**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.hmsa.com.

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

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$100** individual / **$300** family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Certain preventive care and well-child care services will be covered before you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000** individual / **$9,000** family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, payments for services subject to a maximum once you reach the maximum, any amounts you owe in addition to your copayment for covered services, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. See http://www.hmsa.com/search/providers or call 1-800-776-4672 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider (unless otherwise defined by federal law), and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $14 copay/visit | $14 copay/visit | ---none--- |
| | Specialist visit | $14 copay/visit | $14 copay/visit | ---none--- |
| | **Other practitioner office visit:** | | | |
| | Physical and Occupational Therapist | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Psychologist | $14 copay/visit | $14 copay/visit | ---none--- |
| | Nurse Practitioner | $14 copay/visit | $14 copay/visit | ---none--- |
| | Preventive care (Well Child Physician Visit) | No charge; deductible does not apply | No charge; deductible does not apply | Age and frequency limitations may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| | Screening | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Immunization (Standard and Travel) | No charge; deductible does not apply | No charge; deductible does not apply | |
| **If you have a test** | **Diagnostic test** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 20% coinsurance | |
| | **X-ray** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 20% coinsurance | |
| | **Blood Work** | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | No charge | No charge | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a test** | **Imaging** (CT/PET scans, MRIs) | | | |
| | Inpatient | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Outpatient | 20% coinsurance | 20% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | **Generic drugs (retail)** | | | |
| | Contraceptives - Oral & Other Methods | No charge; deductible does not apply | No charge; deductible does not apply | Retail benefits limited to a 30-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Diabetic Drugs | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | Insulin | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | Oral Chemotherapy | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Over the Counter Contraceptives | No charge; deductible does not apply | No charge; deductible does not apply | |
| | USPSTF Recommended Drugs | No charge; deductible does not apply | No charge; deductible does not apply | |
| | **Generic drugs (mail order)** | | | |
| | Contraceptives - Oral & Other Methods | No charge; deductible does not apply | Not covered | Mail order benefits limited to a 90-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | Not covered | |
| | Diabetic Drugs | 20% coinsurance; deductible does not apply | Not covered | |
| | Insulin | 20% coinsurance; deductible does not apply | Not covered | |
| | Oral Chemotherapy | No charge; deductible does not apply | Not covered | |
| | Over the Counter Contraceptives | No charge; deductible does not apply | Not covered | |
| | USPSTF Recommended Drugs | No charge; deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | **Preferred Formulary Drugs (retail)** | | | |
| | Contraceptives - Oral & Other Methods | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | Retail benefits limited to a 30-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Diabetic Drugs | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | Diabetic Supplies | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Insulin | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | Oral Chemotherapy | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Over the Counter Contraceptives | No charge; deductible does not apply | No charge; deductible does not apply | |
| | USPSTF Recommended Drugs | No charge; deductible does not apply | No charge; deductible does not apply | |
| | **Preferred Formulary Drugs (mail order)** | | | |
| | Contraceptives - Oral & Other Methods | 20% coinsurance; deductible does not apply | Not covered | Mail order benefits limited to a 90-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | Not covered | |
| | Diabetic Drugs | 20% coinsurance; deductible does not apply | Not covered | |
| | Diabetic Supplies | No charge; deductible does not apply | Not covered | |
| | Insulin | 20% coinsurance; deductible does not apply | Not covered | |
| | Oral Chemotherapy | No charge; deductible does not apply | Not covered | |
| | Over the Counter Contraceptives | No charge; deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | USPSTF Recommended Drugs | No charge; deductible does not apply | Not covered | |
| | **Non-preferred Formulary Drugs (retail)** | | | |
| | Contraceptives - Oral & Other Methods | 30% coinsurance; deductible does not apply | 30% coinsurance; deductible does not apply | Retail benefits limited to a 30-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Diabetic Drugs | 30% coinsurance; deductible does not apply | 30% coinsurance; deductible does not apply | |
| | Diabetic Supplies | 20% coinsurance; deductible does not apply | 20% coinsurance; deductible does not apply | |
| | Insulin | 30% coinsurance; deductible does not apply | 30% coinsurance; deductible does not apply | |
| | Oral Chemotherapy | No charge; deductible does not apply | No charge; deductible does not apply | |
| | Over the Counter Contraceptives | No charge; deductible does not apply | No charge; deductible does not apply | |
| | USPSTF Recommended Drugs | No charge; deductible does not apply | No charge; deductible does not apply | |
| | **Non-preferred Formulary Drugs (mail order)** | | | |
| | Contraceptives - Oral & Other Methods | 30% coinsurance; deductible does not apply | Not covered | Mail order benefits limited to a 90-day supply<br>Contraceptives may be covered up to a 12-month supply<br>Over the counter contraceptives are available by prescription only |
| | Contraceptives - Diaphragms/ Cervical Caps | No charge; deductible does not apply | Not covered | |
| | Diabetic Drugs | 30% coinsurance; deductible does not apply | Not covered | |
| | Diabetic Supplies | 20% coinsurance; deductible does not apply | Not covered | |
| | Insulin | 30% coinsurance; deductible does not apply | Not covered | |
| | Oral Chemotherapy | No charge; deductible does not apply | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.hmsa.com. | Over the Counter Contraceptives | No charge; deductible does not apply | Not covered | |
| | USPSTF Recommended Drugs | No charge; deductible does not apply | Not covered | |
| | Specialty drugs | 20% coinsurance | 20% coinsurance | Limited to outpatient injectable drugs |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | ---none--- |
| | Physician Visits | $14 copay/visit | $14 copay/visit | ---none--- |
| | Surgeon fees | 20% coinsurance (cutting) | 20% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 20% coinsurance (non-cutting) | ---none--- |
| **If you need immediate medical attention** | **Emergency room care** | | | |
| | Physician Visit | $20 copay/visit | $20 copay/visit | ---none--- |
| | Emergency room | $100 copay/visit | $100 copay/visit | ---none--- |
| | Emergency medical transportation (air) | 20% coinsurance | 20% coinsurance | Limited to air transport to the nearest adequate hospital within the State of Hawaii. |
| | Emergency medical transportation (ground) | 20% coinsurance | 20% coinsurance | Ground transportation to the nearest, adequate hospital to treat your illness or injury. |
| | Urgent care | $14 copay/visit | $14 copay/visit | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | ---none--- |
| | Physician Visits | $20 copay/visit | $20 copay/visit | ---none--- |
| | Surgeon fee | 20% coinsurance (cutting) | 20% coinsurance (cutting) | ---none--- |
| | | 20% coinsurance (non-cutting) | 20% coinsurance (non-cutting) | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | **Outpatient services** | | | |
| | Physician services | $14 copay/visit | $14 copay/visit | ---none--- |
| | Hospital and facility services | 20% coinsurance | 20% coinsurance | ---none--- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have mental health, behavioral health, or substance abuse needs** | **Inpatient services** | | | |
| | Physician services | No charge | No charge | ---none--- |
| | Hospital and facility services | 20% coinsurance | 20% coinsurance | ---none--- |
| **If you are pregnant** | Office visit (Prenatal and postnatal care) | 10% coinsurance | 10% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or copay may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 10% coinsurance | 10% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 10% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | 150 Visits per Calendar Year |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. Excludes cardiac rehabilitation. |
| | Habilitation services | Not covered | Not covered | Excluded service |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | 120 Days per Calendar Year. Includes extended care facilities (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities) to the extent care is for Skilled nursing care, sub-acute care, or long-term acute care. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Services may require preauthorization. Benefits may be denied if preauthorization is not obtained. |
| | Hospice services | No charge | No charge | ---none--- |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Excluded service |
| | Children's glasses (single vision lenses and frames selected within designated group) | Not covered | Not covered | Excluded service |
| | Children's dental check-up | Not covered | Not covered | Excluded service |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Habilitation services | • Routine eye care (Child) |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |
| • Dental care (Child) | • Routine eye care (Adult) | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Bariatric surgery | • Infertility Treatment (Artificial Insemination and In Vitro Fertilization. Please refer to your plan document for limitations and additional details) | |
| • Chiropractic care (e.g., office visits, x-ray films - limited to services covered by this medical plan and within the scope of a chiropractor's license) | • Non-emergency care when traveling outside the U.S. For more information, see www.hmsa.com | |
| • Hearing aids (limited to one hearing aid per ear every 60 months) | | |

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

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

- For group health coverage subject to ERISA, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch - External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808) 586-2804.
- For non-federal governmental group health plans and church plans that are group health plans, you must submit a written request for an appeal to: HMSA Member Advocacy and Appeals, P.O. Box 1958, Honolulu, Hawaii 96805-1958. If you have any questions about appeals, you can call us at (808) 948-5090 or toll free at 1-800-462-2085. You may also file a grievance with the Insurance Commissioner. You must send the request to the Insurance Commissioner at: Hawaii Insurance Division, ATTN: Health Insurance Branch - External Appeals, 335 Merchant Street, Room 213, Honolulu, Hawaii 96813. Telephone: (808)

586-2804.

### Does this Coverage Provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this Coverage Meet the Minimum Value Standard? Yes

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-776-4672.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-776-4672.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-776-4672.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-776-4672.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

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

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist copayment | $14 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| Total Example Cost | $12,700 |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $20 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,880** |

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist copayment | $14 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| Total Example Cost | $5,600 |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $100 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,020** |

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

| | |
|---|---|
| The plan's overall deductible | $100 |
| Specialist copayment | $14 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| Total Example Cost | $2,800 |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $200 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$600** |

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

# 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)

hmsa
An Independent Licensee of the Blue Cross and Blue Shield Association

1020-1276050 6.25 LE

Commercial/ACA/Medicare
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S3994_1020_1276050_L3G4AH717_26_C
H8481_1020_1276050_L3G4AH718_26_C

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) 447-5990번으로 전화하거나 서비스 제공자와 상의하십시오. Medicare Advantage 및 민간 플랜 가입자는 1 (800) 776-4672 또는 TDD/TTY 1 (877) 447-5990번으로 전화하십시오.

**ພາສາລາວ**

ເຊີນຊາບ: ຖ້າທ່ານບໍ່ເວົ້າພາສາອັງກິດແມ່ນມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍພ້ອມໃຫ້ທ່ານ. ນອກຈາກນັ້ນກໍຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການເສີມເພື່ອໃຫ້ຂໍ້ມູນແກ່ທ່ານໃນຮູບແບບທີ່ ເຂົ້າເຖິງໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ສະມາຊິກ QUEST ແມ່ນໂທບໍ່ເສຍຄ່າໄດ້ທີ່ເບີ 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.

(continued on next page)

**Kajin Ṃajōļ**
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.