



**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:
<b>What is the overall deductible?</b>	<b>\$0</b>	See the chart starting on page 2 for your costs for services this plan covers.
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. <b>\$2,500</b> person/ <b>\$7,500</b> family.	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billed charges, prescription drug copayments, 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 <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. See <a href="http://www.hmsa.com/search/providers">http://www.hmsa.com/search/providers</a> or call 1-800-776-4672 for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	Yes. Both verbal and written referrals are acceptable to see a specialist.	This plan will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
<b>Are there services this plan doesn't cover?</b>	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about <b>excluded services</b> .

**Questions:** Call 1-800-776-4672 or visit us at <http://www.hmsa.com>.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.hmsa.com/sbc> or call 1-800-776-4672 to request a copy. For TTY assistance, call 711.



- **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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	Not covered	---none---
	Specialist visit	\$15 copay/visit	Not covered	---none---
	<b>Other practitioner office visit:</b> Physical and Occupational Therapist	\$15 copay/visit	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Psychologist	\$15 copay/visit	Not covered	---none---
	Nurse Practitioner	\$15 copay/visit	Not covered	---none---
	<b>Preventive care</b> (Well Child Physician Visit)	No charge	Not covered	Age and frequency limitations may apply.
	<b>Screening</b> Colonoscopy Screening	No charge	Not covered	---none---
	Mammography Screening	No charge	Not covered	For age 40 and over, limited to one screening per calendar year.
	Pap Smears Screening	No charge	Not covered	Limited to one every three years for women ages 21 to 65.
	Prostate Specific Antigen Test Screening	10% co-insurance	Not covered	---none---
Sigmoidoscopy Screening	No charge	Not covered	---none---	
<b>Immunization</b> (Standard)	No charge	Not covered	---none---	

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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
<b>If you have a test</b>	<b>Diagnostic test</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>X-ray</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>Blood Work</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	<b>Imaging (CT/PET scans, MRIs)</b> Inpatient Outpatient	No charge 10% co-insurance	Not covered Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.hmsa.com">http://www.hmsa.com</a> .	Generic drugs (retail)	\$10 copay/prescription	\$10 copay/prescription	Retail benefits limited to a 30-day supply
	Generic drugs (mail order)	\$20 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply
	Preferred brand drugs (retail)	\$30 copay/prescription	\$30 copay/prescription	Retail benefits limited to a 30-day supply
	Preferred brand drugs (mail order)	\$60 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply
	Non-preferred brand drugs (retail)	\$30 copay/prescription	\$30 copay/prescription	Retail benefits limited to a 30-day supply
	Non-preferred brand drugs (mail order)	\$60 copay/prescription	Not covered	Mail order benefits limited to a 90-day supply
	Specialty drugs (retail) Specialty drugs (mail order)	\$30 copay/prescription \$60 copay/prescription	\$30 copay/prescription Not covered	Retail benefits limited to a 30-day supply Mail order benefits limited to a 90-day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	---none---
	Physician Visit	\$15 copay/visit	Not covered	---none---

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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 outpatient surgery	Surgeon fees	\$15 copay (cutting) \$15 copay (non-cutting)	Not covered Not covered	---none--- ---none---
	<b>Emergency room services</b>			
If you need immediate medical attention	Physician Visit	No charge	No charge	---none---
	Emergency Room	\$75 copay/visit	\$75 copay/visit	---none---
	Emergency medical transportation (air)	20% co-insurance	Not covered	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	Emergency medical transportation (ground)	20% co-insurance	Not covered	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	\$15 copay/visit	Not covered	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	\$75 copay/day	Not covered	1 Copay Per Day
	Physician Visit	No charge	Not covered	---none---
	Surgeon fee	No charge (cutting) No charge (non-cutting)	Not covered Not covered	---none--- ---none---
If you have mental health, behavioral health, or substance abuse needs	<b>Mental/Behavioral health outpatient services</b>			
	Physician services	\$15 copay/visit	Not covered	---none---
	Hospital and facility services	No charge	Not covered	---none---
	<b>Mental/Behavioral health inpatient services</b>			
	Physician services	No charge	Not covered	---none---
	Hospital and facility services	\$75 copay/day	Not covered	---none---
	<b>Substance use disorder outpatient services</b>			
	Physician services	\$15 copay/visit	Not covered	---none---
Hospital and facility services	No charge	Not covered	---none---	
<b>Substance use disorder inpatient services</b>				
Physician services	No charge	Not covered	---none---	

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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
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Hospital and facility services	\$75 copay/day	Not covered	---none---
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Not covered	---none---
	Delivery (surgery)	No charge	Not covered	---none---
	Inpatient services (hospital room and board)	\$75 copay/day	Not covered	1 Copay Per Day
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	Not covered	365 Visits per illness/injury
	Rehabilitation services	\$15 copay/visit	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained. Excludes cardiac rehabilitation.
	Habilitation services	Not covered	Not covered	Excluded service
	Skilled nursing care	No charge	Not covered	60 Days per Benefit Period
	Durable medical equipment	50% co-insurance	Not covered	Services may require precertification. Benefits may be denied if precertification is not obtained.
	Hospice service	No charge	Not covered	---none---
<b>If your child needs dental or eye care</b>	Eye exam	\$15 copay/exam	Not covered	Limited to one routine vision exam per calendar year.
	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

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## 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
- Chiropractic care (e.g. hot/cold application, laser therapy)
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Vision Appliances (Child)
- 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)
- 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)
- Private-duty nursing
- Routine eye care (Adult)

## 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>.

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## 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, kwijjigo holne' 1-800-776-4672.

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

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## 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: \$7,230**
- **Patient pays: \$310**

#### 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	\$90
Co-insurance	\$70
Limits or exclusions	\$150

**Total \$310**

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

- **Amount owed to providers: \$5,400**
- **Plan pays: \$4,120**
- **Patient pays: \$1,280**

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Co-pays	\$550
Co-insurance	\$650
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,280</b>

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.

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# 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.

## 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
- Email: [Compliance\\_Ethics@hmsa.com](mailto: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](https://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](https://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.

**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.

**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.

**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。

**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。

**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.

**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.

**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.

**Samoan - Fa'asamoa:** O lenei fa'aliga tāua e fa'ataua i lau tusi talosaga ma fa'amanuiaga 'e te ono agava'a ai, pe'a fa'amanuiaina 'oe i le polokalame 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 poloka-

lame soifua maloloina ‘ua fa’ata’atia po’o se fesoasoani fo’i mo le toto-gi’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.

**Marshallese:** Kojella in ej boktok jet melele ko reurok kin application ak jipan ko jen HMSA bwilan ne am. Emaron bar kwalok jet raan ko reurok 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 kojella 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.

**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 transladini non kapasen fonuom, ese kamo. Ika ka mwochen kapas ngeni emon chon chiakku, kosemochen kopwe kori 1 (800) 776-4672, ese kamo.

**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.

**Micronesian - Pohnpeian:** Kisin likou en pakair wet audaudki ire kesempwal me pid sapwelimwomwi aplikasin en HMSA de koasoandih sawas en kapai kan. E pil kak audaudki rahn me pahn kesempwal 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.

**Bisayan - Visayan:** Kini nga pahibalo adunay importanteng impormasyon mahitungod sa imong aplikasyon sa HMSA o mga benepisyong 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.

**Tongan - Fakatonga:** Ko e fakatokanga mahu’inga eni fekau’aki mo ho’o kole ki he HMSA pe palani penefiti. ‘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 lelei pe ko ho’o ma’u ha tokoni fekau’aki mo e totongi.

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 eni 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.

**Laotian:** ດູ່ຈັກກຽນສະບັບມືຂໍ້ມູນທຳອິດກ່ຽວກັບການສະມັກ HMSA ຂອງທ່ານ ຫຼື ຜູ້ທີ່ປະເໜີຄູ່ກາກ HMSA ອາດມີຂໍ້ມູນກ່ຽວກັບວັນທຳອິດ. ທ່ານອາດຕ້ອງໄດ້ດາວນຳການໃບວັນທຳອິດເພື່ອຮກສາ ຜນສຸຂະພາບຂອງທ່ານ ຫຼື ສູບການຊ່ວຍເຫຼືອຄາຣກສາ.

ຖ້ຳຫາກທ່ານ ຫຼື ຜູ້ທີ່ປະເໜີຄູ່ກາກ HMSA, ທ່ານມັດື ທຈະໄດ້ຮູບູຮູງການສະບັບ ແລະ ການຊ່ວຍເຫຼືອອນໄປນພາສາຂອງທ່ານ ໂດຍບັດຕ້ອງເສຍຄ່າ. ເພື່ອໂທຫາພາສາ ຫຼື ກະນຸນາໂທໄປ 1 (800) 776-4672 ໂດຍບັດເສຍຄ່າ.