Annual Notice of Change

HMSA Akamai Advantage
Standard (PPO)

2026

hmsa

MedicareRx Prescription Drug Coverage

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

Annual Notice of Change for 2026

You're enrolled as a member of *HMSA Akamai Advantage Standard*.

This material describes changes to our plan's costs and benefits next year.

- **You have from October 15 – December 7 to make changes to your Medicare coverage for next year.** If you don't join another plan by December 7, 2025, you'll stay in *HMSA Akamai Advantage Standard*.
- To change to a **different plan**, visit www.Medicare.gov or review the list in the back of your *Medicare & You 2026* handbook.
- Note this is only a summary of changes. More information about costs, benefits, and rules is in the *Evidence of Coverage.* Get a copy at www.hmsa.com/advantage or call Customer Relations at 1-800-660-4672 (TTY users call 711) to get a copy by mail.

More Resources

- Call Customer Relations at (808) 948-6000 on Oahu or toll-free from the Neighbor Islands and U.S. Mainland at 1-800-660-4672 (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 5 of this booklet).
- This information is available in large print. Please call Customer Relations if you need plan information in another format.

About *HMSA Akamai Advantage Standard*

- HMSA Akamai Advantage® is a PPO plan with a Medicare contract. Enrollment in HMSA Akamai Advantage depends on contract renewal.
- When this material 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.*
- **If you do nothing by December 7, 2025, you'll automatically be enrolled in *HMSA Akamai Advantage Standard*.** Starting January 1, 2026, you'll get your medical and drug coverage through *HMSA Akamai Advantage Standard*. Go to Section 3 for more information about how to change plans and deadlines for making a change.

OMB Approval 0938-1051 (Expires: August 31, 2026)

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Summary of Important Costs for 2026

	2025 (this year)	2026 (next year)
Monthly plan premium* *Your premium may be higher or lower than this amount. Go to Section 1.1 for details.	$0	$20
Maximum out-of-pocket amount This is the most you'll pay out of pocket for your covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: $6,700 From network and out-of-network providers combined: $10,000	From network providers: $7,700 From network and out-of-network providers combined: $11,000
Primary care office visits	$0 copayment per visit	$0 copayment per visit
Specialist office visits	$50 copayment per visit	$55 copayment per visit
Inpatient hospital stays Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.	For Medicare-covered hospital stays: Days 1-6: $370 copayment per day Days 7-60: $50 copayment per day Days 61-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.	For Medicare-covered hospital stays: Days 1-5: $475 copayment per day Days 6-60: $50 copayment per day Days 61-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.
Part D drug coverage deductible	Deductible: $400 except for covered insulin products and most adult Part D vaccines.	Deductible: $300 except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Section 1.6 for details.)	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $5.00 copayment • Drug Tier 2: $20 copayment	Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0.00 copayment • Drug Tier 2: $11 copayment

	2025 (this year)	2026 (next year)
	• Drug Tier 3: $47 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 copayment You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 27% of the cost You pay $35 per month supply of each covered insulin product on this tier.	• Drug Tier 3: 20% of the cost You pay the lesser of $35 and 25% per month supply of each covered insulin product on this tier. • Drug Tier 4: 30% of the cost • Drug Tier 5: 29% of the cost You pay the lesser of $35 and 25% 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.	Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 – Changes to the Monthly Plan Premium

	2025 (this year)	2026 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$20
Part B premium reduction This amount will be deducted from your Part B premium. This means you'll pay less for Part B.	As a member of our plan, *HMSA Akamai Advantage Standard* 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.	There is no Part B premium reduction in 2026.

Factors that could change your Part D Premium Amount

- Late Enrollment Penalty - Your monthly plan premium will be *more* if you're required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that's at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- Higher Income Surcharge - If you have a higher income, you may have to pay an additional amount each month directly to the government for Medicare drug coverage.
- Extra Help - Your monthly premium will be *less* if you get Extra Help with your drug costs. Go to Section 5 for more information about 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. This limit is called the maximum out-of-pocket amount. Once you've paid this amount, you generally pay nothing for covered Part A and Part B services for the rest of the calendar year.

	2025 (this year)	2026 (next year)
In-network maximum out-of-pocket amount Your costs for covered medical services (such as copayments) from network providers **count** toward your in-network maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs **don't count** toward your maximum out-of-pocket amount.	$6,700	$7,700 Once you've paid $7,700 out of pocket for covered Part A and Part B services, you'll 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 copayments) from in-network and out-of-network providers **count** toward your combined maximum out-of-pocket amount. Our costs for outpatient prescription drugs **don't count** toward your maximum out-of-pocket amount for medical services.	$10,000	$11,000 Once you've paid $11,000 out of pocket for covered Part A and Part B services, you'll 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 Network

Our network of providers has changed for next year. Review the 2026 *Provider Directory* at www.hmsa.com/advantage to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Please review the 2026 *Directory of Routine Vision Providers* to see if your routine vision providers are in our network. Please review the 2026 *Directory of Dental Providers* to see if your dental providers are in our network. Here's how to get an updated Provider Directory:

- Visit our website at www.hmsa.com/advantage
- Call Customer Relations at 1-800-660-4672 (TTY users call 711) to get current provider information or to ask us to mail you a *Provider Directory*.

We can make changes to the hospitals, doctors, and specialists (providers) that are part of our plan during the year. If a mid-year change in our providers affects you, call Customer Relations at 1-800-660-4672 (TTY users call 711) for help.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs can 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.

Our network of pharmacies has changed for next year. Review the 2026 *Provider Directory* to see which pharmacies are in our network.

Here's how to get an updated *Provider Directory:*

- Visit our website at www.hmsa.com/advantage
- Call Customer Relations at 1-800-660-4672 (TTY users call 711) to get current pharmacy information or to ask us to mail you a *Provider Directory*.

We can make changes to pharmacies that are part of our plan during the year. If a mid-year change in our pharmacies affects you, call Customer Relations 1-800-660-4672 (TTY users call 711) for help.

Section 1.5 – Changes to Benefits and Costs for Medical Services

	2025 (this year)	2026 (next year)
Acupuncture for chronic low back pain	**In-Network** $50 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist.	**In-Network** $55 copayment for each Medicare-covered acupuncture for chronic low back pain visit from a specialist.
Ambulance services	**In-Network and Out-of-network** $250 copayment per one-way trip per ambulance provider per day for Medicare-covered ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines.	**In-Network and Out-of-network** $350 copayment per one-way trip per ambulance provider per day for Medicare-covered ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines.
Cardiac rehabilitation services	**In-Network** $30 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. $50 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician.	**In-Network** $30 copayment for each Medicare-covered cardiac rehabilitation service ordered by your physician. $40 copayment for each Medicare-covered intensive cardiac rehabilitation service ordered by your physician.

	2025 (this year)	2026 (next year)
Chronic pain management services	Chronic pain management and treatment services is covered, but not listed in the Medical Benefits Chart.	Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. **In-Network and Out-of-Network** For cost-sharing for Chronic pain management and treatment services, see *Physician/Practitioner services, including doctor's office visit.*
Colorectal cancer screening	The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening	The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not a high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.

	2025 (this year)	2026 (next year)
Colorectal cancer screening (continued)	barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. **In-Network and Out-of-network** There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 for each Medicare-covered colorectal cancer screening exam for your doctors' services. In a hospital outpatient setting, you also pay the hospital $0 for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply. $0 copayment for each Medicare-covered barium enema. positive result.	• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. **In-Network and Out-of-network** There is no coinsurance or copayment for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay $0 for each Medicare-covered colorectal cancer screening exam for your doctors' services. In a hospital outpatient setting,

	2025 (this year)	2026 (next year)
Colorectal cancer screening (continued)		you also pay the hospital $0 for each Medicare-covered colorectal cancer screening exam. The Part B deductible doesn't apply.
Dental services **Dental services (continued)**	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 **In-Network** $50 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.	In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ 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 (simple and surgical): 4 per calendar year • Therapeutic cleanings: 2 per calendar year **In-Network** $55 copayment for each visit for Medicare-covered dental services.

	2025 (this year)	2026 (next year)
Dental services (continued)	40% of the cost for diagnostic and preventive and comprehensive dental services.	$0 copayment for diagnostic and preventive dental services 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 dental services and comprehensive dental services.
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 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* and are using a brand of diabetic supplies that is not	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: • Accu-Chek Aviva • Accu-Chek Guide • Accu-Chek SmartView • FreeStyle • FreeStyle InsuLinx • FreeStyle Lite • FreeStyle Precision Neo • 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

	2025 (this year)	2026 (next year)
Diabetes self-management training, diabetic services, and supplies (continued)	preferred, we will continue to 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: 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.	medical needs. However, if you are new to *HMSA Akamai Advantage Standard* 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 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: o Dexcom o 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 2 additional pairs of inserts, or one pair of depth shoes and 3 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.
Emergency care	**In-Network and Out-of-network** $100 copayment for each Medicare-covered emergency room visit.	**In-Network and Out-of-network** $115 copayment for each Medicare-covered emergency room visit.
Health and wellness education programs	HMSA Health Education Workshops are fun and interactive workshops to teach members about fitness, nutrition, stress management, and other aspects of health and well-being that can impact physical, emotional and social health. To learn more	Health and wellness education programs is not covered as a benefit in 2026.

	2025 (this year)	2026 (next year)
Health and wellness education programs (continued)	about HMSA Health Education Workshops, go to www.hmsa.com/healtheducation. **In-Network and Out-of-network** $0 copayment for covered supplemental health education workshops.	
Hospice care **Hospice care (continued)**	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 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: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B 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 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-	You're 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 can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have 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 When you're admitted to a hospice, you have the right to stay in our plan if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B and not related to your**

	2025 (this year)	2026 (next year)
Hospice care (continued)	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 the plan cost-sharing for out-of-network service For services that are covered by *HMSA Akamai Advantage Standard* but are not covered by Medicare Part A or B: *HMSA Akamai Advantage Standard* 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 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	**terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't 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 (like if there's a requirement to get prior authorization): • If you get the covered services from a network provider and follow plan rules for getting service, you only pay our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services that are covered by *HMSA Akamai Advantage Standard* but are not covered by Medicare Part A or B:** *HMSA Akamai Advantage Standard* will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our 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're related to your terminal hospice condition, 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. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

	2025 (this year)	2026 (next year)
Hospice care (continued)	your terminal prognosis are paid for by Original Medicare, not *HMSA Akamai Advantage Standard*. 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*.	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*. 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*.
Inpatient hospital care	Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered:	Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. The plan covers the following hospital days per stay: • The plan covers 90 hospital days. • The plan covers 60 Lifetime Reserve Days. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy

	2025 (this year)	2026 (next year)
Inpatient hospital care (continued)	corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *HMSA Akamai Advantage Standard* provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Additionally, we will cover transplant at a distant location, as well as lodging and transportation costs for you and a companion if the transplant is not available in Hawaii or if the distant location is deemed more medically favorable, per HMSA's policy. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Medicare Hospital Benefits.* This fact sheet is	• Inpatient abuse disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *HMSA Akamai Advantage Standard* provides transplant services at a location outside the pattern of care for transplants in your community and you chose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Additionally, we will cover transplant at a distant location, as well as lodging and transportation costs for you and a companion if the transplant is not available in Hawaii or if the distant location is deemed more medically favorable, per HMSA's policy. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered starting with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital

	2025 (this year)	2026 (next year)
Inpatient hospital care (continued)	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 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. **In-Network** For Medicare-covered hospital stays: Days 1-6: $370 copayment per day Days 7-60: $50 copayment per day Days 61-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply. **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $400 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.	overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in a Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at https://www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. **In-Network** For Medicare-covered hospital stays: Days 1-5: $475 copayment per day Days 6-60: $50 copayment per day Days 61-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Authorization rules may apply. **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $500 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.
Inpatient services in a psychiatric hospital	**In-Network** For Medicare-covered hospital stays: Days 1-6: $320 copayment per day Days 7-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Authorization rules may apply. **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $400 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.	**In-Network** For Medicare-covered hospital stays: Days 1-5: $415 copayment per day Days 6-90: $0 copayment per day $0 copayment per Lifetime Reserve Day. Authorization rules may apply. **Out-of-network** For Medicare-covered hospital stays: Days 1-14: $440 copayment per day Days 15-90: $0 copayment per day $0 copayment per Lifetime Reserve Day.

	2025 (this year)	2026 (next year)
Medicare Part B 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) 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 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 f or 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	**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 our 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 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. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug

	2025 (this year)	2026 (next year)
Medicare Part B drugs (continued)	• 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 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/.	• 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 covered under Medicare Part B • Calcimimetic and phosphate binder 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®)

	2025 (this year)	2026 (next year)
Medicare Part B drugs (continued)	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.	• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) This 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 drug benefit. Chapter 5 explains the Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.
Opioid treatment program services	**In-Network** $50 copayment for Medicare-approved Opioid Treatment Program services.	**In-Network** $55 copayment for Medicare-approved Opioid Treatment Program services.
Outpatient mental health care	**In-Network** $40 copayment for each Medicare-covered individual or group therapy visit.	**In-Network** $50 copayment for each Medicare-covered individual or group therapy visit.
Outpatient substance abuse services	**In-Network** $50 copayment for each Medicare-covered individual or group visit.	**In-Network** $55 copayment for each Medicare-covered individual or group visit.
Over-the-Counter (OTC) Health Products Allowance	Your over-the-counter (OTC) health products allowance is loaded onto a HMSA Extra Benefits Debit Card. The allowance 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.	Over-the-Counter (OTC) Health Products Allowance is not covered in 2026.

	2025 (this year)	2026 (next year)
Over-the-Counter (OTC) Health Products Allowance (continued)	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.	
Partial hospitalization services and Intensive outpatient services	**In-Network** $50 copayment for Medicare-covered partial hospitalization program services. $50 copayment for Medicare-covered intensive outpatient program services.	**In-Network** $55 copayment for Medicare-covered partial hospitalization program services. $55 copayment for Medicare-covered intensive outpatient program services.
Physician/ practitioner services including doctor's office visits	Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including for: primary care provider visits, specialist visits, mental health therapy or substance abuse therapy visits, visits with an advanced practice registered nurse, nurse practitioner, or physician assistant, or Opioid Treatment Program services • You have the option of receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider who offers the service by telehealth • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other locations approved by Medicare	Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care provider visits, specialist visits, mental health therapy or substance abuse therapy visits, visits with an advanced practice registered nurse, nurse practitioner, or physician assistant, or Opioid Treatment Program services • You have the option of receiving these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, you must use a network provider who offers the service by telehealth • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for

	2025 (this year)	2026 (next year)
Physician/ practitioner services including doctor's office visits (continued)	• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate or treat symptoms of a stroke regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: • You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and**	patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while receiving these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: • You're not a new patient **and** • The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:

	2025 (this year)	2026 (next year)
Physician/ practitioner services including doctor's office visits (continued)	• The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) **In-Network** $0 copayment for each primary care provider visit in the primary care provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant in the provider's office or in the member's home for Medicare-covered benefits. $50 copayment for each specialist visit for Medicare-covered benefits. $0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the *Provider Directory*.	• You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician, including a dentist or dental surgeon, a non-physician practitioner, or other auxiliary personnel) **In-Network** $0 copayment for each primary care provider visit in the primary care provider's office or in the member's home for Medicare-covered benefits. $0 copayment for each visit with an advanced practice registered nurse, nurse practitioner, or physician assistant in the provider's office or in the member's home for Medicare-covered benefits. $55 copayment for each specialist visit for Medicare-covered benefits. $0 copayment for certain telehealth services from eligible network providers. For a list of primary care providers, please refer to the *Provider Directory*.
Podiatry services	**In-Network** $50 copayment for each visit for Medicare-covered services.	**In-Network** $55 copayment for each visit for Medicare-covered services.

	2025 (this year)	2026 (next year)
Pre-exposure prophylaxis (PrEP) for HIV prevention	Pre-exposure prophylaxis (PrEP) for HIV prevention is covered, but not listed in the Medical Benefits Chart.	If you don't have HIV, but your doctor or other health care practitioner determines you're at increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening. **In-Network and Out-of-network** There is no coinsurance or copayment for the PrEP benefit.
Screening for Hepatitis C Virus Infection	Screening for Hepatitis C Virus Infection is covered, but not listed in the Medical Benefits Chart.	We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.

	2025 (this year)	2026 (next year)
Skilled nursing facility (SNF) care	**In-Network** For Medicare-covered SNF stays: Days 1-20: $0 copayment per day Days 21-60: $200 copayment per day Days 61-100: $0 copayment per day Authorization rules may apply. **Out-of-network** For Medicare-covered SNF stays: Days 1-50: $200 copayment per day Days 51-100: $0 copayment per day	**In-Network** For Medicare-covered SNF stays: Days 1-20: $0 copayment per day Days 21-60: $218 copayment per day Days 61-100: $0 copayment per day Authorization rules may apply. **Out-of-network** For Medicare-covered SNF stays: Days 1-50: $218 copayment per day Days 51-100: $0 copayment per day
Supervised Exercise Therapy (SET)	**In-Network** $25 copayment for each Medicare-covered SET for PAD service ordered by your physician.	**In-Network** $20 copayment for each Medicare-covered SET for PAD service ordered by your physician.
Urgently needed services	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 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. **In-Network and Out-of-network** $50 copayment to the facility for each covered urgently needed care visit. If you get additional services at an out-of-network facility as part of your urgently needed care visit, your cost is the cost-sharing you would pay to a network provider.	A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. **In-Network and Out-of-network** $40 copayment to the facility for each covered urgently needed care visit. If you get additional services at an out-of-network facility as part of your urgently needed care visit, your cost is the cost-sharing you would pay to a network provider.

	2025 (this year)	2026 (next year)
	For cost-sharing for physician services (if billed separately), see In-Network *Physician/Practitioner services, including doctor's office visits*.	For cost-sharing for physician services (if billed separately), see In-Network *Physician/Practitioner services, including doctor's office visits*.
Vision care	Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each calendar year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant	Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each calendar year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.
Vision care (continued)	Supplemental covered services include: • One routine eye exam every calendar year • The plan will pay up to $300 every calendar year for any combination of eyeglasses with standard frames, contact lenses, and contact lens fitting • International travel solution: We cover the following services when you travel abroad:	Supplemental covered services include: • One routine eye exam every calendar year • One refraction eye exam every calendar year • The plan will pay up to $300 every calendar year for any combination of eyeglasses with standard frames, contact lenses, eyewear upgrades and contact lens fitting

	2025 (this year)	2026 (next year)
Vision care (continued)	• Receive a temporary pair of glasses in case of an emergency • Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions) **In-Network** $10 copayment for one routine eye exam every calendar year. **Out-of-network** 40% of the cost for one routine eye exam every calendar year. **In-Network and Out-of-network** 100% for any amounts above the plan coverage limit for routine eyewear. Plan pays up to $300 every calendar year, for any combination of frames, lenses, contact lenses, or contact lens fitting.	• International travel solution: We cover the following services when you travel abroad: • Receive a temporary pair of glasses in case of an emergency • Get help to find an eye doctor (Out-of-network benefits apply) (See Section 3.1 of this chapter for a list of exclusions) **In-Network** $10 copayment for one routine eye exam every calendar year. $10 copayment for one refraction eye exam every calendar year. **Out-of-network** 40% of the cost for one routine eye exam every calendar year. 40% of the cost for one refraction eye exam every calendar year. **In-Network and Out-of-network** 100% for any amounts above the plan coverage limit for routine eyewear. Plan pays up to $300 every calendar year, for any combination of frames, lenses, contact lenses, eyewear upgrades and contact lens fitting.

Section 1.6 – 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 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're taking, we'll send you a notice about the change.

If you're 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 prescriber to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. Call Customer Relations at 1-800-660-4672 (TTY users call 711) for more information.

We currently can immediately remove a brand name drug on our Drug List if we replace it with a new generic drug version on the same or a lower cost-sharing tier and with the same or fewer restrictions as the brand name drug it replaces. Also, when adding a new generic, we may also decide to keep the brand name drug on our Drug List but immediately move it to a different cost-sharing tier or add new restrictions or both.

Starting in 2026, we can immediately replace original biological products with certain biosimilars. This means, for instance, if you're taking a brand name drug or biological product that is being replaced by a biosimilar, 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 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, go to Chapter 12 of your *Evidence of Coverage*. The Food and Drug Administration (FDA) also provides consumer information on drugs. Go to the FDA website: https://www.fda.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients. You can also call Customer Relations at 1-800-660-4672 (TTY users call 711) or ask your health care provider, prescriber, or pharmacist for more information.

Section 1.7 – Changes to Prescription Drug Benefits & Costs

Do you get Extra Help to pay for your drug coverage costs?

If you're 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*, which tells you about your drug costs. If you get Extra Help and you don't get this material by September 30, 2025, please call Customer Relations and ask for the *LIS Rider*.

Drug Payment Stages

There are **3 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 no longer exist in the Part D benefit.

- ***Stage 1: Yearly Deductible***
  You start in this payment stage each calendar year. During this stage, you pay the full cost of your Tier 2, 3, 4, and 5 drugs until you reach the yearly deductible.
- ***Stage 2: Initial Coverage***
  Once you pay the yearly deductible, you move to the Initial Coverage Stage. In this stage, our plan pays its share of the cost of your drugs, and you pay your share of the cost. You generally stay in this stage until your year-to-date total drug costs reach $2,100.

- ***Stage 3: Catastrophic Coverage***
  This is the third and final drug payment stage. In this stage, you pay nothing for your covered Part D drugs. You generally stay in this stage for the rest of the calendar year.

The Coverage Gap Discount Program has been replaced by the Manufacturer Discount Program. Under the Manufacturer Discount Program, drug manufacturers pay a portion of our 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 don't count toward out-of-pocket costs.

Drug Costs in Stage 1: Yearly Deductible

This table shows your cost per prescription during this stage.

	2025 (this year)	2026 (next year)
Stage 1: Yearly Deductible	The deductible is $400. During this stage, you pay $5 copayment cost-sharing for drugs on Tier 1 and the full cost of drugs on Tiers 2, 3, 4 and 5 until you have reached the yearly deductible.	The deductible is $300. During this stage, you pay $0 copayment cost-sharing for drugs on Tier 1 and the full cost of drugs on Tiers 2, 3, 4 and 5 until you have reached the yearly deductible.

Drug Costs in Stage 2: Initial Coverage

For drugs on Tier 3 and Tier 4, your cost sharing in the Initial Coverage Stage is changing from a copayment to a coinsurance. Go to the following table for the changes from 2025 to 2026. 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. For more information about the costs of vaccines, or information about the costs for a long-term supply, go to Chapter 6 of your *Evidence of Coverage.*

Once you've paid $2,100 out of pocket for Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2025 (this year)	2026 (next year)
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.		
Tier 1 Preferred Generic	$5 copayment.	$0 copayment.
Tier 2 Generic	$20 copayment.	$11 copayment.
Tier 3 Preferred Brand	$47 copayment. You pay $35 per month supply of each covered insulin product on this tier.	20% of the cost. You pay the lesser of $35 and 25% per month supply of each covered insulin product on this tier.

	2025 (this year)	2026 (next year)
Tier 4 Non-Preferred Drug	$100 copayment of the cost. You pay $35 per month supply of each covered insulin product on this tier.	30% of the cost.
Tier 5 Specialty Tier	27% of the cost. You pay $35 per month supply of each covered insulin product on this tier.	**Tier 5 Specialty Tier** 29% of the cost. You pay the lesser of $35 and 25% per month supply of each covered insulin product on this tier.

Changes to the Catastrophic Coverage Stage

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

SECTION 2 Administrative Changes

Description	2025 (this year)	2026 (next year)
Option to pay your plan premium by phone via IVR See Chapter 1, Section 5.1 of the EOC for available premium payment options.	Pay by phone or IVR was a phone payment method offered through September 30, 2025.	Effective October 1, 2025, we have upgraded to a new billing and payment system called eInvoice Connect. With this new platform, IVR will no longer be available. But you can continue to pay your bill online, in-person at our HMSA Centers, or by mail.
Option to pay your plan premium online See Chapter 1, Section 5.1 of the EOC for more information about online bill pay and automatic payment through My Account.	Online setup of automatic payment through My Account is offered in 2025.	Effective October 1, 2025, we have upgraded to a new billing and payment system called eInvoice Connect. If you already have automated payment set up through My Account with HMSA, you will need to update your payment information in your account. You will need to reenter and confirm your automatic payment preferences to ensure future payments are processed successfully.

Description	2025 (this year)	2026 (next year)
Dually Eligible Individual (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	A person who is eligible for Medicare and Medicaid coverage.
Maximum Fair Price (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	The price Medicare negotiated for a selected drug.
Medication Therapy Management (MTM) program (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.
Open Enrollment Period (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.
Preventive services (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).
Referral (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.
Selected Drug (See Chapter 12 of the EOC, *Definitions*)	This definition was not included in the 2025 *Evidence of Coverage*	A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

SECTION 3 How to Change Plans

To stay in *HMSA Akamai Advantage Standard*, you don't need to do anything. Unless you sign up for a different plan or change to Original Medicare by December 7, 2025, you'll automatically be enrolled in our *HMSA Akamai Advantage Standard*.

If you want to change plans for 2026, follow these steps:

- **To change to a different Medicare health plan,** enroll in the new plan. You'll be automatically disenrolled from *HMSA Akamai Advantage Standard.*
- **To change to Original Medicare with Medicare drug coverage,** enroll in the new Medicare drug plan. You'll be automatically disenrolled from *HMSA Akamai Advantage Standard*.
- **To change to Original Medicare without a drug plan**, you can send us a written request to disenroll. Call Customer Relations at 1-800-660-4672 (TTY users call 711) for more information on how to do this. Or call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users can call 1-877-486-2048. If you don't enroll in a Medicare drug plan, you may pay a Part D late enrollment penalty (Go to Section 1.1).
- **To learn more about Original Medicare and the different types of Medicare plans**, visit www.Medicare.gov, check the *Medicare & You 2026* handbook, call your State Health Insurance Assistance Program (go to Section 5), or call 1-800-MEDICARE (1-800-633-4227). As a reminder, HMSA offers other Medicare health plans and Medicare drug plans. These other plans can have different coverage, monthly plan premiums, and cost-sharing amounts.

Section 3.1 – Deadlines for Changing Plans

People with Medicare can make changes to their coverage from October 15-December 7 each year.

If you enrolled in a Medicare Advantage plan for January 1, 2026, and don't like your plan choice, you can switch to another Medicare health plan (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) between January 1 – March 31, 2026.

Section 3.2 – Are there other times of the year to make a change?

In certain situations, people can have other changes to change their coverage during the year.

Examples include people who:

- Have Medicaid
- Get Extra Help paying for their drugs
- Have or are leaving employer coverage
- Move out of our plan's service area

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 (with or without Medicare drug coverage) or switch to Original Medicare (with or without separate Medicare drug coverage) at any time. If you recently moved out of an institution, you have an opportunity to switch plans or switch to Original Medicare for 2 full months after the month you move out.

SECTION 4 Get Help Paying for Prescription Drugs

You can qualify for help paying for prescription drugs. Different kinds of help are available:

- **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 drug plan premiums, yearly deductibles, and coinsurance. Also, people who qualify won't have a late enrollment penalty. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048, 24 hours a day, 7 days a week.
  - Social Security at 1-800-772-1213 between 8 a.m. and 7 p.m., Monday -Friday for a representative. Automated messages are available 24 hours a day. TTY users call 1-800-325-0778.
  - Your State Medicaid Office.
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible people living with HIV/AIDS have access to life-saving HIV medications. To be eligible for the ADAP operating in your state, you 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 drugs that are also covered by ADAP qualify for prescription cost-sharing help through the HIV Drug Assistance Program (HDAP). For more information on eligibility criteria, covered drugs, how to enroll in the program, or, if you're currently enrolled, how to continue getting help, call (808) 733-9360. Be sure, when calling, to inform them of your Medicare Part D plan name or policy number.
- **The Medicare Prescription Payment Plan.** The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **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 the Medicare Prescription Payment Plan. To learn more about this payment option, call us at 1-855-479-3659 (TTY users should call 711) or visit www.Medicare.gov.

SECTION 5 Questions?

Get Help from *HMSA Akamai Advantage Standard*

- Call Customer Relations at 1-800-660-4672 (TTY users call 711.)
  We're available for phone calls 8:00 am - 8:00 pm, 7 days a week. Calls to these numbers are free.
- **Read your 2026 *Evidence of Coverage***
  This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2026. For details, go to the 2026 *Evidence of Coverage* for *HMSA Akamai Advantage Standard*. The *Evidence of Coverage* is the legal, detailed description of our plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. Get the *Evidence of*

Coverage on our website at www.hmsa.com/advantage or call 1-800-660-4672 (TTY users call 711) to ask us to mail you a copy. You can also review the separately mailed *Evidence of Coverage* to see if other benefit or cost changes affect you.

- **Visit www.hmsa.com/advantage**
  Our website has the most up-to-date information about our provider network (*Provider Directory*) and our *List of Covered Drugs* (formulary/Drug List).

Get 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.

Call Hawaii SHIP to get free personalized health insurance counseling. They can help you understand your Medicare plan choices and answer questions about switching plans. Call Hawaii SHIP at 1-888-875-9229. Learn more about Hawaii SHIP by visiting www.hawaiiship.org.

Get Help 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 can call 1-877-486-2048.
- **Chat live with www.**Medicare.gov
  You can chat live at www.Medicare.gov/talk-to-someone.
- **Write to Medicare**
  You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit www.**Medicare.gov
  The official Medicare website has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area.
- **Read *Medicare & You 2026***
  The *Medicare & You 2026* handbook is mailed to people with Medicare every fall. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. Get a copy at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

HMSA Akamai Advantage (PPO)

2026 *Evidence of Coverage*

Available starting Oct. 1, 2025

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 any questions.

View the 2026 *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 2026 *Evidence of Coverage*.

The 2025 *Evidence of Coverage* will be available until Dec. 31, 2025.

Not registered for My Account?

Go to hmsa.com and click My Account Login. Click Sign Up to create an account. 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 2026 Provider Directory will be available Oct. 15, 2025.

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 Dental.
- HMSA Akamai Advantage Routine Vision.

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.

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HMSA Akamai Advantage (PPO)

Prescription Drug List 2026
(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, 2025.

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 2026 Formulary (drug list).

Not registered for My Account?

Go to hmsa.com and click My Account Login. Click Sign Up to create an account. 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.

Request a hard copy.

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.

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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Discrimination is against the law

HMSA complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)). HMSA does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Services HMSA provides

HMSA offers the following services to support people with disabilities and those whose primary language is not English. There is no cost to you.

- Qualified sign language interpreters are available for people who are deaf or hard of hearing.
- Large print, audio, braille, or other electronic formats of written information is available for people who are blind or have low vision.
- Language assistance services are available for those who have trouble with speaking or reading in English. This includes:
  - Qualified interpreters.
  - Information written in other languages.

If you need modifications, appropriate auxiliary aids and services, or language assistance services, please call 1 (800) 776-4672. TTY users, call 711.

How to file a grievance or complaint

If you believe HMSA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- Phone: 1 (800) 462-2085
- TTY: 711
- Email: appeals@hmsa.com
- Fax: (808) 952-7546
- Mail: HMSA Member Advocacy and Appeals
  P.O. Box 1958
  Honolulu, HI 96805-1958

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1 (800) 368-1019, 1 (800) 537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

This notice is available at HMSA's website: https://hmsa.com/non-discrimination-notice/.

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ATTENTION: If you don't speak English, language assistance services are available to you at no cost. Auxiliary aids and services are also available to give you information in accessible formats at no cost. QUEST members, call 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, or speak to your provider. Medicare Advantage and commercial plan members, call 1 (800) 776-4672 or TDD/TTY 1 (877) 447-5990.

'Ōlelo Hawai'i
NĀ MEA: Inā 'a'ole 'oe 'ōlelo Pelekania, loa'a nā lawelawe kōkua 'ōlelo iā 'oe me ka uku 'ole. Loa'a nā kōkua kōkua a me nā lawelawe no ka hā'awi 'ana iā 'oe i ka 'ike ma nā 'ano like 'ole me ka uku 'ole. Nā lālā QUEST, e kelepona iā 1 (800) 440-0640 me ka uku 'ole, TTY 1 (877) 447-5990, a i 'ole e kama'ilio me kāu mea ho'olako. 'O nā lālā Medicare Advantage a me nā lālā ho'olālā kalepa, e kelepona iā 1 (800) 776-4672 a i 'ole TDD/TTY 1 (877) 447-5990.

Bisaya
PAHIBALO: Kung dili English ang imong pinulongan, magamit nimo ang mga serbisyo sa tabang sa pinulongan nga walay bayad. Ang mga auxiliary nga tabang ug serbisyo anaa sab aron mohatag og impormasyon kanimo sa daling ma-access nga mga format nga walay bayad. Mga membro sa QUEST, tawag sa 1 (800) 440-0640 toll-free, TTY 1 (877) 447-5990, o pakig-istorya sa imong provider. Mga membro sa Medicare Advantage ug commercial plan, tawag sa 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

繁體中文
請注意：如果你不諳英文，我們將為您提供免費的語言協助服務。輔助支援和服務也能免費以無障礙的方式為您提供資訊。QUEST **會員請致電免費熱線** 1 (800) 440-0640、**聽障熱線** (TTY) 1 (877) 447-5990 **或與您的服務提供者聯絡。**Medicare Advantage **及商業計劃會員請致電** 1 (800) 776-4672 **或聽障／語障熱線** (TDD/TTY) 1 (877) 447-5990。

简体中文
注意：如果您不会说英语，我们可以免费为您提供语言协助服务。同时，我们还配备辅助工具和相关服务，免费为您提供无障碍格式的信息。
QUEST 会员请拨打免费电话 1 (800) 440-0640，TTY 1 (877) 447-5990，或咨询您的医疗服务提供者。Medicare Advantage 和商业计划会员请致电 1 (800) 776-4672 或 TDD/TTY 1 (877) 447-5990。

Ilokano
BASAEN: No saanka nga agsasao iti Ingles, mabalinmo a magun-odan ti libre a serbisio a tulong iti lengguahe. Adda met dagiti kanayonan a tulong ken serbisio a makaited kenka iti libre nga impormasion iti nalaka a maawatan a pormat. Dagiti miembro ti QUEST, tawaganyo ti 1 (800) 440-0640 a libre iti toll, TTY 1 (877) 447-5990, wenno makisaritaka iti provider-yo. Dagiti miembro ti Medicare Advantage ken plano a pang-komersio, tawaganyo ti 1 (800) 776-4672 wenno TDD/TTY 1 (877) 447-5990.

日本語
注意：英語を話されない方には、無料で言語支援サービスをご利用いただけます。また、情報をアクセシブルな形式で提供するための補助ツールやサービスも無料でご利用いただけます。QUESTプログラムの加入者の方は、フリーダイヤル1 (800) 440-0640**までお電話ください。TTYをご利用の場合は**1 (877) 447-5990**までお電話いただくか、担当医療機関にご相談ください。**Medicare Advantage**プランおよび民間保険プランの加入者の方は、**1 (800) 776-4672**までお電話いただくか、TDD/TTYをご利用の場合は**1 (877) 447-5990**までお電話ください。**

한국어
주의: 영어를 사용하지 않는 경우, 무료로 언어 지원 서비스를 이용할 수 있습니다. 무료로 접근 가능한 형식으로 정보를 받기 위해 보조 지원 및 서비스 역시 이용할 수 있습니다. QUEST 가입자는 수신자 부담 전화 1 (800) 440-0640, TTY 1 (877) 447-5990 번으로 전화하거나 서비스 제공자와 상의하십시오. Medicare Advantage 및 민간 플랜 가입자는 1 (800) 776-4672 또는 TDD/TTY 1 (877) 447-5990 번으로 전화하십시오.

ພາສາລາວ
ຊຶ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ ເຊົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍ່ເສຍຄ່າໄດ້ທີ່ ເບີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.ສະມາຊິກແຜນ ປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

(continued on next page)

Kajin Ṃajōḷ
KŌJELLA: Ñe kwōjab jelā kenono kajin Belle, ewōr jibañ in ukok ñan kwe im ejellok wonnen. Ewōr kein roñjak im jibañ ko jet ñan wāween ko kwōmaron ebōk melele im ejellok wonnen. Armej ro rej kōjrbal QUEST, kall e 1 (800) 440-0640 ejellok wonnen, TTY 1 (877) 447-5990, ñe ejab kenono ibben taktō eo am. Medicare Advantage im ro rej kōjerbal injuran ko rej make wia, kall e 1 (800) 776-4672 ñe ejab TDD/TTY 1 (877) 447-5990.

Lokaiahn Pohnpei
Kohdo: Ma ke mwahu en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. Me mwengei en kaiahn Pohnpei, me mwengei en kaiahn Pohnpei. QUEST mwengei, kohdo mwengei 1 (800) 440-0640, TTY 1 (877) 447-5990, me mwengei en kaiahn Pohnpei. Medicare Advantage me mwengei en kaiahn Pohnpei, kohdo mwengei 1 (800) 776-4672 me TDD/TTY 1 (877) 447-5990.

Gagana Sāmoa
FAASILASILAGA: Afai e te lē tautala le faa-Igilisi, o loo avanoa mo oe e aunoa ma se totogi auaunaga fesoasoani i le gagana. O loo maua fo'i fesoasoani faaopo'opo ma auaunaga e tuuina atu ai iā te oe faamatalaga i auala eseese lea e maua e aunoa ma se totogi. Sui auai o le QUEST, valaau aunoa ma se totogi i le 1 (800) 440-0640, TTY 1 (877) 447-5990, pe talanoa i lē e saunia lau tausiga. Sui auai o le Medicare Advantage ma sui auai o peleni inisiua tumaoti, valaau i le 1 (800) 776-4672 po o le TDD/TTY 1 (877) 447-5990.

Español
ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia con el idioma. También están disponibles ayuda y servicios auxiliares para brindarle información en formatos accesibles sin costo alguno. Los miembros de QUEST deben llamar al número gratuito 1 (800) 440-0640, TTY 1 (877) 447-5990 o hablar con su proveedor. Los miembros de Medicare Advantage y de planes comerciales deben llamar al 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

Tagalog
PAUNAWA: Kung hindi ka nakapagsasalita ng Ingles, mayroon kang makukuhang mga serbisyo sa tulong sa wika nang libre. Mayroon ding mga auxiliary na tulong at serbisyo para bigyan ka ng impormasyon sa mga naa-access na format nang libre. Sa mga miyembro ng QUEST, tumawag sa 1 (800) 440-0640 nang toll-free, TTY 1 (877) 447-5990, o makipag-usap sa iyong provider. Sa mga miyembro ng Medicare Advantage at commercial plan, tumawag sa 1 (800) 776-4672 o TDD/TTY 1 (877) 447-5990.

ไทย
โปรดให้ความสนใจ: หากท่านไม่พูดภาษาอังกฤษ เรามีบริการให้ความช่วยเหลือทางภาษาแก่ท่านโดยไม่มีค่าใช้จ่าย และยังมีความช่วยเหลือและบริการเสริมเพื่อให้ข้อมูลแก่ท่านในรูปแบบที่เข้าถึงได้โดยไม่มีค่าใช้จ่าย สำหรับสมาชิก QUEST โปรดโทรไปที่หมายเลขโทรฟรีที่หมายเลข 1 (800) 440-0640, TTY 1 (877) 447-5990 หรือพูดคุยกับผู้ให้บริการของคุณ สำหรับสมาชิก Medicare Advantage และแผนเชิงพาณิชย์ โปรดโทรไปที่หมายเลข 1 (800) 776-4672 หรือ TDD/TTY 1 (877) 447-5990

Tonga
FAKATOKANGA: Kapau óku íkai keke lea Faka-Pilitania, óku í ai e tokotaha fakatonulea óku í ai ke tokonií koe íkai ha totongi. Óku í ai mo e kulupu tokoni ken au óatu e ngaahi fakamatala mo e tokoni íkai ha totongi. Kau memipa QUEST, ta ki he 1 (800) 440-0640 taé totongi, TTY 1 (877) 447-5990, pe talanoa ki hoó kautaha. Ko kinautolu óku Medicare Advantage mo e palani fakakomesiale, ta ki he 1 (800) 776-4672 or TDD/TTY 1 (877) 447-5990.

Foosun Chuuk
ESINESIN: Ika kese sine Fosun Merika, mei wor aninisin fosun fonu ese kamo mi kawor ngonuk. Mei pwan wor pisekin aninis mi kawor an epwe esinei ngonuk porous non och wewe ika nikinik epwe mecheres me weweoch ngonuk ese kamo. Chon apach non QUEST, kekeri 1 (800) 440-0640 namba ese kamo, TTY 1 (877) 447-5990, ika fos ngeni noumw ewe chon awora aninis. Medicare Advantage ika chon apach non ekoch otot, kekeri 1 (800) 776-4672 ika TDD/TTY 1 (877) 447-5990.

Tiếng Việt
CHÚ Ý: Nếu quý vị không nói được tiếng Anh, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các phương tiện và dịch vụ hỗ trợ cũng có sẵn để cung cấp cho quý vị thông tin ở các định dạng dễ tiếp cận mà không mất phí. Hội viên QUEST, xin gọi số miễn cước 1 (800) 440-0640, TTY 1 (877) 447-5990, hoặc nói chuyện với nhà cung cấp dịch vụ của quý vị. Hội viên Medicare Advantage và chương trình thương mại, xin gọi số 1 (800) 776-4672 hoặc TDD/TTY 1 (877) 447-5990.

Notes

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.

Hawaii SHIP

Hawaii 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	Hawaii 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

8700-1397954 8.25