

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hmsa.com.

For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary/> or call 1-800-776-4672 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$350 individual / \$1,050 family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | No. | This plan does not have a deductible . You do not have to meet a deductible amount before the plan pays for any services. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 individual / \$9,000 family (applies to medical plan coverage). \$3,600 individual / \$4,200 family (applies to prescription drug coverage). A separate out-of-pocket limit may apply for pediatric dental services. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| 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 . |
| Will you pay less if you use a network provider ? | Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$20 copay /visit; deductible does not apply | Not covered | ---none--- |
| | Specialist visit | \$20 copay /visit; deductible does not apply | Not covered | ---none--- |
| | Other practitioner office visit: | | | |
| | Physical and Occupational Therapist | \$20 copay /visit | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Psychologist | \$20 copay /visit; deductible does not apply | Not covered | ---none--- |
| | Nurse Practitioner | \$20 copay /visit; deductible does not apply | Not covered | ---none--- |
| | Preventive care (Well Child Physician Visit) | No charge | Not covered | Age and frequency limitations may apply. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. |
| | Screening | No charge | Not covered | |
| Immunization (Standard and Travel) | No charge | Not covered | | |
| If you have a test | Diagnostic test | | | |
| | Inpatient | 20% coinsurance | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | Not covered | |
| | X-ray | | | |
| | Inpatient | 20% coinsurance | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| Outpatient | 20% coinsurance | Not covered | | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|---|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a test | Blood Work | | | |
| | Inpatient | 20% coinsurance | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance ; deductible does not apply | Not covered | |
| | Imaging (CT/PET scans, MRIs) | | | |
| | Inpatient | 20% coinsurance | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | Not covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmsa.com . | Tier 1 – mostly Generic drugs (retail) | \$7 copay /prescription | \$7 copay and 20% coinsurance /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 Formulary Drugs (retail) | \$30 copay /prescription | \$30 copay and 20% coinsurance /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 Formulary 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 | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.hmsa.com . | Tier 3 – mostly Non-preferred Formulary Drugs (retail) | \$30 copay /prescription | \$30 copay and 20% coinsurance /prescription | In addition to your copay and/or coinsurance , you will be responsible for a \$45 Tier 3 Cost Share per retail copay . Cost to you for retail Tier 3 drugs: One copay plus one Tier 3 Cost Share for 1-30 day supply, two copays plus two Tier 3 Cost Shares for 31-60 day supply, and three copays plus three Tier 3 Cost Shares for 61-90 day supply. |
| | Tier 3 – mostly Non-preferred Formulary Drugs (mail order) | \$65 copay /prescription | Not covered | In addition to your copay and/or coinsurance , you will be responsible for a \$135 Tier 3 Cost Share per mail order copay . Cost to you for mail order Tier 3 drugs: One mail order copay plus one mail order Tier 3 Cost Share for an 84-90 day supply at a 90 day at retail network or contracted mail order provider. |
| | Tier 4 – mostly Preferred Formulary Specialty drugs (retail) | \$100 copay /prescription | Not covered | Retail benefits for Tier 4 and Tier 5 drugs are limited to a 30-day supply. Available in participating Specialty Pharmacies only. |
| | Tier 5 – mostly Non-preferred Formulary 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) | 20% coinsurance | Not covered | ---none--- |
| | Physician Visits | \$20 copay /visit | Not covered | ---none--- |
| | Surgeon fees | \$20 copay (cutting) | Not covered (cutting) | ---none--- |
| | | \$20 copay (non-cutting) | Not covered (non-cutting) | ---none--- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | | | |
| | Physician Visit | No charge | No charge | ---none--- |
| | <u>Emergency room</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | ---none--- |
| | <u>Emergency medical transportation</u> (air) | 20% <u>coinsurance</u> | Not covered | Limited to air transport to the nearest adequate hospital within the State of Hawaii. |
| | <u>Emergency medical transportation</u> (ground) | 20% <u>coinsurance</u> | Not covered | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | <u>Urgent care</u> | \$20 <u>copay</u> /visit | Not covered | ---none--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not covered | ---none--- |
| | Physician Visits | 20% <u>coinsurance</u> | Not covered | ---none--- |
| | Surgeon fee | 20% <u>coinsurance</u> (cutting) | Not covered (cutting) | ---none--- |
| | | 20% <u>coinsurance</u> (non-cutting) | Not covered (non-cutting) | ---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Outpatient services | | | |
| | Physician services | \$20 <u>copay</u> /visit; <u>deductible</u> does not apply | Not covered | ---none--- |
| | Hospital and facility services | No charge | Not covered | ---none--- |
| | Inpatient services | | | |
| | Physician services | 20% <u>coinsurance</u> | Not covered | ---none--- |
| | Hospital and facility services | 20% <u>coinsurance</u> | Not covered | ---none--- |
| If you are pregnant | Office visit (Prenatal and postnatal care) | 20% <u>coinsurance</u> | Not covered | <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or <u>copay</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | Not covered | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | ---none--- |
| | Rehabilitation services | \$20 copay /visit | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |
| | Skilled nursing care | 20% coinsurance | Not covered | 60 Days per Benefit Period. |
| | Durable medical equipment | 50% coinsurance | Not covered | Services may require preauthorization . Benefits may be denied if preauthorization is not obtained. |
| | Hospice services | No charge | Not covered | ---none--- |
| | If your child needs dental or eye care | Children's eye exam | \$20 copay /exam | Not covered |
| Children's glasses (single vision lenses and frames selected within designated group) | | \$20 copay /glasses | 50% coinsurance | Limited to one routine vision exam per calendar year. Benefits available through age 18. |
| Children's dental check-up | | Not covered | Not covered | Excluded Service |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cardiac rehabilitation
- 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
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- 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)
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1) 1-800-776-4672 for HMSA; 2) (808) 586-2790 for the State of Hawaii, Dept. of Commerce and Consumer Affairs – Insurance Division; 3) 1-866-444-3272 or <http://www.dol.gov/ebsa/healthreform> for the U.S. Department of Labor, Employee Benefits Security Administration; or 4) 1-877-267-2323 x61565 or <http://www.cciio.cms.gov> for the U.S. Department of Health and Human Services. Church plans are not covered by the Federal COBRA continuation coverage rules. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, 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.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| Total Example Cost | \$12,800 |
|--|----------------|
| In this example, Peg would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$350 |
| Copayments | \$70 |
| Coinsurance | \$2,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,980 |

| Total Example Cost | \$7,400 |
|--|----------------|
| In this example, Joe would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$350 |
| Copayments | \$800 |
| Coinsurance | \$900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$2,110 |

| Total Example Cost | \$1,900 |
|--|--------------|
| In this example, Mia would pay: | |
| <i>Cost Sharing</i> | |
| Deductibles | \$350 |
| Copayments | \$100 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$650 |

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
- 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.

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 numerā 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 telephohn 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: ດູ່ຈັກກະສະບັບມີຂໍ້ມູນທຳອິດກ່ຽວກັບການສະມັກ HMSA ຂອງທ່ານ ຫຼື ຜູ້ທີ່ປະເທືອດຂອງທ່ານ HMSA ອາດມີຂໍ້ມູນກ່ຽວກັບວັນທຳອິດ. ທ່ານອາດຕ້ອງໄດ້ດາວນຳການໃບວັນທຳອິດເພື່ອຮັກສາແຜນສະຖາບັນຂອງທ່ານ ຫຼື ສູບການຊ່ວຍເຫຼືອຄາຣາສາ.

ຖ້າຫາກທ່ານ ຫຼື ຜູ້ທີ່ກ່ຽວຂ້ອງອື່ນຄຳຖາມກ່ຽວກັບ HMSA, ທ່ານມັສິດີ ທີ່ຈະໄດ້ຮັບຮູບຮ່າງການສະບັບ ແລະ ການຊ່ວຍເຫຼືອອື່ນໆ ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ຕ້ອງເສຍຄ່າ. ເພື່ອໂທຫາພາສາ ແລະ ພາສາ, ກະລຸນາໂທໄປ 1 (800) 776-4672 ໂດຍບໍ່ເສຍຄ່າ.