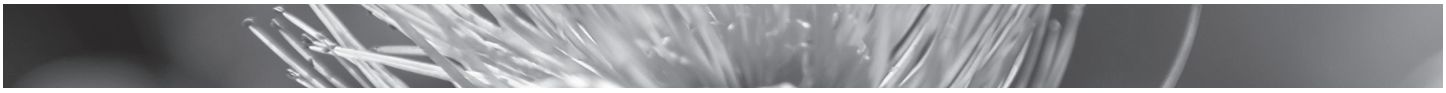
Annual Notice of Changes



HMSA Akamai Advantage
Standard Plus (PPO)

2025

MedicareRx
Prescription Drug Coverage

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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HMSA Akamai Advantage Standard Plus (PPO) offered by Hawai'i Medical Service Association (HMSA)

Annual Notice of Changes for 2025

You are currently enrolled as a member of *HMSA Akamai Advantage Standard Plus*. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium***.

This document tells about changes to your plan. To get more information about costs, benefits, or rules, please review the *Evidence of Coverage*, which is located on our website at www.hmsa.com/advantage. You may also call Customer Relations to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. **ASK**: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including coverage restrictions and cost sharing.
- Think about how much you will spend on premiums, deductibles, and cost sharing.
- Check the changes in the 2025 "Drug List" to make sure the drugs you currently take are still covered.
- Compare the 2024 and 2025 plan information to see if any of these drugs are moving to a different cost-sharing tier or will be subject to different restrictions, such as prior authorization, step therapy, or a quantity limit, for 2025.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies, will be in our network next year.

☐ Check if you qualify for help paying for prescription drugs. People with limited incomes may qualify for "Extra Help" from Medicare.

☐ Think about whether you are happy with our plan.

2. **COMPARE:** Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2025* handbook. For additional support, contact your State Health Insurance Assistance Program (SHIP) to speak with a trained counselor.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan

- If you don't join another plan by December 7, 2024, you will stay in *HMSA Akamai Advantage Standard Plus*.
- To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2025.** This will end your enrollment in *HMSA Akamai Advantage Standard Plus*.
- If you recently moved into or currently live in, an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

Additional Resources

- Please contact our Customer Relations number at (808) 948-6000 on Oahu or toll-free from the Neighbor Islands and U.S. Mainland at 1-800-660-4672 for additional information. (TTY users should call 711). Hours are 8:00 am - 8:00 pm, 7 days a week. This call is free.
- Customer Relations has free language interpreter services available for non-English speakers (phone numbers are in Section 7.1 of this booklet).
- This information is available in large print. Please call Customer Relations if you need plan information in another format.
- **Coverage under this plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About *HMSA Akamai Advantage Standard Plus*

- HMSA Akamai Advantage® is a PPO plan with a Medicare contract. Enrollment in HMSA Akamai Advantage depends on contract renewal.
- When this document says "we," "us," or "our," it means Hawai‘i Medical Service Association (HMSA). When it says "plan" or "our plan," it means *HMSA Akamai Advantage Standard Plus.*

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Summary of Important Costs for 2025

The table below compares the 2024 costs and 2025 costs for *HMSA Akamai Advantage Standard Plus* in several important areas. **Please note this is only a summary of costs.**

Cost	2024 (this year)	2025 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. See Section 1.1 for details.	$130	$125
Maximum out-of-pocket amounts This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	From network providers: $3,850 From network and out-of-network providers combined: $5,750	From network providers: $3,850 From network and out-of-network providers combined: $5,750
Doctor office visits	Primary care visits: $0 copayment per visit Specialist visits: $40 copayment per visit	Primary care visits: $0 copayment per visit Specialist visits: $40 copayment per visit
Inpatient hospital stays	For Medicare-covered hospital stays: Days 1-5: $350 copayment per day Days 6-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. $0 copayment for additional hospital days.	For Medicare-covered hospital stays: Days 1-5: $350 copayment per day Days 6-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. $0 copayment for additional hospital days.

Cost	2024 (this year)	2025 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copayment • Drug Tier 2: $11 copayment • Drug Tier 3: $45 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% of the cost You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $4 copayment • Drug Tier 2: $11 copayment • Drug Tier 3: $45 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $95 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% of the cost You pay $35 per month supply of each covered insulin product on this tier. Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2024 (this year)	2025 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$130	$125
Part B premium reduction	There is no Part B premium reduction in 2024.	As a member of our plan, *HMSA Akamai Advantage Standard Plus* will reduce your monthly Medicare Part B premium by $6. The reduction is set up by Medicare and administered through the Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social Security check or credited on your Medicare Part B premium statement.

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs. Please see Section 6 regarding "Extra Help" from Medicare.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amounts

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. These limits are called the maximum out-of-pocket amounts. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2024 (this year)	2025 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copays) from network providers count toward your in-network maximum out-of-pocket amount. Your plan premium and costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,850	$3,850 Once you have paid $3,850 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network providers for the rest of the calendar year.
Combined maximum out-of-pocket amount Your costs for covered medical services (such as copays) from in-network and out-of-network providers count toward your combined maximum out-of-pocket amount. Your plan premium and costs for outpatient prescription drugs do not count toward your maximum out-of-pocket amount for medical services.	$5,750	$5,750 Once you have paid $5,750 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services from network or out-of-network providers for the rest of the calendar year.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Updated directories are also located on our website at www.hmsa.com/advantage. You may also call Customer Relations for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers, routine vision providers, and dental providers for next year. **Please review the 2025 *Provider Directory* to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**. **Please review the 2025 *Directory of Routine Vision Providers* to see if your routine vision providers are in our network. Please review the 2025 *Directory of Dental Providers* to see if your dental providers are in our network.**

There are changes to our network of pharmacies for next year. **Please review the 2025 *Provider Directory* to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors, routine vision providers, dental providers, specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Customer Relations so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2024 (this year)	2025 (next year)
Ambulatory infusion suite (AIS) drug administration and nursing services	Ambulatory infusion suite (AIS) drug administration and nursing services is <u>not</u> covered.	Ambulatory infusion centers provide intravenous or subcutaneous administration of drugs or biologicals to an individual in an outpatient setting. The components needed to perform infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Medicare Part B prescription drugs • Supplies (for example, tubing and catheters) We also cover the administration of Part D drugs in the ambulatory infusion suite. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6. **In-Network** 20% of the cost for professional services, including nursing services, and supplies furnished in the ambulatory infusion center. **Out-of-network** 40% of the cost for professional services, including nursing services, and supplies furnished in the ambulatory infusion center. For cost-sharing for certain drugs and biologicals that you can't give yourself, see *Medicare Part B prescription drugs*.

Cost	2024 (this year)	2025 (next year)
Dental services	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Preventive Dental Services:** • Oral exams: 2 per calendar year • Cleanings: 2 per calendar year • Full mouth X-rays or Panoramic X-ray: 1 set per 5 calendar years • Bitewing X-rays: 1 set per calendar year except when performed within 12 months of full mouth x-rays or panoramic x-ray • Fluoride: 2 treatments per calendar year • Silver Diamine Fluoride: 2 treatments per calendar year **Additional Comprehensive Dental Services:** • Fillings: 2 per calendar year • Extractions: 4 per calendar year **In-Network** $40 copayment for each visit for Medicare-covered dental benefits. $0 copayment for preventive and additional comprehensive dental services. **Out-of-network** 40% of the cost for each visit for Medicare-covered dental benefits. 40% of the cost for preventive and additional comprehensive dental services.	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: **Diagnostic and Preventive Dental Services:** • Oral Exams: 2 per calendar year • Cleanings: 2 per calendar year • Full mouth X-rays or Panoramic X-ray: 1 set per 5 calendar years • Bitewing X-rays: 1 set per calendar year except when performed within 12 months of full mouth x-rays or panoramic x-ray • Fluoride: 2 treatments per calendar year • Silver Diamine Fluoride: 2 treatments per calendar year **Comprehensive Dental Services:** • Fillings: 2 per calendar year • Extractions: 4 per calendar year • Root canals: 1 per calendar year **In-Network** $40 copayment for each visit for Medicare-covered dental services. $0 copayment for diagnostic and preventive and comprehensive dental services. **Out-of-Network** 40% of the cost for each visit for Medicare-covered dental services. 40% of the cost for diagnostic and preventive and comprehensive dental services.

Cost	2024 (this year)	2025 (next year)
Diabetes screening	We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.
Diabetes self-management training, diabetic services and supplies	For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. There are quantity limits for diabetic test strips. If your doctor believes you require a higher number of test strips, they can request an exception. We cover the following preferred brands and manufacturers of supplies to monitor your blood glucose: • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • OneTouch Ultra 2 • OneTouch Verio • Precision Xtra You can also ask your pharmacist to tell you which brands and manufacturers we cover. Generally, we will not cover other brands and manufacturers of diabetic supplies unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *HMSA Akamai Advantage Standard Plus* and are using a brand of diabetic supplies that is not preferred, we will continue to	For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. There are quantity limits for diabetic test strips. If your doctor believes you require a higher number of test strips, they can request an exception. We cover the following preferred brands and manufacturers of Blood Glucose Monitors (BGM) and related supplies to monitor your blood glucose: • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • OneTouch Ultra 2 • OneTouch Verio • Precision Xtra You can also ask your pharmacist to tell you which brands and manufacturers we cover. Generally, we will not cover other brands and manufacturers of diabetic supplies unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to *HMSA Akamai Advantage Standard Plus* and are using a brand of diabetic supplies that is not preferred, we will continue to cover this brand for up to 100 days. During

Cost	2024 (this year)	2025 (next year)
Diabetes self-management training, diabetic services and supplies (continued)	cover this brand for up to 100 days. During this time, you should talk with your doctor to decide the preferred brand that is medically appropriate for you after this 100-day period. • Other supplies to monitor your blood glucose: Medicare-covered Continuous Glucose Monitoring System (CGMS), and related supplies For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions.	this time, you should talk with your doctor to decide the preferred brand that is medically appropriate for you after this 100-day period. • Other supplies to monitor your blood glucose: Continuous Glucose Monitoring System (CGMS), and related supplies. We cover the following preferred brands and manufacturers Continuous Glucose Monitoring System (CGMS), and related supplies to monitor your blood glucose: • Dexcom • Freestyle Libre For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. Diabetes self-management training is covered under certain conditions.
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program	The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Healthy Aging Coaching, plus other features. Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit	The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Healthy Aging Coaching, plus other features. Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard membership services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit www.silverandfit.com or call Silver&Fit Customer Service.

Cost	2024 (this year)	2025 (next year)
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program (continued)	www.silverandfit.com or call Silver&Fit Customer Service. Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost. Healthy Aging Coaching: You can access Silver&Fit Healthy Aging Coaching sessions by phone, video, or chat with a trained coach at no additional cost. Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, and live virtual classes and events. Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). *The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, and Silver&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are subject to change.*	Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost. Healthy Aging Coaching: You can access Silver&Fit Healthy Aging Coaching sessions by phone, video, or chat with a trained coach at no additional cost. Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, and live virtual classes and events, and social groups. Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). *The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, and Silver&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are subject to change.*

Cost	2024 (this year)	2025 (next year)
Fitness Program – The Silver&Fit® Healthy Aging and Exercise Program (continued)	**In-Network and Out-of-network** The Silver&Fit Program Fitness Center Membership $0 monthly fee for Standard Network fitness centers $30-$200 monthly fee for Premium Network fitness centers. Home Fitness Kits $0 copayment for one Home Fitness Kit per calendar year. Healthy Aging Coaching $0 copayment for unlimited sessions of Healthy Aging Coaching.	**In-Network and Out-of-network** The Silver&Fit Program Fitness Center Membership $0 monthly fee for Standard Network fitness centers $30-$250 monthly fee for Premium Network fitness centers. Home Fitness Kits $0 copayment for one Home Fitness Kit per calendar year. Healthy Aging Coaching $0 copayment for unlimited sessions of Healthy Aging Coaching.
Hearing services	Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. See Section 3.1 of this chapter for services we do not cover. **In-Network** $40 copayment for each Medicare-covered diagnostic hearing and balance exam. **Out-of-network** 40% of the cost for each Medicare-covered diagnostic hearing and balance exam.	Medicare-covered services include: Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. See Section 3.1 of this chapter for services we do not cover. **In-Network** $0 copayment for each Medicare-covered diagnostic hearing and balance exam. **Out-of-network** 40% of the cost for each Medicare-covered diagnostic hearing and balance exam. Supplemental covered services include: • One routine hearing exam per calendar year • Up to two hearing aids from the TruHearing Catalog every year (limit 1 hearing aid per ear). Call 1-855-739-4111 to schedule an appointment (for TTY, dial 711). Hearing aid purchase includes: • First year of follow-up provider visits • 60 day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models (See Section 3.1 of this chapter for a list of exclusions).

Cost	2024 (this year)	2025 (next year)
Hearing services (continued)		**In-Network** $0 copayment for one routine hearing exam per calendar year. $0 copayment for first year of follow-up provider visits. $195 copayment per aid for Basic Aids $595 copayment per aid for Standard Aids $995 copayment per aid for Advanced Aids $1,395 copayment per aid for Premium Aids **Out-of-Network** 40% of the cost for one routine hearing exam per calendar year. 40% of the cost for first year of follow-up provider visits. 40% of the cost per aid up to the maximum allowable charge of $1,850 per aid, plus the difference between the actual hearing aid cost and the maximum allowable charge, if any. When using an out-of-network provider you are responsible for submitting a claim. For additional information, see Chapter 7.
Help with Certain Chronic Conditions Dental services – Oral Health for Total Health	This program focuses on health conditions such as diabetes, coronary artery disease, pregnancy, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, head and neck cancer, oral cancer and Sjögren's syndrome that affect oral health. Programs include additional dental benefits for members identified with specific health conditions and outreach activities to support members and promote oral health. For more information on this program, please visit www.hmsadental.com/members/oral-health-for-total-health/enroll or call Customer Relations (phone numbers are listed on the back cover of this document). Members diagnosed with diabetes, coronary artery disease, stroke, pregnancy, chronic obstructive pulmonary disease, end stage renal disease or metabolic syndrome are eligible for the following services in addition to the plan's dental benefits:	This program focuses on health conditions such as diabetes, coronary artery disease, pregnancy, stroke, chronic obstructive pulmonary disease, end stage renal disease, metabolic syndrome, head and neck cancer, oral cancer and Sjögren's syndrome that affect oral health. Programs include additional dental benefits for members identified with specific health conditions and outreach activities to support members and promote oral health. For more information on this program, please visit www.hmsadental.com/members/oral-health-for-total-health/enroll or call Customer Relations (phone numbers are listed on the back cover of this document). Members diagnosed with diabetes, coronary artery disease, stroke, pregnancy, chronic obstructive pulmonary disease, end stage renal disease or metabolic syndrome are eligible for the following services in addition to the plan's dental benefits:

Cost	2024 (this year)	2025 (next year)
Help with Certain Chronic Conditions Dental services – Oral Health for Total Health (continued)	**Dental Services:** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years Members diagnosed with head and neck cancer, oral cancer or Sjögren's syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services:** • Cleanings: 2 additional per calendar year • Dental deep cleaning: 1 per 2 calendar years • Fluoride: 2 additional treatments per calendar year at least 3 months apart • Oral exams: 2 additional exams per calendar year	**Dental Services:** • Cleanings: 2 additional per calendar year • Dental full mouth debridement: 1 per 2 calendar years • Dental deep cleaning: 1 per quadrant per 2 calendar years Members diagnosed with head and neck cancer, oral cancer or Sjögren's syndrome are eligible for the following services in addition to the plan's dental benefits: **Dental Services:** • Cleanings: 2 additional per calendar year • Dental full mouth debridement: 1 per 2 calendar years • Fluoride: 2 additional treatments per calendar year at least 3 months apart • Oral exams: 2 additional per calendar year
Hospice services	You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan. If you choose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: *HMSA Akamai Advantage Standard Plus* will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. The plan also covers transitional concurrent care for members enrolled in a network Medicare-certified hospice	You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays

Cost	2024 (this year)	2025 (next year)
Hospice services (continued)	program for up to 30 days after election. You will get comfort-directed palliative care while continuing to receive outpatient curative treatment from an interdisciplinary team of practitioners. Transitional concurrent care is not available to members transitioning from the *Supportive Care* benefit into the Medicare hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay cost-sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." For services that are covered by *HMSA Akamai Advantage Standard Plus* but are not covered by Medicare Part A or B: *HMSA Akamai Advantage Standard Plus* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization): • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay cost-sharing under Fee-for-Service Medicare (Original Medicare). For services that are covered by *HMSA Akamai Advantage Standard Plus* but are not covered by Medicare Part A or B: *HMSA Akamai Advantage Standard Plus* will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill

Cost	2024 (this year)	2025 (next year)
Hospice services (continued)	Our plan covers hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by *HMSA Akamai Advantage Standard Plus*. **In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for Medicare-covered hospice services. $0 copayment for prescription drugs and biologics. $0 copayment for inpatient respite care. For cost-sharing for hospice consultation services (one time only) for a member who hasn't elected the hospice benefit but may be considering and be eligible for the hospice benefit, along with their family or caregiver, see *Physician/Practitioner services, including doctor's office visits.*	person who hasn't elected the hospice benefit. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not *HMSA Akamai Advantage Standard Plus*. For cost-sharing for hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit, see *Physician/Practitioner services, including doctor's office visits.* Original Medicare covers all hospice care from the effective date of election to the date of discharge or revocation. During the election, Original Medicare also covers attending physician services and all care unrelated to the terminal illness. Transitional concurrent care for members enrolled in a Medicare-certified hospice program will not be covered in 2025. Your cost sharing for Medicare-covered hospice services will be: 5% of the cost and no more than $5 for prescription drugs and biologics. 5% of the cost for inpatient respite care.
Immunizations	Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines) once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D prescription drug benefit. Refer to Chapter 6, Section 8 for additional information.

Cost	2024 (this year)	2025 (next year)
Immunizations (continued)	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. For coverage of other vaccines (if you are at risk and the vaccine(s) meet Medicare Part B coverage rules), see *Medicare Part B prescription drugs.*	**In-Network and Out-of-network** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. For coverage of other vaccines (if you are at risk and the vaccine(s) meet Medicare Part B coverage rules), see *Medicare Part B prescription drugs.*
Inpatient hospital care	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 18774862048. You can call these numbers for free, 24 hours a day, 7 days a week.
Medicare Part B prescription drugs	These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers or insulin pumps) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone	These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • The Alzheimer's drug, Leqembi® , (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and

Cost	2024 (this year)	2025 (next year)
Medicare Part B prescription drugs (continued)	fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.hmsa.com/part-b-step/. We also cover some vaccines under our Part B and Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/Immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form

Cost	2024 (this year)	2025 (next year)
Medicare Part B prescription drugs (continued)		and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv,® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.hmsa.com/part-b-step/. We also cover some vaccines under our Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.
Outpatient diagnostic tests & therapeutic services & supplies	**In-Network** 20% of the cost for Medicare-covered lab services.	**In-Network** $0 copayment for Medicare-covered lab services.
Outpatient hospital observation	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1800MEDICARE (18006334227). TTY users call 18774862048. You can call	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Cost	2024 (this year)	2025 (next year)
Outpatient hospital observation (continued)	these numbers for free, 24 hours a day, 7 days a week.	
Outpatient hospital services	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1800MEDICARE (18006334227). TTY users call 18774862048. You can call these numbers for free, 24 hours a day, 7 days a week.	You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 18774862048. You can call these numbers for free, 24 hours a day, 7 days a week.
Over-the-Counter (OTC) Health Products Allowance	You are eligible for a $95 quarterly benefit to be used in-store or online shopping for over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores. The benefit renews at the beginning of each quarter of the calendar year (January, April, July, and October), and unused benefit balances do not carry over between quarters. You will receive your HMSA Extra Benefits carrier card with your HMSA Extra Benefits Debit Card in the mail to use towards the purchase of OTC health and wellness products available through United Medco, or at select retail stores. If you order OTC items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtraBenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am - 8:00 pm Hawaii Standard Time, Monday through Friday. **In-Network** $0 copayment for up to $95 quarterly of over-the-counter (OTC) health and wellness products available through our mail order service and at select retail stores.	Your over-the-counter (OTC) health products allowance is loaded onto a HMSA Extra Benefits Debit Card. The allowance benefit renews at the beginning of each quarter of the calendar year (January, April, July, and October), and unused benefit balances do not carry over between quarters. You can use your allowance benefit for: • OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, toothpaste, bandages, and more. You will receive your HMSA Extra Benefits Debit Card in the mail. You can use the card to purchase covered OTC health products available at select retail stores or through mail order with our mail order partner – Medline. If you order OTC items online, by phone, or by mail, your items will be delivered to your door at no additional cost. Visit https://HMSAExtraBenefits.com to shop online or manage your Extra Benefits account, or call 1-800-790-6019 from 8:00 am - 8:00 pm Hawaii Standard Time, Monday through Friday. **In-Network** $0 copayment for up to $200 quarterly of over-the-counter (OTC) health products.

Cost	2024 (this year)	2025 (next year)
Partial hospitalization services and Intensive outpatient services	Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	*Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.
Prosthetic and orthotic devices and related supplies	Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail.	Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see *Vision Care* later in this section for more detail.
Urgently needed services	Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider	A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts with. Your plan must cover urgently needed services and only charge you in-network cost

Cost	2024 (this year)	2025 (next year)
Urgently needed services (continued)	out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
Welcome to Medicare preventive visit	The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit.

Section 1.5 – Changes to Your Part D Prescription Drug Coverage

Changes to Our Drug List

Our list of covered drugs is called a Formulary or Drug List. A copy of our Drug List is provided electronically. We will send you a document that explains how to request a copy of the Drug List.

We made changes to our Drug List, which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the Drug List are new for the beginning of each year. However, we might make other changes that are allowed by Medicare rules that will affect you during the plan year. We update our online Drug List at least monthly to provide the most up-to-date list of drugs. If we make a change that will affect your access to a drug you are taking, we will send you a notice about the change.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Customer Relations for more information.

Starting in 2025, we may immediately remove brand name drugs or original biological products on our Drug List if we replace them with new generics or certain biosimilar versions of the brand name drug or original biological product on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding a new version, we may decide to keep the brand name drug or original biological product on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions or both.

Starting in 2025, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you are taking a brand name drug or biological product that is being replaced by a generic or biosimilar version, you may not get notice of the change 30 days before we make it or get a month's supply of your brand name drug or biological product at a network pharmacy. If you are taking the brand name drug or biological product at the time we make the change, you will still get information on the specific change we made, but it may arrive after we make the change.

Some of these drug types may be new to you. For definitions of the drug types that are discussed throughout this chapter, please see Chapter 10 of your Evidence of Coverage. The Food and Drug Administration (FDA) also provides consumer information on drugs. See FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You may also contact Customer Relations or ask your health care provider, prescriber, or pharmacist for more information.

Changes to Prescription Drug Benefits and Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2024, please call Customer Relations and ask for the LIS Rider.

Beginning in 2025, there are three **drug payment stages:** the Yearly Deductible Stage, the Initial Coverage Stage, and the Catastrophic Coverage Stage. The Coverage Gap Stage and the Coverage Gap Discount Program will no longer exist in the Part D benefit.

The Coverage Gap Discount Program will also be replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Initial Coverage Stage and the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

Changes to the Deductible Stage

Stage	2024 (this year)	2025 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost-sharing in the Initial Coverage Stage

Stage	2024 (this year)	2025 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost-sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List. Most adult Part D vaccines are covered at no cost to you.	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 Preferred Generic:** You pay $4 copayment. **Tier 2 Generic:** You pay $11 copayment. **Tier 3 Preferred Brand:** You pay $45 copayment. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** You pay $95 copayment. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty Tier:** You pay 33% of the cost. You pay $35 per month supply of each covered insulin product on this tier. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing: **Tier 1 Preferred Generic:** You pay $4 copayment. **Tier 2 Generic:** You pay $11 copayment. **Tier 3 Preferred Brand:** You pay $45 copayment. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Drug:** You pay $95 copayment. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty Tier:** You pay 33% of the cost. You pay $35 per month supply of each covered insulin product on this tier. _____ Once you have paid $2,000 out of pocket for Part D drugs, you will move to the next stage (the Catastrophic Stage).

Changes to the Catastrophic Coverage Stage

The Catastrophic Coverage Stage is the third and final stage. Beginning in 2025, drug manufacturers pay a portion of the plan's full cost for covered Part D brand name drugs and biologics during the Catastrophic Coverage Stage. Discounts paid by manufacturers under the Manufacturer Discount Program do not count toward out-of-pocket costs.

For specific information about your costs in the Catastrophic Coverage Stage, look at Chapter 6, Section 6, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2024 (this year)	2025 (next year)
Prior Authorization of Services Outpatient hospital observation services	In 2024, prior authorization of outpatient hospital observation services may be required.	In 2025, prior authorization of outpatient hospital observation services is not required.
Interchangeable Biosimilar (See Chapter 12 of the EOC, *Definitions of Important Words*)	This definition was not included in the 2024 *Evidence of Coverage.*	A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.
Original Biological Product (See Chapter 12 of the EOC, *Definitions of Important Words*)	This definition was not included in the 2024 *Evidence of Coverage.*	A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.
Medicare Prescription Payment Plan	Not Applicable	The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). To learn more about this payment option, please contact us at 1-855-479-3659 or visit Medicare.gov.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in *HMSA Akamai Advantage Standard Plus*

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our *HMSA Akamai Advantage Standard Plus*.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2025 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- – *OR* – You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, see Section 1.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.cov/plan-compare), read the *Medicare & You 2025* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

As a reminder, Hawai‘i Medical Service Association (HMSA) offers other Medicare health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from *HMSA Akamai Advantage Standard Plus*.
- To **change to Original Medicare with a prescription drug plan**, enroll in the new drug plan. You will automatically be disenrolled from *HMSA Akamai Advantage Standard Plus*.
- To **change to Original Medicare without a prescription drug plan**, you must either:
  - Send us a written request to disenroll. Contact Customer Relations if you need more information on how to do so.
  - – *OR* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7**. The change will take effect on January 1, 2025.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2025, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2025.

If you recently moved into or currently live in an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for two full months after the month you move out.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Hawaii, the SHIP is called Hawaii SHIP.

It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Hawaii SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Hawaii SHIP at (808) 586-7299. You can learn more about Hawaii SHIP by visiting their website (www.hawaiiship.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare**. People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, yearly deductibles, and coinsurance. Additionally, those who qualify will not have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/ 7 days a week;
  - The Social Security Office at 1-800-772-1213 between 8:00 am – 7:00 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call 1-800-325-0778; or
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS**. The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-

sharing assistance through the HIV Drug Assistance Program (HDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (808) 733-9360 from 7:45 am - 4:30 pm, Monday through Friday, except State holidays. You can also visit https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/.

- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a new payment option to help you manage your out-of-pocket drug costs, starting in 2025. This new payment option works with your current drug coverage, and it can help you manage your drug costs by spreading them across **monthly payments that vary throughout the year** (January – December). **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs.**

  "Extra Help" from Medicare and help from your ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. All members are eligible to participate in this payment option, regardless of income level, and all Medicare drug plans and Medicare health plans with drug coverage must offer this payment option. To learn more about this payment option, please contact us at 1-855-479-3659 or visit Medicare.gov.

SECTION 7 Questions?

Section 7.1 – Getting Help from *HMSA Akamai Advantage Standard Plus*

Questions? We're here to help. Please call Customer Relations at (808) 948-6000 on Oahu or 1-800-660-4672 toll-free from the Neighbor Islands or U.S. Mainland. (TTY only, call 711.) We are available for phone calls 8:00 am - 8:00 pm, 7 days a week. Calls to these numbers are free. You may also visit your local HMSA office. See the back cover of this booklet for HMSA office locations and hours.

Read your 2025 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2025. For details, look in the 2025 *Evidence of Coverage* for *HMSA Akamai Advantage Standard Plus*. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.hmsa.com/advantage. You may also call Customer Relations to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.hmsa.com/advantage. As a reminder, our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs (Formulary/"Drug List")*.

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2025*

Read the *Medicare & You 2025* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

HMSA Akamai Advantage (PPO)

2025 Evidence of Coverage
Available starting Oct. 1, 2024

Learn about your health plan
See what your health plan pays for and other details, including how to:

- Get medical services.
- Pay your monthly premium.
- Contact us, Medicare, or Social Security if you have questions.

View the *2025 Evidence of Coverage* online in My Account

- Go to hmsa.com, click My Account Login, and log in.
- Scroll down to Your plan benefits and click view more.
- On the Benefits page, scroll down to the Guides section and click *2025 Evidence of Coverage*.

The *2024 Evidence of Coverage* will be available until Dec. 31, 2024.

Not registered for My Account? Go to hmsa.com and click My Account Login. Click Create an account to sign up. All you need is your HMSA membership card and an email address. It only takes a few minutes to create an account and link to your plan.

Don't have a computer? We'll mail the *Evidence of Coverage* to you. Call us daily, 8 a.m. to 8 p.m.

- (808) 948-6000 or 1 (800) 660-4672
- TTY: 711

Questions? Call us and we'll be happy to help you.

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HMSA Akamai Advantage (PPO)

Looking for a Doctor?

The 2025 Provider Directory will be available Oct. 1, 2024.

Visit hmsa.com/advantage.

1. Click Find a Doctor.
2. Under Medicare, select your plan.
3. Click Remember my plans then the Search button. You can search by location, specialty, or ailment.

Get our Provider Directory. You have three options:

- **View online.** Go to hmsa.com/advantage. Under Plan Documents, click your plan then Provider Directory.
- **Go online to request a printed copy.** Go to hmsa.com/advantage. Under Plan Documents, click your plan. Click Request hard copy. Follow the instructions and click Submit.
- **Call us to request a printed copy.** Call (808) 948-6000 or 1 (800) 660-4672 daily, 8 a.m. to 8 p.m. For TTY, call 711.

We can mail you a provider directory for:

- HMSA Akamai Advantage® (PPO)
- HMSA Akamai Advantage (PPO D-SNP)
- HMSA Akamai Advantage PPO Dental
- HMSA Akamai Advantage Routine Vision

You also can request a copy of **HMSA's Silver&Fit® Healthy Aging & Exercise program** directory. Call us and ask for the Silver&Fit directory. We'll be happy to mail you one.

The providers listed in our directories participate with HMSA. However, call the provider to make sure they're in your plan's network to get the most savings.

Questions? If you need help finding a provider, call us and we'll be happy to help you.

HMSA Akamai Advantage® is a PPO plan with a Medicare contract. Enrollment in HMSA Akamai Advantage depends on contract renewal.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). ASH is an independent specialty health organization, offering musculoskeletal health provider networks and programs, fitness center networks and programs, and well-being solutions on behalf of HMSA.

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HMSA Akamai Advantage (PPO)

Prescription Drug List 2025 (Formulary)

Find out what medications your plan helps pay for

Go online — it's quick and easy!

View medication costs, availability, and any requirements. **The updated drug list will be available starting Oct. 1, 2024**.

Go to My Account

- On hmsa.com, click My Account Login and log in. Scroll down to Your plan benefits and click view more.
- On the Benefits page, scroll down to the Guides section and click 2025 Formulary (drug list).

You can also ask us to mail you a copy of the drug list. Go to hmsa.com/advantage. Under Plan Documents, click your plan. Click Request hard copy, fill out the form, and click Submit.

Not registered for My Account?

Go to hmsa.com and click My Account Login. Click Create an account to sign up. All you need is your HMSA membership card and an email address. It only takes a few minutes to create an account and link to your plan.

Don't have a computer?

We can mail the drug list to you. Call us daily, 8 a.m. to 8 p.m.

- (808) 948-6000 or 1 (800) 660-4672
- TTY: 711

Questions? Call us and we'll be happy to help you.

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Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1 (800) 660-4672 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1 (800) 660-4672 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1 (800) 660-4672 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1 (800) 660-4672 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1 (800) 660-4672 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1 (800) 660-4672 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1 (800) 660-4672 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1 (800) 660-4672 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1 (800) 660-4672 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1 (800) 660-4672 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إنني أقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديني. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1 (800) 660-4672 (TTY: 711). هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1 (800) 660-4672 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1 (800) 660-4672 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1 (800) 660-4672 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1 (800) 660-4672 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1 (800) 660-4672 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1 (800) 660-4672 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Notes

HMSA Medicare Advantage Customer Relations

CALL	(808) 948-6000 or 1 (800) 660-4672 daily, 8 a.m.-8 p.m. Calls to these numbers are free. Customer Relations also has free language interpreter services available for non-English speakers.
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	(808) 948-6433
WRITE	HMSA Medicare Advantage Customer Relations P.O. Box 860 Honolulu, HI 96808-0860
WEBSITE	hmsa.com/advantage
VISIT	Hours of operation may change. Please go to hmsa.com/contact before your visit. HMSA Centers with extended evening and weekend hours **Honolulu, Oahu** | 818 Keeaumoku St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m. **Pearl City, Oahu** | Pearl City Gateway, 1132 Kuala St., Suite 400 Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Hilo, Hawaii Island** | Waiakea Center, 303A E. Makaala St. Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m. **Kahului, Maui** | Puunene Shopping Center, 70 Hookele St. Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–1 p.m. **Lihue, Kauai** | Kuhio Medical Center, 3-3295 Kuhio Highway, Suite 202 Monday–Friday, 8 a.m.–4 p.m.

Hawai'i SHIP

Hawai'i SHIP is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	(808) 586-7299 or 1 (888) 875-9229 Monday-Sunday. This is a prerecorded helpline. Calls will be returned within five business days.
TTY	1 (866) 810-4379. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Hawai'i SHIP Executive Office on Aging Hawaii State Department of Health No. 1 Capitol District 250 S. Hotel St., Suite 406 Honolulu, HI 96813-2831
WEBSITE	hawaiiship.org

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