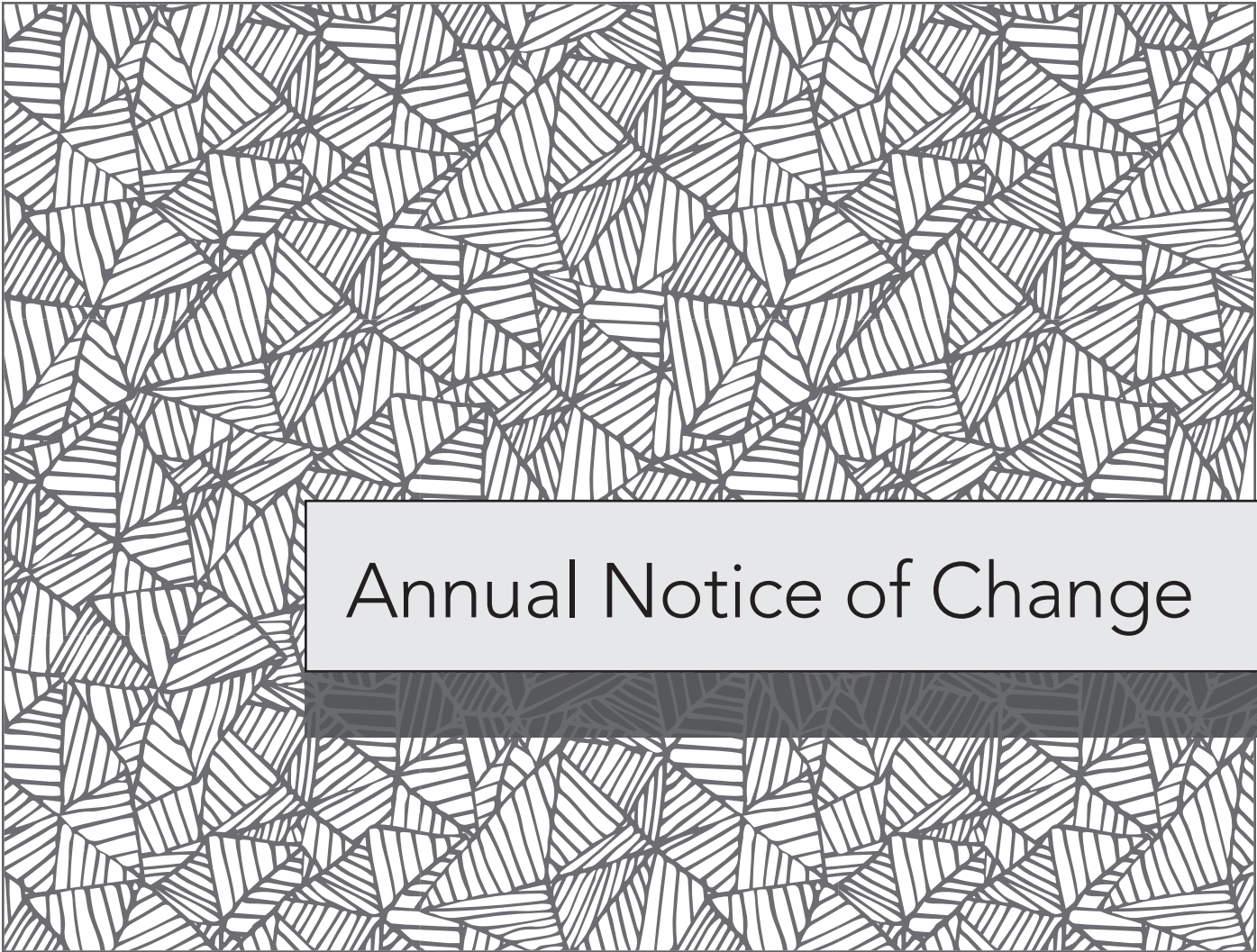




Annual Notice of Change

**HMSA Akamai Advantage
Dual Care (PPO D-SNP)**

2027



An Independent Licensee of the Blue Cross and Blue Shield Association

MedicareRx
Prescription Drug Coverage X

H8481_1140_1875207_AA_Dual_Care_27_M

HMSA Akamai Advantage Dual Care (PPO D-SNP) offered by Hawai'i Medical Service Association (HMSA)

Annual Notice of Change for 2027

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

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, 2026, you'll stay in *HMSA Akamai Advantage Dual Care*.
- To change to a **different plan**, visit Medicare.gov or review the list in the back of your *Medicare & You 2027* 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, option 6 (TTY users call 711) to get a copy by mail.

More Resources

- This document is available for free in Ilocano, Vietnamese, Chinese, and Korean.
- 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) for more information. Hours are 7:45 a.m. - 8 p.m., 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 Dual Care*

- HMSA Akamai Advantage® Dual Care is a PPO D-SNP plan with a Medicare contract and is a state of Hawaii Medicaid Managed Care Program. Enrollment in HMSA Akamai Advantage Dual Care depends on contract renewal. Our plan also has a written agreement with the Hawaii Medicaid program to coordinate your Medicaid benefits.
- When this material says "we," "us," or "our," it means Hawaii Medical Service Association (HMSA). When it says "plan" or "our plan," it means *HMSA Akamai Advantage Dual Care*.
- **If you do nothing by December 7, 2026, you'll automatically be enrolled in *HMSA Akamai Advantage Dual Care*.** Starting January 1, 2027, you'll get your medical coverage through *HMSA Akamai Advantage Dual Care*. Go to Section 3 for more information about how to change plans and deadlines for making a change.

OMB Approval 0938-1051 (Expires: July 31, 2029)

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Summary of Important Costs for 2027

	2026 (this year)	2027 (next year)
Monthly plan premium* * Your premium can be higher or lower than this amount. Go to Section 1.1 for details.	As a member of our plan, you pay a monthly plan premium unless you qualify for Extra Help with your prescription drug costs. You do not pay a monthly plan premium (prescription drug plan premium) if you qualify for Extra Help. People with Medicare and QUEST (Medicaid) automatically qualify for "Extra Help". For 2026, the monthly premium for our plan is \$42.30.	As a member of our plan, you pay a monthly plan premium unless you qualify for "Extra Help" with your prescription drug costs. You do not pay a monthly plan premium (prescription drug plan premium) if you qualify for "Extra Help". People with Medicare and QUEST (Medicaid) automatically qualify for "Extra Help". For 2027, the monthly premium for our plan is \$17.10.
Deductible	\$283 for Medicare Part B covered services except for insulin furnished through an item of durable medical equipment. If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.	\$283 for Medicare Part B covered services except for insulin furnished through an item of durable medical equipment. This amount may change for 2027. If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for covered Part A and Part B services. (Go to Section 1.2 for details.)	From network providers: \$9,250 From network and out-of-network providers combined: \$13,900 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.	From network providers: \$9,850 From network and out-of-network providers combined: \$14,800 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.
Primary care office visits	20% of the cost per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0 per visit.	20% of the cost per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0 per visit.

	2026 (this year)	2027 (next year)
Specialist office visits	20% of the cost per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0 per visit.	20% of the cost per visit If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0 per visit.
Inpatient hospital stays Includes various inpatient hospital stays such as acute care, rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	\$1,736 deductible and Days 1-60: \$0 copayment per day Days 61-90: \$434 copayment per day \$868 copayment per Lifetime Reserve Day. If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0.	\$1,736 deductible and Days 1-60: \$0 copayment per day Days 61-90: \$434 copayment per day \$868 copayment per Lifetime Reserve Day. These amounts may change for 2027. If you are eligible for Medicare cost-sharing help under Medicaid, you most likely pay \$0.
Part D drug coverage (Go to Section 1.7 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	Part D drug coverage deductible \$615, except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: For those who <u>do</u> qualify for "Extra Help", you will pay the following for your covered prescription drugs: The lesser of plan tier copayment or: • Generic/Preferred Multi-Source Drugs: \$0, \$1.60, or \$5.10 • Other Drugs: \$0, \$4.90, or \$12.65 For those who <u>don't</u> qualify for "Extra Help", you will pay the following plan tier copayment for your covered prescription drugs: • Drug Tier 1: \$0 • Drug Tier 2: \$0	Part D drug coverage deductible \$700, except for covered insulin products and most adult Part D vaccines. Copayment/Coinsurance during the Initial Coverage Stage: For those who <u>do</u> qualify for "Extra Help", you will pay the following for your covered prescription drugs: • \$0 copayment You pay \$0 per month supply of each covered insulin product. For those who <u>don't</u> qualify for "Extra Help", you will pay the following for your covered prescription drugs: • 25% of the cost You pay the lesser of \$35 and 25% of the cost per month

	2026 (this year)	2027 (next year)
	• Drug Tier 3: 25% of the cost You pay the lesser of \$35 and 25% of the cost per month supply of each covered insulin product on this tier. • Drug Tier 4: 30% of the cost • Drug Tier 5: 25% of the cost You pay the lesser of \$35 and 25% of the cost per month supply of each covered insulin product on this tier. Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.	supply of each covered insulin product. Catastrophic Coverage Stage: • During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 1 Changes to Benefits & Costs for Next Year

Section 1.1 Changes to the Monthly Plan Premium

	2026 (this year)	2027 (next year)
Monthly plan premium (You must also continue to pay your Medicare Part B premium unless it's paid for you by QUEST (Medicaid).)	As a member of our plan, you pay a monthly plan premium unless you qualify for “Extra Help” with your prescription drug costs. You do not pay a monthly plan premium (prescription drug plan premium) if you qualify for “Extra Help”. People with Medicare and QUEST (Medicaid) automatically qualify for “Extra Help”. For 2026, the monthly plan premium for our plan is \$42.30.	As a member of our plan, you pay a monthly plan premium unless you qualify for “Extra Help” with your prescription drug costs. You do not pay a monthly Plan premium (prescription drug plan premium) if you qualify for “Extra Help”. People with Medicare and QUEST (Medicaid) automatically qualify for “Extra Help”. For 2027, the monthly plan premium for our plan is \$17.10.

Section 1.2 Changes to Your Maximum Out-of-Pocket Amount

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.

	2026 (this year)	2027 (next year)
Maximum out-of-pocket amount Cost-sharing paid by the beneficiary, Medicaid, and other secondary insurance contributes towards this out-of-pocket maximum. Because our members get most cost sharing paid by Medicaid, very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as copayments and deductibles) count toward your maximum out-of-pocket amount. Our plan premium and your costs for prescription drugs don't count toward your maximum out-of-pocket amount.	\$13,900	\$14,800 Once you've paid \$14,800 out of pocket for covered Part A and Part B services, you'll pay nothing for your covered Part A and Part B services 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 *2027 Provider and Pharmacy Directory* at www.hmsa.com/advantage to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network. Please review the *2027 Directory of Routine Vision Providers* to see if your routine vision providers are in our network. Please review the *2027 Directory of Dental Providers* to see if your dental providers are in our network. Here's how to get an updated *Provider and Pharmacy 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 and Pharmacy 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. You may have a special enrollment period if your provider leaves the plan network. For more information on your rights when a network provider leaves our plan, go to Chapter 3, Section 2.3 of your *Evidence of Coverage*.

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 2027 *Provider and Pharmacy Directory* at www.hmsa.com/advantage to see which pharmacies are in our network. Here's how to get an updated *Provider and Pharmacy 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 and Pharmacy Directory*.

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

Section 1.5 Changes to Benefits & Costs for Medical Services

The Annual Notice of Change tells you about changes to your Medicare benefits and costs.

	2026 (this year)	2027 (next year)
Ambulance services	In-Network \$0 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. Out-of-network 30% of the cost per one-way trip for Medicare-covered ambulance benefits.	In-Network \$0 copayment per one-way trip for Medicare-covered ground ambulance benefits. \$0 copayment per one-way trip for Medicare-covered air ambulance benefits. Air ambulance is covered only in emergency situations based on Medicare guidelines. Out-of-network 30% of the cost per one-way trip for Medicare-covered ground ambulance benefits. 30% of the cost per one-way trip for Medicare-covered air ambulance benefits.
Cardiac rehabilitation services	Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery

	2026 (this year)	2027 (next year)
		• Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure Coverage limitations: You can get 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.
Chiropractic services	In-Network \$0 copayment for each visit for Medicare-covered services. Authorization rules do not apply.	In-Network \$0 copayment for each visit for Medicare-covered services. Authorization rules may apply.
Chronic pain management and treatment services	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 visits. Cost sharing for this service will vary depending on individual	Chronic pain management and treatment services are no longer listed as a separate benefit category. These services may be covered under other benefit categories depending on the services received.

	2026 (this year)	2027 (next year)
	services provided under the course of treatment.	
Fitness Program – The Silver&Fit Healthy Aging and Exercise Program	The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Well-Being Coaching, plus other features. • Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at one of thousands of participating fitness centers or select YMCAs nationally. (Non-standard membership services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) If you choose a Standard Fitness Network membership, you may change your fitness center once per month. You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit www.silverandfit.com or call Silver&Fit Customer Service. • Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost. • Well-Being Coaching: You can access Silver&Fit Well-Being Coaching sessions by phone, video, or chat with a trained coach at no additional cost.	The Silver&Fit Healthy Aging and Exercise program provides you access to a Fitness Center Membership, Home Fitness Kit, and Well-Being Coaching, plus other features. • Fitness Center Membership: You can access a no-cost Standard Fitness Network membership at thousands of participating fitness centers or select YMCAs nationally. (Non-standard membership services at participating fitness centers/YMCAs are not included in the Silver&Fit program.) You can also access the Premium Fitness Network, which includes thousands of additional fitness centers, for a monthly buy-up fee. Fees vary by Premium fitness center. To find a participating fitness center/YMCA or change your fitness center/YMCA, visit www.silverandfit.com or call Silver&Fit Customer Service. • Home Fitness Kits: You can receive one Home Fitness Kit per calendar year at no additional cost. • Well-Being Coaching: You can access Silver&Fit Well-Being Coaching sessions by phone, video, or chat with

	2026 (this year)	2027 (next year)
	• Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, live virtual classes and events, and social groups. • Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. • Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. • Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). <i>The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated</i>	a trained coach at no additional cost. • Well-Being Club: By setting your preferences for well-being topics on the website, you can discover resources tailored to your interests and healthy aging goals including articles, videos, live virtual classes and events, and social groups. • Digital Workouts: You can view on-demand videos through the website's digital workout library, including Silver&Fit Signature Series Classes®. • Silver&Fit Connected!™: The Silver&Fit Connected! tool can assist with tracking your activity. Purchase of some wearable fitness trackers or apps may be required to use the Connected! tool and are not reimbursable by the Silver&Fit program. • Visit www.silverandfit.com to register and access online newsletters, on-demand workout videos, a fitness center search, and the Silver&Fit Connected!™ tool. You can also enroll online to obtain a Silver&Fit card and take it directly to a participating fitness center/YMCA. For details, visit

	2026 (this year)	2027 (next year)
	(ASH). <i>Silver&Fit</i>, <i>Silver&Fit Signature Series Classes</i>, and <i>Silver&Fit Connected!</i> are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are subject to change. In-Network and Out-of-network The Silver&Fit Program Fitness Center Membership \$0 monthly fee for Standard Network fitness centers \$30-\$580 monthly fee for Premium Network fitness centers. Home Fitness Kits \$0 copayment for one Home Fitness Kit per calendar year. Well-Being Coaching \$0 copayment for unlimited sessions of Well-Being Coaching.	www.silverandfit.com or call Silver&Fit Customer Service at 1-888-354-4934, Monday through Friday, 8 am to 5 pm HST (TTY/TDD 711). <i>The Silver&Fit program is provided by American Specialty Health Fitness, Inc., (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit, Silver&Fit Signature Series Classes, and Silver&Fit Connected! are trademarks of ASH and used with permission herein. Fitness center participation may vary by location and is subject to change. Kits are based on availability and subject to change.</i> In-Network The Silver&Fit Healthy Aging and Exercise Program Fitness Center Membership \$0 monthly fee for Standard Network fitness centers \$30-\$764 monthly fee for Premium Network fitness centers. Home Fitness Kits \$0 copayment for one Home Fitness Kit per calendar year. Well-Being Coaching \$0 copayment for unlimited sessions of Well-Being Coaching. Out-of-network Fitness Center Membership 50% of the cost. When using an out-of-network provider you are responsible for submitting a claim. For additional information, see Chapter 7.

	2026 (this year)	2027 (next year)
Help with Certain Chronic Conditions In-home Health Assessments Program	This program provides an in-home health assessment once per calendar year. A nurse practitioner will conduct the visit, and may also provide health screening recommendations, health prevention tips, and care resource assistance. After the visit, the assessment summary will be shared with the member and the member's PCP or care team, as appropriate. Members who have been diagnosed with chronic conditions including diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, coronary artery disease (CAD), mood disorders, rheumatoid arthritis, dementia, cancer, vascular disease, chronic kidney disease (CKD), nutrition-related disorders, including obesity, or hematological disorders and who either do not have a PCP or need assistance managing their chronic condition with their PCP may be contacted to arrange an in-home health assessment. In-Network and Out-of-network There is no coinsurance or copayment for the In-home Health Assessments Program.	The In-home Health Assessments Program is not covered in 2027.
Immunizations	Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or	Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you

	2026 (this year)	2027 (next year)
	intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.
Online Care	With HMSA's Online Care, you can see a doctor or other health care provider from the comfort and privacy of home, work, or anywhere you can go online. Medical doctors are available 24 hours a day, 7 days a week and can diagnose conditions, recommend treatment and prescribe medications if necessary. Online therapy and counseling sessions are available by appointment. In-Network and Out-of-network You pay a \$0 copayment per Online Care visit.	Online Care is not covered in 2027.
Over-the-Counter (OTC) Health Products Allowance	In-Network \$0 copayment for up to \$125 monthly of over-the-counter (OTC) health products.	In-Network and Out-of-network \$0 copayment for up to \$115 monthly of over-the-counter (OTC) health products.
Physician/practitioner services, including office visits	Covered services include: 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	Covered services include: Telehealth services for diagnosis, evaluation, and treatment of mental health disorders

	2026 (this year)	2027 (next year)
	receiving these telehealth services • Exceptions can be made to the above for certain circumstances	
Special supplemental benefits for the chronically ill (SSBCI) - Healthy Food and Home Utilities Allowance	In-Network \$0 copayment for up to \$125 monthly allowance of healthy food and home utilities. Your Healthy Food and Home Utilities Allowance is combined with your Over-the-Counter (OTC) Health Products Allowance. For more information, see <i>Over-the-Counter (OTC) Health Products Allowance</i> .	In-Network and Out-of-network \$0 copayment for up to \$115 monthly allowance of healthy food and home utilities. Your Healthy Food and Home Utilities Allowance is combined with your Over-the-Counter (OTC) Health Products Allowance. For more information, see <i>Over-the-Counter (OTC) Health Products Allowance</i>.
Vision care	Plan pays up to \$300 every calendar year, for any combination of frames, lenses, contact lenses, eyewear upgrades and contact lens fitting.	Plan pays up to \$200 every calendar year, for any combination of frames, lenses, contact lenses, eyewear upgrades and contact lens fitting.

Section 1.6 Changes to Part D 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 and posted online at www.hmsa.com/advantage.

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 calendar 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, 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 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: [FDA.gov/drugs/biosimilars/multimedia-education-materials-biosimilars#For%20Patients](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 drugs may not apply to you.** We sent you a separate material, 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, 2026, call Customer Relations at 1 (800) 660-4672 (TTY users call 711) 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.

- **Stage 1: Yearly Deductible**

You start in this payment stage each calendar year. During this stage, you pay the full cost of your 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 Out-of-Pocket costs reach \$2,400.

- **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.

Drug Costs in Stage 1 : Yearly Deductible

The table shows your cost per prescription during this stage.

	2026 (this year)	2027 (next year)
Yearly Deductible	Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive Extra Help, this payment stage does not apply to you. The deductible is \$615. During this stage, you pay \$0 cost sharing for drugs on Tier 1 and Tier 2 and the full cost of drugs on Tier 3, Tier 4, and Tier 5.	Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive Extra Help, this payment stage does not apply to you. The deductible is \$700.

Drug Costs in Stage 2: Initial Coverage

The table shows your cost per prescription for a one-month supply filled at a network pharmacy with standard cost sharing.

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 or for mail-order prescriptions, go to Chapter 6 of your *Evidence of Coverage*.

Once you've paid \$2,400 out of pocket for covered Part D drugs, you'll move to the next stage (the Catastrophic Coverage Stage).

	2026 (this year)	2027 (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.	If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, your costs for your Medicare Part D prescription drug will be lower than the amounts listed in the chart below. If you have coverage with QUEST (Medicaid), you automatically qualify for Extra Help. For those who <u>don't</u> qualify for "Extra Help", you will pay the following for your covered prescription drugs:	If you qualify for "Extra Help" from Medicare to help pay for your prescription drug costs, you pay nothing for covered Part D prescription drugs. If you have coverage with QUEST (Medicaid), you automatically qualify for Extra Help.

	2026 (this year)	2027 (next year)
Tier 1 Preferred Generic	\$0 copayment.	For those who <u>don't</u> qualify for "Extra Help", you will pay the following for your covered prescription drugs: • 25% of the cost. • You pay the lesser of \$35 and 25% of the cost per month supply of each covered insulin product.
Tier 2 Generic	\$0 copayment.	
Tier 3 Preferred Brand	25% of the cost. You pay the lesser of \$35 and 25% of the cost per month supply of each covered insulin product on this tier.	
Tier 4 Non-Preferred Drug	30% of the cost.	
Tier 5 Specialty Tier	25% of the cost. You pay the lesser of \$35 and 25% of the cost per month supply of each covered insulin product on this tier.	

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.

SECTION 2 Administrative Changes

	2026 (this year)	2027 (next year)
Appeals for Part D Prescription Drugs - Contact Information See Chapter 2, Section 1 of the EOC for contact information.	In the 2026 Evidence of Coverage, the contact information for Appeals for Medical and Part D Prescription Drugs was combined.	In the 2027 Evidence of Coverage, the contact information for Appeals for Part D Prescription Drugs has changed. Call: 1 (855) 479-3659 TTY: 711 Fax: 1 (855) 633-7673 Write: CVS Caremark Part D Appeals and Exceptions P.O. Box 52000, MC109 Phoenix, AZ 85072-2000
Our plan membership card See Chapter 1, Section 3.1 of the EOC.	You should also show the provider your Medicaid card for services that are covered only by Medicaid.	Your membership card is an integrated card that serves as the card for both your HMSA Medicare and HMSA QUEST (Medicaid) plans.
Preventive services See Chapter 12 of the EOC, Definitions	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).	Health care services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

SECTION 3 How to Change Plans

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

If you want to change plans for 2027, 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 Dual Care*. Remember, not all Medicare health plans cover prescription drugs. Also, be aware that for many plans, you can't join a Medicare health plan and simultaneously purchase a prescription drug plan.
- **To change to Original Medicare with separate Medicare drug coverage**, you can enroll in a Part D plan, and you'll automatically be disenrolled from *HMSA Akamai Advantage Dual Care*.
- **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.
- **To learn more about Original Medicare and the different types of Medicare plans**, visit Medicare.gov, check the *Medicare & You 2027* 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 prescription drug plans. These other plans can differ in 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, 2027, 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, 2027.

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

In certain situations, people may have other chances 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

Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

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 may 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 coinsurances. 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 can 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 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.

SECTION 5 Questions?

Get Help from HMSA Akamai Advantage Dual Care

- **Call Customer Relations at 1 (800) 660-4672, option 6. (TTY users call 711.)**
We're available for phone calls 7:45 a.m.-8 p.m., 7 days a week. Calls to these numbers are free.
- **Read your 2027 Evidence of Coverage**

This *Annual Notice of Change* gives you a summary of changes in your benefits and costs for 2027. For details, go to the *2027 Evidence of Coverage for HMSA Akamai Advantage Dual Care*. 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 Customer Relations at 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 and Pharmacy 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 and Medicaid 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 Medicare.gov**
You can chat live at [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone).
- **Write to Medicare**
You can write to Medicare at PO Box 1270, Lawrence, KS 66044
- **Visit 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 2027***
The *Medicare & You 2027* 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 [Medicare.gov](https://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Get Help from Medicaid

Call State of Hawai'i Department of Human Services Med-QUEST Division at 1 (800) 316-8005 (TTY users call 711) for help with Medicaid enrollment or benefit questions.

HMSA Akamai Advantage Dual Care (PPO D-SNP)

2027 *Evidence of Coverage*

Available starting Oct. 1, 2026

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 2027 *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 2027 *Evidence of Coverage*.

The 2026 *Evidence of Coverage* will be available until Dec. 31, 2026.

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 (808) 948-6000, option 6, or 1 (800) 660-4672, option 6, toll-free daily, 7:45 a.m.-8 p.m. For TTY, call 711.

Questions?

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



HMSA Akamai Advantage Dual Care (PPO D-SNP) Provider and Pharmacy Directory

Looking for a Doctor?

The 2027 provider directory will be available Oct. 15, 2026.

Visit hmsa.com/advantage.

1. Click Find a Doctor.
2. Under Medicare, select HMSA Akamai Advantage Dual Care (PPO D-SNP).
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 HMSA Akamai Advantage Dual Care (PPO D-SNP) then Provider Directory.
- **Go online to request a printed copy.** Go to hmsa.com/advantage. Under Plan Documents, click HMSA Akamai Advantage Dual Care (PPO D-SNP). Click Request hard copy. Follow the instructions and click Submit.
- **Call us to request a printed copy.**
Call (808) 948-6000, option 6, or 1 (800) 660-4672, option 6, toll-free daily, 7:45 a.m.-8 p.m. For TTY, call 711.

We can mail you a provider directory for:

- HMSA Akamai Advantage Dual Care (PPO D-SNP).
- HMSA Akamai Advantage Dental.
- HMSA Akamai Advantage Routine Vision.

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

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

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



HMSA Akamai Advantage Dual Care is a PPO D-SNP plan with a Medicare contract and is a state of Hawaii Medicaid Managed Care Program. Enrollment in HMSA Akamai Advantage Dual Care depends on contract renewal.

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



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HMSA Akamai Advantage Dual Care (PPO D-SNP)

Prescription Drug List 2027 (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, 2026.

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 2027 Formulary (drug list).

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

Not registered for My Account?

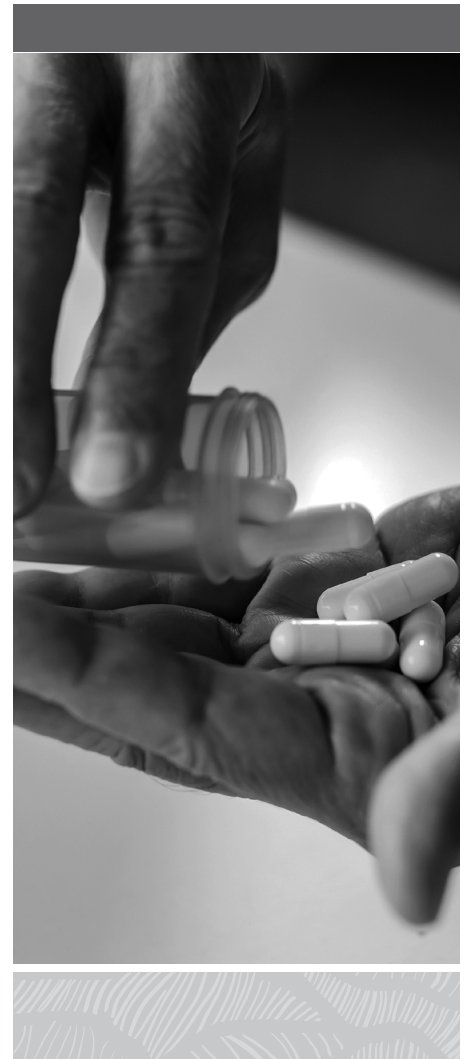
Go to hmsa.com and click My Account Login. Click Sign up to create an account. All you need is your HMSA membership card and an email address. It only takes a few minutes to create an account and link to your plan.

Don't have a computer?

We can mail the drug list to you.

Call (808) 948-6000, option 6, or 1 (800) 660-4672, option 6, toll-free daily, 7:45 a.m.-8 p.m. For TTY, call 711.

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



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/>.

(continued on next page)



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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 kanimong 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

ເລິ່ນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍ່ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ເຂົາເຈົ້າໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍລິການໄດ້ທີ 1 (800) 440-0640, TTY 1 (877) 447-5990 ຫຼື ປຶກສາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ. ສະມາຊິກແຜນປະກັນ Medicare Advantage ແລະ ຊັ້ນທຸລະກິດ, ໂທ 1 (800) 776-4672 ຫຼື TDD/TTY 1 (877) 447-5990.

Kajin Majōl

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 kōjrbal 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-lgilisi, 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 inisiaua 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 โปรดโทรไปที่หมายเลขโทรศัพท์ที่หมายเลข 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.

HMSA Medicare Advantage Customer Relations

CALL	(808) 948-6000 or 1 (800) 660-4672, option 6, toll-free daily, 7:45 a.m.–8 p.m. Oct. 1–March 31: Seven days a week. April 1–Sept. 30: Monday–Friday. 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 toll-free 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	hawaiiiship.org

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