**Lmt**	—	—	**$200.00**	**$200.00**	OTC Allowance/cal yr
—										
Emergency Services										
Emergency Services	**In Network**	—	Y-I	—	**1**	MOOP	**$75.00 copay**	—	—	—
—										
General Exclusions										
Custodial Care Services	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Personal Convenience Items	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Laser Vision Correction	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Sterilization Reversal	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Hearing Services										
Hearing Aid Exam	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
One Hearing Aid, Left Ear	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
		—			**Lmt**	—	—	**1 Units**	**1 Units**	Hearing Aid (left)/3 years
—										
One Hearing Aid, Right Ear	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
		—			**Lmt**	—	—	**1 Units**	**1 Units**	Hearing Aid (right)/3 years
—										
Hearing Aid Batteries	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Home Health/Hospice Svcs										
Home Health	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Hospice Services Covered By Medicare	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Hospital Services, IP										
Hospital Services Inpatient	**In Network**	—	Y-I	—	**1**	MOOP	**$75.00 copay**	—	—	—
—										
Hospital Services Inpatient Visit	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Imaging, Lab Tests & Special Procedures										
Lab Services Outpatient	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Radiology Services Outpatient	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Specialty Imaging Outpatient	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Sleep Lab	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Infertility Services										
Infertility Treatment Services Office Visit	**In Network**	—	Y-I	—	**1**	MOOP	**$0.00 copay**	—	—	—
—										
Infertility Treatment Services Outpatient Surgery	**In Network**	—	Y-I	—	**1**	MOOP	**$25.00 copay**	—	—	—
—										
Infertility IVF Services	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Infertility Ovum Procedures	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—
—										
Infertility Ovum Procedures DC/MD	**In Network**	—	Y-I	—	**1**	—	**Not covered**	—	—	—

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
—										
Fertility Preservation for Iatrogenic Infertility	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Maternity Services										
Delivery Services, Inpatient	**In Network**	—	Y-I	—	**1**	MOOP	**$0.00 copay**	—	—	—
—										
Maternity Care	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Office Visits										
Primary Care Office Visit	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Specialty Office Visit	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Travel Immunizations	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Outpatient Services										
Surgical Services Outpatient	**In Network**	—	Y-I	—	**1**	MOOP	**$25.00 copay**	—	—	—
—										
Elective Abortion , OP/ASC	**N/A**	—	N	—	**1**	—	**Not covered**	—	—	—
—										
Therapeutic Abortion, OP/ASC	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Surgical Services, Physician Serv	**In Network**	—	Y-I	—	**1**	MOOP	**$0.00 copay**	—	—	—
—										
Outpatient Facility Services	**In Network**	—	Y-I	—	**1**	MOOP	**$25.00 copay**	—	—	—
—										
Dialysis	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Chemotherapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Radiation Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Preventive Care Services										
Preventive Care	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
—										
Preventive Care Screenings (colonoscopy & flexible sigmoidoscopy)	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Immunizations	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Mammogram Screening	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Diabetes Prevention Program	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Physical, Occupational, Speech Therapy & Multidisciplinary Rehabilitation										
Physical Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Occupational Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Speech Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Cardiac Rehabilitation	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Intensive Cardiac Rehab	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Pulmonary Rehab OP	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Video Visit Occupational Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Video Visit Physical Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Video Visit Speech Therapy	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Skilled Nursing Admission										
Skilled Nursing Facility Services	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	**100 Units**	**90 Units**	SNF copay mx/admit (qty)

Component Group	Net	Tier	Aut	Ben Ref Clsfr	Level	MOOP/Ded	Patient Portion	Limit	Left	Benefit Bucket
										(5/22/21-5/31/21)
#1 (5/22/2021-5/31/2021)		—			**1**	—	**$0.00 copay**	**100 Units**	**87 Units**	SNF copay mx/admit (qty) (2/15/24-2/28/24)
#2 (2/15/2024-2/28/2024)		—			**2**	—	**Not Covered**	—	—	—
—										
Urgent Care Services										
Urgent Care	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Virtual Services										
Televideo Consults	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Telephone Consults	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
Vision Services										
Lenses & Frames	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
		—			**Lmt**	—	—	**$100.00**	**$100.00**	KP Lens/Frames $mx/cal year
—										
Contact Lenses	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
		—			**Lmt**	—	—	**$50.00**	**$50.00**	KP Contacts $max/cal year
—										
Contact Lenses Medical Necessary	**In Network**	—	Y-I	—	**1**	—	**$0.00 copay**	—	—	—
—										
		—			**Lmt**	—	—	**$50.00**	**$50.00**	KP Contacts $max/cal year
—										