HMSA: MED 754/DRG 860

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual / Family | **Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.hmsa.com or by calling 1-800-776-4672.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating providers **$0** For non-participating providers **$100** person/**$300** family Doesn't apply to contraceptives, emergency services, prescription drugs and supplies, preventive care and well-child care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** person/**$7,500** family (applies to medical plan coverage). **$3,600** person/**$4,200** family (applies to prescription drug coverage).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$12 copay/visit	30% co-insurance	---none---
	Specialist visit	$12 copay/visit	30% co-insurance	---none---
	Other practitioner office visit: Physical and Occupational Therapist	20% co-insurance	30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Psychologist	$12 copay/visit	30% co-insurance	---none---
	Nurse Practitioner	$12 copay/visit	30% co-insurance	---none---
	Preventive care (Well Child Physician Visit)	No charge	30% co-insurance	Age and frequency limitations may apply.
	Screening Colonoscopy Screening	No charge	30% co-insurance	Coverage is provided in accordance with HMSA's medical policies
	Mammography Screening	No charge	30% co-insurance	For age 40 and over, limited to one screening per calendar year.
	Pap Smears Screening	No charge	30% co-insurance	Limited to one every three years for women ages 21 to 65.
	Prostate Specific Antigen Test Screening	20% co-insurance	30% co-insurance	1 Services/Visits per Calendar Year 50 Years of Age and Above
	Sigmoidoscopy Screening	No charge	30% co-insurance	Coverage is provided in accordance with HMSA's medical policies

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	**Immunization** (Standard)	No charge	30% co-insurance	---none---
If you have a test	**Diagnostic test** Inpatient Outpatient	 10% co-insurance 20% co-insurance	 30% co-insurance 30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
	X-ray Inpatient Outpatient	 10% co-insurance 20% co-insurance	 30% co-insurance 30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Blood Work Inpatient Outpatient	 10% co-insurance 20% co-insurance	 30% co-insurance 30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Imaging (CT/PET scans, MRIs) Inpatient Outpatient	 10% co-insurance 20% co-insurance	 30% co-insurance 30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.hmsa.com.	Tier 1 – mostly Generic drugs (retail)	$7 copay/prescription	$7 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Tier 1 – mostly Generic drugs (mail order)	$11 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.
	Tier 2 – mostly Preferred drugs (retail)	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Tier 2 – mostly Preferred drugs (mail order)	$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.hmsa.com.	Tier 3 – mostly Other Brand Name drugs (retail)	$30 copay/prescription	$30 copay and 20% co-insurance/prescription	One retail copay for 1-30 day supply, two retail copays for 31-60 day supply, and three retail copays for 61-90 day supply.
	Tier 3 – mostly Other Brand Name drugs (mail order)	$65 copay/prescription	Not covered	One mail order copay for a 84-90 day supply at a 90 day at retail network or contracted mail order provider. Tier 3 Cost Share of $45 per each retail copay or $135 at a 90 day at retail network or mail order provider.
	Tier 4 – mostly Preferred Specialty Drugs (retail)	$100 copay/prescription	Not covered	Retail benefit limited to a 30 day supply
	Tier 5 – mostly Other Brand Name Specialty Drugs (retail)	$200 copay/prescription	Not covered	
	Tier 4 & 5 (mail order)	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	30% co-insurance	---none---
	Physician Visit	$12 copay/visit	30% co-insurance	---none---
	Surgeon fees	10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)	---none--- ---none---
If you need immediate medical attention	**Emergency room services** Physician Visit	$12 copay/visit	$12 copay/visit	---none---
	Emergency Room	20% co-insurance	20% co-insurance	---none---
	Emergency medical transportation (air)	20% co-insurance	30% co-insurance	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	Emergency medical transportation (ground)	20% co-insurance	30% co-insurance	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	$12 copay/visit	30% co-insurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	30% co-insurance	---none---
	Physician Visit	$12 copay/visit	30% co-insurance	---none---
	Surgeon fee	10% co-insurance (cutting) 20% co-insurance (non-cutting)	30% co-insurance (cutting) 30% co-insurance (non-cutting)	---none--- ---none---
If you have mental health, behavioral health, or substance abuse needs	**Mental/Behavioral health outpatient services**			
	Physician services	$12 copay/visit	30% co-insurance	---none---
	Hospital and facility services	10% co-insurance	30% co-insurance	---none---
	Mental/Behavioral health inpatient services			
	Physician services	10% co-insurance	30% co-insurance	---none---
	Hospital and facility services	10% co-insurance	30% co-insurance	---none---
	Substance use disorder outpatient services			
	Physician services	$12 copay/visit	30% co-insurance	---none---
	Hospital and facility services	10% co-insurance	30% co-insurance	---none---
	Substance use disorder inpatient services			
	Physician services	10% co-insurance	30% co-insurance	---none---
	Hospital and facility services	10% co-insurance	30% co-insurance	---none---
If you are pregnant	Prenatal and postnatal care	10% co-insurance	30% co-insurance	---none---
	Delivery (surgery)	10% co-insurance	30% co-insurance	---none---
	Inpatient services (hospital room and board)	10% co-insurance	30% co-insurance	---none---
If you need help recovering or have other special health needs	Home health care	No charge	30% co-insurance	150 Services/Visits per Calendar Year
	Rehabilitation services	20% co-insurance	30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained. Excludes cardiac rehabilitation.
	Habilitation services	Not covered	Not covered	Excluded service

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Skilled nursing care	10% co-insurance	30% co-insurance	120 Days per Calendar Year
	Durable medical equipment	20% co-insurance	30% co-insurance	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Hospice service	No charge	Not covered	---none---
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Excluded service
	Glasses (single vision lenses and frames selected within designated group)	Not covered	Not covered	Excluded service
	Dental check-up	Not covered	Not covered	Excluded service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cardiac rehabilitation
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Child)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (requires precertification)
- Chiropractic care (e.g. office visits, x-ray films – limited to services covered by this medical plan and within the scope of a chiropractor's license)
- Hearing aids (limited to one hearing aid per ear every 60 months)
- Infertility treatment (requires precertification and limited to a one time only benefit for one outpatient procedure while you are an HMSA member)
- Non-emergency care when traveling outside the U.S. For more information, see http://www.hmsa.com

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-776-4672. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:

All benefits are subject to the definitions, limitations, and exclusions set forth in the Guide to Benefits (GTB). If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

For group health coverage subject to ERISA, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.

If you disagree with our appeals decision and coverage is insured (i.e. fully insured) you must request review by an Independent Review Organization (IRO) selected by the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch – External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804. If coverage is self-funded, you must request review by an Independent Review Organization (IRO) selected by HMSA at random from a panel of three IROs. Send written requests to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii, 96805-1958.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-776-4672.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays: $6,580**
- **Patient pays: $960**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$10
Co-insurance	$800
Limits or exclusions	$150
Total	**$960**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays: $4,640**
- **Patient pays: $760**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$400
Co-insurance	$280
Limits or exclusions	$80
Total	**$760**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-800-776-4672.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Important Information About Your Health Plan

HMSA doesn't discriminate

We comply with applicable federal civil rights laws. We don't discriminate, exclude people, or treat people differently because of:

- Race.
- Color.
- National origin.
- Age.
- Disability.
- Sex.

Services that HMSA provides

To better communicate with people who have disabilities or whose primary language isn't English, HMSA provides free services such as:

- Language services and translations.
- Text Relay Services.
- Information written in other languages.
- Information in other formats, such as large print, audio, and accessible digital formats.

If you need these services, please call 1 (800) 776-4672 toll-free. TTY 711.

How to file a grievance or complaint

If you believe that we've failed to provide these services or discriminated in another way, you can file a grievance in any of the following ways:

- Phone: 1 (800) 776-4672 toll-free
- TTY: 711
- Email: Compliance_Ethics@hmsa.com
- Fax: (808) 948-6414 on Oahu
- Mail: 818 Keeaumoku St., Honolulu, HI 96814

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, in any of the following ways:

- Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Phone: 1 (800) 368-1019 toll-free; TDD users, call 1 (800) 537-7697 toll-free
- Mail: U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, DC 20201

For complaint forms, please go to hhs.gov/ocr/office/file/index.html.

English: This notice has important information about your HMSA application or plan benefits. It may also include key dates. You may need to take action by certain dates to keep your health plan or to get help with costs.

If you or someone you're helping has questions about HMSA, you have the right to get this notice and other help in your language at no cost. To talk to an interpreter, please call 1 (800) 776-4672 toll-free. TTY 711.

Ilocano: Daytoy a pakaammo ket naglaon iti napateg nga impormasion maipanggep iti aplikasionyo iti HMSA wenno kadagiti benepisioyo iti plano. Mabalin nga adda pay nairaman a petsa. Mabalin a masapulyo ti mangaramid iti addang agpatingga kadagiti partikular a petsa tapno agtalinaed kayo iti plano wenno makaala kayo iti tulong kadagiti gastos.

No addaan kayo wenno addaan ti maysa a tao a tultulonganyo iti salud-sod maipanggep iti HMSA, karbenganyo a maala daytoy a pakaammo ken dadduma pay a tulong iti bukodyo a pagsasao nga awan ti bayadna. Tapno makapatang ti maysa a mangipatarus ti pagsasao, tumawag kay koma iti 1 (800) 776-4672 toll-free. TTY 711.

Tagalog: Ang abiso na ito ay naglalaman ng mahalagang impormasyon tungkol sa inyong aplikasyon sa HMSA o mga benepisyo sa plano. Maaari ding kasama dito ang mga petsa. Maaaring kailangan ninyong gumawa ng hakbang bago sumapit ang mga partikular na petsa upang mapanatili ninyo ang inyong planong pangkalusugan o makakuha ng tulong sa mga gastos.

Kung kayo o isang taong tinutulungan ninyo ay may mga tanong tungkol sa HMSA, may karapatan kayong makuha ang abiso na ito at iba pang tulong sa inyong wika nang walang bayad. Upang makipag-usap sa isang tagapagsalin ng wika, mangyaring tumawag sa 1 (800) 776-4672 toll-free. TTY 711.

Japanese: 本通知書には、HMSAへの申請や医療給付に関する重要な情報や 日付が記載されています。 医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の日付に手続きしてください。

患者さん、または付き添いの方がHMSAについて質問がある場合は、母国語で無料で通知を受けとったり、他のサポートを受ける権利があります。 通訳を希望する場合は、ダイヤルフリー電話 1 (800) 776-4672 をご利用ください。TTY 711.

Chinese: 本通告包含關於您的 HMSA 申請或計劃福利的重要資訊。 也可能包含關鍵日期。 您可能需要在某確定日期前採取行動，以維持您的健康計劃或者獲取費用幫助。

如果您或您正在幫助的某人對 HMSA 存在疑問，您有權免費獲得以您母語表述的本通告及其他幫助。 如需與口譯員通話，請撥打免費電話 1 (800) 776-4672。TTY 711.

Korean: 이 통지서에는 HMSA 신청서 또는 보험 혜택에 대한 중요한 정보가 들어 있으며, 중요한 날짜가 포함되었을 수도 있습니다. 해당 건강보험을 그대로 유지하거나 보상비를 수령하려면 해당 기한 내에 조치를 취하셔야 합니다.

신청자 본인 또는 본인의 도움을 받는 누군가가 HMSA에 대해 궁금한 사항이 있으면 본 통지서를 받고 아무런 비용 부담 없이 모국어로 다른 도움을 받을 수 있습니다. 통역사를 이용하려면 수신자 부담 전화 1 (800) 776-4672번으로 연락해 주시기 바랍니다. TTY 711.

Spanish: Este aviso contiene información importante sobre su solicitud a HMSA o beneficios del plan. También puede incluir fechas clave. Pueda que tenga que tomar medidas antes de determinadas fechas a fin de mantener su plan de salud u obtener ayuda con los gastos.

Si usted o alguien a quien le preste ayuda tiene preguntas respecto a HMSA, usted tiene el derecho de recibir este aviso y otra ayuda en su idioma, sin ningún costo. Para hablar con un intérprete, llame al número gratuito 1 (800) 776-4672. TTY 711.

Vietnamese: Thông báo này có thông tin quan trọng về đơn đăng ký HMSA hoặc phúc lợi chương trình của quý vị. Thông báo cũng có thể bao gồm những ngày quan trọng. Quý vị có thể cần hành động trước một số ngày để duy trì chương trình bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí.

Nếu quý vị hoặc người quý vị đang giúp đỡ có thắc mắc về HMSA, quý vị có quyền nhận thông báo này và trợ giúp khác bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, vui lòng gọi số miễn cước 1 (800) 776-4672. TTY 711.

Samoan - Fa'asamoa: O lenei fa'aliga tāua e fa'atatau i lau tusi talosaga ma fa'amanuiaga 'e te ono agava'a ai, pe'ā fa'amanuiaina 'oe i le poloka-lame o le HMSA. E aofia ai fo'i i lalo o lenei fa'aliga ia aso tāua. E ono mana'omia 'oe e fa'atinoina ni galuega e fa'atonuina ai 'oe i totonu o le

taimi fa'atulagaina, ina 'ia e agava'a ai pea mo fa'amanuiaga i le polokalame soifua maloloina 'ua fa'ata'atia po'o se fesoasoani fo'i mo le totogi'ina.

Afai e iai ni fesili e fa'atatau i le HMSA, e iai lou aiātatau e te talosaga ai e maua lenei fa'aliga i lau gagana e aunoa ma se totogi. A mana'omia le feasoasoani a se fa'aliliu 'upu, fa'amolemole fa'afeso'ota'i le numera 1 (800) 776-4672 e leai se totogi o lenei 'au'aunaga. TTY 711.

Marshallese: Kojella in ej boktok jet melele ko reaurok kin application ak jipan ko jen HMSA bwilan ne am. Emaron bar kwalok jet raan ko reaurok bwe kwon jela. Komaron aikiuj kommane jet bunten ne ko mokta jen detlain ko aer bwe kwon jab tum jen health bwilan en am ak bok jipan kin wonaan takto.

Ne ewor kajjitok kin HMSA, jen kwe ak juon eo kwoj jipane, ewor am jimwe im maron nan am ba ren ukot kojjella in kab melele ko kin jipan ko jet nan kajin ne am ilo ejjelok wonaan. Bwe kwon kenono ippan juon ri-ukok, jouj im calle 1 (800) 776-4672 tollfree, enaj ejjelok wonaan. TTY 711.

Trukese: Ei esinesin a kawor auchean porausen omw HMSA apilikeison me/ika omw kewe plan benefit. A pwan pachanong porausen ekoch ran mei auchea ngeni omw ei plan Ina epwe pwan auchea omw kopwe fori ekoch fofor me mwen ekei ran (mei pachanong) pwe omw health plan esap kouno, are/ika ren omw kopwe angei aninisin monien omw ei plan.

Ika a wor omw kapas eis usun HMSA, ka tongeni tungoren aninis, iwe ka pwan tongeni tungoren ar repwe ngonuk eche kapin ei taropwe mei translatini non kapasen fonuom, ese kamo. Ika ka mwochen kapas ngeni emon chon chiakku, kosemochen kopwe kori 1 (800) 776-4672, ese kamo. TTY 711.

Hawaiian: He 'ike ko'iko'i ko kēia ho'olaha pili i kou 'inikua a i 'ole palapala noi 'inikua HMSA. Aia paha he mau lā ko'iko'i ma kēia ho'olaha. Pono paha 'oe e hana i kekahi mea ma mua o kekahi lā no ka ho'omau i kou 'inikua a i 'ole ka 'imi kōkua me ka uku.

Inā he mau nīnau kou no HMSA, he kuleana ko mākou no ka hā'awi manuahi i kēia ho'olaha a me nā kōkua 'ē a'e ma kou 'ōlelo pono'ī. No ke kama'ilio me kekahi mea unuhi, e kelepona manuahi iā 1 (800) 776-4672. TTY 711.

Micronesian - Pohnpeian: Kisin likou en pakair wet audaudki ire kesempwal me pid sapwelimwomwi aplikasin en HMSA de koasoandihn sawas en kapai kan. E pil kak audaudki rahn me pahn kesemwpwal ieng komwi. Komw pahn kakete anahne wia kemwekid ni rahn akan me koasoandi kan pwe komwi en kak kolokol sawas en roson mwahu de pil ale pweinen sawas pwukat.

Ma komwi de emen aramas tohrohr me komw sewese ahniki kalelapak me pid duwen HMSA, komw ahniki pwuhng en ale pakair wet oh sawas teikan ni sapwelimwomwi mahsen ni soh isepe. Ma komw men mahsenieng souhn kawehwe, menlau eker telepohn 1 (800) 776-4672 ni soh isepe. TTY 711.

Bisayan - Visayan: Kini nga pahibalo adunay importanteng impormasyon mahitungod sa imong aplikasyon sa HMSA o mga benepisyo sa plano. Mahimo sab nga aduna kini mga importanteng petsa. Mahimong kinahanglan kang magbuhat og aksyon sa mga partikular nga petsa aron mapabilin ang imong plano sa panglawas o aron mangayo og tabang sa mga gastos.

Kung ikaw o ang usa ka tawo nga imong gitabangan adunay mga pangutana mahitungod sa HMSA, aduna kay katungod nga kuhaon kini nga pahibalo ug ang uban pang tabang sa imong lengguwahe nga walay bayad. Aron makig-istorya sa usa ka tighubad, palihug tawag sa 1 (800) 776-4672 nga walay toll. TTY 711.

Tongan - Fakatonga: Ko e fakatokanga mahu'inga eni fekau'aki mo ho'o kole ki he HMSA pe palani penefitī. 'E malava ke hā ai ha ngaahi 'aho 'oku mahu'inga. 'E i ai e ngaahi 'aho pau 'e fiema'u ke ke fai e 'ū me'a 'uhiā ko ho'o palani mo'ui leleí pe ko ho'o ma'u ha tokoni fekau'aki mo e totongí.

Kapau 'oku 'i ai ha'o fehu'i pe ha fehu'i ha'a taha 'oku ke tokonia fekau'aki mo e HMSA, 'oku totonu ke ke ma'u e fakatokanga ko ení pe ha toe tokoni pē 'i ho'o lea faka-fonuá ta'e totongi. Ke talanoa ki ha taha fakatonulea, kātaki tā ta'etotongi ki he 1 (800) 776-4672. TTY 711.

Laotian: ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ HMSA ຂອງທ່ານ ຫຼືຜົນປະໂຫຍດຈາກ HMSA. ອາດມີຂໍ້ມູນກ່ຽວກັບວັນທີສຳຄັນ. ທ່ານອາດຕ້ອງໄດ້ດຳເນີນການໃນວັນທີໃດໜຶ່ງເພື່ອຮັກສາແຜນສຸຂະພາບຂອງທ່ານ ຫຼືຮັບການຊ່ວຍເຫຼືອຄ່າຮັກສາ.
ຖ້າຫາກທ່ານ ຫຼືຜູ້ທີ່ທ່ານຊ່ວຍເຫຼືອມີຄຳຖາມກ່ຽວກັບ HMSA, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບແຈ້ງການສະບັບນີ້ ແລະການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ຕ້ອງເສຍຄ່າ. ເພື່ອໂທຫານາຍແປພາສາ, ກະລຸນາໂທໄປ 1 (800) 776-4672 ໂດຍບໍ່ເສຍຄ່າ. TTY 711.