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?	For network providers **$0** For out-of-network providers **$100** individual / **$300** 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?	Yes. All services received from a participating or in-network provider will be covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	Yes. **$2,500** individual / **$7,500** family (applies to medical plan coverage). **$3,600** individual / **$4,200** family (applies to prescription drug coverage).	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?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

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	$12 copay/visit	30% coinsurance	---none---
	Specialist visit	$12 copay/visit	30% coinsurance	---none---
	Other practitioner office visit:			
	Physical and Occupational Therapist	20% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Psychologist	$12 copay/visit	30% coinsurance	---none---
	Nurse Practitioner	$12 copay/visit	30% coinsurance	---none---
	Preventive care (Well Child Physician Visit)	No charge	30% coinsurance; deductible does not apply	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	30% coinsurance	---none---
	Immunization (Standard and Travel)	No charge	30% coinsurance	---none---
If you have a test	**Diagnostic test**			
	Inpatient	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	20% coinsurance	30% coinsurance	
	X-ray			
	Inpatient	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	20% coinsurance	30% coinsurance	
	Blood Work			
	Inpatient	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if preauthorization is not obtained.
	Outpatient	20% coinsurance	30% coinsurance	
	Imaging (CT/PET scans, MRIs)			
	Inpatient	10% coinsurance	30% coinsurance	Services may require preauthorization. Benefits may be denied if

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	Outpatient	20% coinsurance	30% coinsurance	preauthorization is not obtained.
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; deductible does not apply	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% coinsurance/prescription; deductible does not apply	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.
	Tier 3 – mostly Other Brand Name drugs (retail)	$30 copay/prescription	$30 copay and 20% coinsurance/prescription; deductible does not apply	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.

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 Other Brand Name 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 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. Copayments for prescription drugs and Supplies do not apply toward your annual out-of-pocket limit.
	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% coinsurance	30% coinsurance	---none---
	Physician Visits	$12 copay/visit	30% coinsurance	---none---
	Surgeon fees	10% coinsurance (cutting)	30% coinsurance (cutting)	---none---
		20% coinsurance (non-cutting)	30% coinsurance (non-cutting)	---none---
If you need immediate medical attention	**Emergency room care**			
	Physician Visit	$12 copay/visit	$12 copay/visit; deductible does not apply	---none---
	Emergency room	20% coinsurance	20% coinsurance; deductible does not apply	---none---
	Emergency medical transportation (air)	20% coinsurance	30% coinsurance	Limited to air transport to the nearest adequate hospital within the State of Hawaii.
	Emergency medical transportation (ground)	20% coinsurance	30% coinsurance	Ground transportation to the nearest, adequate hospital to treat your illness or injury.
	Urgent care	$12 copay/visit	30% coinsurance	---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 have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	---none---
	Physician Visits	$12 copay/visit	30% coinsurance	---none---
	Surgeon fee	10% coinsurance (cutting)	30% coinsurance (cutting)	---none---
		20% coinsurance (non-cutting)	30% coinsurance (non-cutting)	---none---
If you have mental health, behavioral health, or substance abuse needs	**Outpatient services**			
	Physician services	$12 copay/visit	30% coinsurance	---none---
	Hospital and facility services	10% coinsurance	30% coinsurance	---none---
	Inpatient services			
	Physician services	10% coinsurance	30% coinsurance	---none---
	Hospital and facility services	10% coinsurance	30% coinsurance	---none---
If you are pregnant	Office visit (Prenatal and postnatal care)	10% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	150 Visits per Calendar Year
	Rehabilitation services	20% coinsurance	30% coinsurance	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	10% coinsurance	30% coinsurance	120 Days per Calendar Year.
	Durable medical equipment	20% coinsurance	30% coinsurance	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	$10 copay/exam	50% coinsurance; deductible does not apply	Limited to one routine vision exam per calendar year.

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 your child needs dental or eye care	Children's glasses (single vision lenses and frames selected within designated group)	$25 copay/glasses	50% coinsurance; deductible does not apply	The frequency in which you can obtain a pair of glasses may vary
	Children's dental check-up	No charge	No charge; deductible does not apply	2 visits per calendar year

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.)

- Acupuncture
- Cardiac rehabilitation
- Cosmetic surgery
- Habilitation services
- Long-term care
- Private-duty nursing
- 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.)

- 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)
- Dental care (Adult) (limited to services covered under a rider)
- 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 www.hmsa.com
- Routine eye care (Adult) (limited to services covered under a rider)

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): 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:

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	$0
Specialist copayment	$12
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,410**

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

The plan's overall deductible	$0
Specialist copayment	$12
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,160**

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

The plan's overall deductible	$0
Specialist copayment	$12
Hospital (facility) coinsurance	10%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

The plan would be responsible for the other costs of these EXAMPLE covered services.

C

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'atatau i lau tusi talosaga ma fa'amanuiaga 'e te ono agava'a ai, pe'ā fa'amanuiaina 'oe i le poloka-

lame 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.

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.

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.

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 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.

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.

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.

Laotian: ແຈ້ງການສະບັບນີ້ມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໝັກ HMSA ຂອງທ່ານ ຫຼືຜົນປະໂຫຍດຈາກ HMSA. ອາດມີຂໍ້ມູນກ່ຽວກັບວັນທີສໍາຄັນ. ທ່ານອາດຕ້ອງໄດ້ດໍາເນີນການໃນວັນທີໃດໜຶ່ງເພື່ອຮັກສາແຜນສຸຂະພາບຂອງທ່ານ ຫຼືຮັບການຊ່ວຍເຫຼືອຄ່າຮັກສາ.

ຖ້າຫາກທ່ານ ຫຼືຜູ້ທີ່ທ່ານຊ່ວຍເຫຼືອມີຄໍາຖາມກ່ຽວກັບ HMSA, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບແຈ້ງການສະບັບນີ້ ແລະການຊ່ວຍເຫຼືອອື່ນໆເປັນພາສາຂອງທ່ານໂດຍບໍ່ຕ້ອງເສຍຄ່າ. ເພື່ອໂທຫານາຍແປພາສາ, ກະລຸນາໂທໄປ 1 (800) 776-4672 ໂດຍບໍ່ເສຍຄ່າ.