MONTHLY REPORT
Medical and Hospital Claims
Processed in September 2023

[redacted]

Forwarding Service Requested
[redacted]

**********ALL FOR AADC 967
[redacted] 18
RODNEY L ARIES
[redacted]

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

This is the cost breakdown for my 2023 hip replacement surgery. I've put a red box around any charges over $1,000.

- Rod

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

For: RODNEY L ARIES
Member ID#: [redacted]

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid out of pocket (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. If you have Part D prescription drug coverage, you will receive a separate report.
- If you notice something suspicious that might be dishonest billing, you can report it by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)

HMSA Member Services

If you have questions, call us: 1(800) 660-4672 toll-free

We're here 8 a.m. to 8 p.m., seven days a week. TTY users call 711.

Or call your local office:
Honolulu: 948-6000
Kauai: 245-3393
Maui: 871-6295
Kona: 329-5291
Hilo: 935-5441

Or write us at:
HMSA's Medicare Programs
Attn: Customer Service
P.O. Box 860
Honolulu, HI 96808-0860

hmsa.com/advantage

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact us. Also, keep in mind that benefits, formulary, pharmacy network, provider network, premium, copayments, and coinsurance may change each year.

These totals are for your 2023 Out-of-Pocket Costs				
TOTALS for medical and hospital claims	Amount providers have billed the plan	Total Cost (amount the plan has approved)	**Plan's share**	**Your share**
Totals for this month (for claims processed from September 1, 2023 through September 30, 2023)	$64,400.96	$16,698.47	$13,799.90	$2,674.89
Totals for 2023 (all claims processed through September 30, 2023)	$80,133.46	$22,092.29	$18,269.39	$3,507.97

2023 DEDUCTIBLE:

Your plan has no deductible.

2023 YEARLY LIMIT - this limit gives you financial protection

This limit is the most you will have to pay in 2023 "out-of-pocket" costs, (copays, and coinsurance, and your deductible) for medical and hospital services covered by the plan.

This yearly limit is called your out-of-pocket maximum. It puts a limit on how much you have to pay, but it doesn't limit the care you get. Your out-of-pocket spending for mandatory supplemental services (these services are marked with an asterisk in the Evidence of Coverage's Medical Benefits Chart) won't count toward your yearly out-of-pocket maximum. This means:

- Once you've reached your out-of-pocket maximum for services that Medicare pays for, you stop paying out of pocket for medical services except for mandatory supplemental services.
- You keep getting your covered medical and hospital services as usual; the plan will pay the full cost for the rest of the year. Your out-of-pocket spending for services that Original Medicare doesn't pay for doesn't count toward your out-of-pocket maximum.

In-network:

As of September 30, 2023 your in-network, out-of-pocket costs have reached $3,450.00 that count toward your $3,450.00 out-of-pocket maximum for covered services.

Combined (in-network + out-of-network) limit

In 2023, $5,150.00 is the most you will have to pay for covered services you get from all providers (in-network providers + out-of-network providers).

As of September 30, 2023 you had $3,450.00 in out-of-pocket costs that count toward your $5,150.00 combined out-of-pocket maximum for covered services.

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		Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes
[redacted]							
Claim Number: [redacted]							
In-Network Provider							
OTHER SVC	1101F	08/23/23	$0.01	$0.00	$0.00	$0.00	16.13CO
OTHER SVC	1126F	08/23/23	$0.01	$0.00	$0.00	$0.00	00027
OTHER SVC	1160F	08/23/23	$0.01	$0.00	$0.00	$0.00	16.13CO
OTHER SVC	1494F	08/23/23	$0.01	$0.00	$0.00	$0.00	16.13CO
ADVNCD CAREPLN	99497	08/23/23	$180.80	$0.00	$0.00	$0.00	9.7OA
WELLNESS VISIT	G0438	08/23/23	$349.72	$148.63	$145.66	$0.00	37.15CO XX0018
OTHER SVC	G8404	08/23/23	$0.01	$0.00	$0.00	$0.00	00027
		TOTALS:	**$530.57**	**$148.63**	**$145.66**	**$0.00**	

NOTE(S)

XX0018 - THIS IS ONE OF THE PREVENTIVE SERVICES THAT IS COVERED AT NO COST UNDER ORIGINAL MEDICARE. THE PLAN COVERS THIS SERVICE FROM AN IN-NETWORK PROVIDER AT NO COST TO YOU.

00027 - THIS CODE IS FOR INFORMATION/REPORTING PURPOSES ONLY. YOU SHOULD NOT BE CHARGED FOR THIS CODE. IF THERE IS A CHARGE, YOU DO NOT HAVE TO PAY THE AMOUNT.

16.13CO - NO PAYMENT CAN BE MADE. THE CODE YOUR PROVIDER USED IS NOT VALID FOR THE DATE OF SERVICE BILLED. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

9.7OA - NO PAYMENT CAN BE MADE AT THIS TIME. WE HAVE ASKED YOUR PROVIDER TO RESUBMIT THE CLAIM WITH THE MISSING OR CORRECT INFORMATION. YOU ARE NOT RESPONSIBLE FOR THIS AMOUNT.

[CONTINUE]

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		Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes

DIAGNOSTIC LAB SERVICES
Claim Number: [redacted]
In-Network Provider
Referred by [redacted]

SPEC COLL FEE	36415	08/29/23	$9.00	$8.57	$6.72	$1.71	37.15CO XX0012
		TOTALS:	**$9.00**	**$8.57**	**$6.72**	**$1.71**	

NOTE(S)
XX0012 - YOU PAY 20% OF THE ELIGIBLE CHARGE FOR SERVICES FROM AN IN-NETWORK PROVIDER.

37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[redacted]
Claim Number: [redacted]
In-Network Provider

ANESTHESIA	01214	09/06/23	$2,465.00	$348.27	$302.10	$40.00	37.15CO XX0011
		TOTALS:	**$2,465.00**	**$348.27**	**$302.10**	**$40.00**	

NOTE(S)
LINE1 XX00 - YOUR COPAYMENT FROM AN IN-NETWORK PROVIDER IS $40.00

37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[CONTINUE]

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		Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes
[redacted]							
Claim Number: [redacted]							
In-Network Provider							
PHYS THERAPY	97110	09/08/23	$42.00	$23.66	$0.00	$23.66	XX0011
PHYS THERAPY	97162	09/08/23	$140.00	$108.33	$99.95	$6.34	37.15CO XX0017
PHYS THERAPY	97530	09/08/23	$55.00	$27.98	$27.42	$0.00	37.15CO
		TOTALS:	**$237.00**	**$159.97**	**$127.37**	**$30.00**	

NOTE(S)
LINE1 XX00 - YOUR COPAYMENT FROM AN IN-NETWORK PROVIDER IS $23.66

XX0017 - COPAY ADJUSTED DUE TO ONE COPAYMENT PER DAY RULE. THE AMOUNT YOU OWE IS EQUAL TO THE AMOUNT FOR THE SERVICE WITH THE HIGHEST COPAYMENT FOR THAT DAY.
37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[redacted]
Claim Number: [redacted]
In-Network Provider

PHYS THERAPY	97110	09/11/23	$42.00	$23.66	$0.00	$23.66	XX0011
PHYS THERAPY	97530	09/11/23	$55.00	$40.80	$33.77	$6.34	37.15CO XX0017
PHYS THERAPY	97112	09/11/23	$45.00	$26.91	$26.37	$0.00	37.15CO
		TOTALS:	**$142.00**	**$91.37**	**$60.14**	**$30.00**	

NOTE(S)
LINE1 XX00 - YOUR COPAYMENT FROM AN IN-NETWORK PROVIDER IS $23.66

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	Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes

NOTE(S)

XX0017 - COPAY ADJUSTED DUE TO ONE COPAYMENT PER DAY RULE. THE AMOUNT YOU OWE IS EQUAL TO THE AMOUNT FOR THE SERVICE WITH THE HIGHEST COPAYMENT FOR THAT DAY.

37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

QUEEN'S NORTH HAWAII COMMUNITY HOSPITAL

Claim Number: [redacted]
In-Network Provider

PHARMACY	0250	09/06/23	$8.00	$0.00	$0.00	$0.00	
PHARMACY	0250	09/06/23	$69.60	$0.00	$0.00	$0.00	
MED SUPPLY	0258	09/06/23	$15.81	$0.00	$0.00	$0.00	
MED SUPPLY	0272	09/06/23	$5,137.32	$0.00	$0.00	$0.00	
EQUIP/SUPPLIES	0278	09/06/23	$16,560.00	$0.00	$0.00	$0.00	
DIAG LAB	0312	09/06/23	$409.00	$0.00	$0.00	$0.00	
DIAG LAB	0312	09/06/23	$155.00	$0.00	$0.00	$0.00	
DIAG XRAY	0320	09/06/23	$401.00	$0.00	$0.00	$0.00	
SURGERY	0360	09/06/23	$28,172.00	$15,650.59	$12,872.67	$2,515.21	37.15CO
ANESTHESIA	0370	09/06/23	$5,266.00	$0.00	$0.00	$0.00	
PHYS THERAPY	0420	09/06/23	$125.00	$0.00	$0.00	$0.00	
PHYS THERAPY	0424	09/06/23	$501.00	$108.33	$106.16	$0.00	37.15CO
INJECTION	0636	09/06/23	$876.39	$0.00	$0.00	$0.00	

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		Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes

QUEEN'S NORTH HAWAII COMMUNITY HOSPITAL
Claim Number: [redacted]
In-Network Provider

Total Hip Replacement Cost Before Insurance: $60,733.39
Amount I Paid (Medicare): $2,573.18

INJECTION	0636	09/06/23	$35.10	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$8.00	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$8.00	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$20.00	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$8.00	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$25.20	$0.00	$0.00	$0.00	
INJECTION	0636	09/06/23	$8.00	$0.00	$0.00	$0.00	
NON-COVERED	0637	09/06/23	$54.53	DENIED	$0.00	$54.53	16.10PR XX0001 XX0003
NON-COVERED	0637	09/06/23	$1.00	DENIED	$0.00	$1.00	16.10PR XX0001 XX0003
NON-COVERED	0637	09/06/23	$1.44	DENIED	$0.00	$1.44	16.10PR XX0001 XX0003
NON-COVERED	0637	09/06/23	$1.00	DENIED	$0.00	$1.00	16.10PR XX0001 XX0003
RECOVERY ROOM	0710	09/06/23	$2,867.00	$0.00	$0.00	$0.00	
		TOTALS:	**$60,733.39**	**$15,758.92**	**$12,978.83**	**$2,573.18**	

NOTE(S)

XX0001 - THIS SERVICE WAS DENIED. YOU MAY BE RESPONSIBLE FOR PAYING THIS AMOUNT. INFORMATION ABOUT YOUR APPEAL RIGHTS CAN BE FOUND AT THE END OF THIS DOCUMENT.

XX0003 - WE DENIED THE PAYMENT OF THIS MEDICAL SERVICE(S)/ITEM(S) BECAUSE THESE ARE CONSIDERED PLAN GENERAL EXCLUSIONS OR FROM MEDICARE COVERAGE AS DESCRIBED IN THE MEDICARE BENEFIT POLICY MANUAL CHAPTER 16.

16.10PR - NO PAYMENT CAN BE MADE. THIS ITEM OR SERVICE IS NOT COVERED. YOU ARE RESPONSIBLE FOR THIS AMOUNT.

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		Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes

NOTE(S)
37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[redacted]
Claim Number: [redacted]
In-Network Provider

PHYS THERAPY	97110	09/14/23	$42.00	$23.66	$23.19	$0.00	37.15CO
PHYS THERAPY	97530	09/14/23	$55.00	$40.80	$39.98	$0.00	37.15CO
PHYS THERAPY	97112	09/14/23	$45.00	$26.91	$26.37	$0.00	37.15CO
		TOTALS:	**$142.00**	**$91.37**	**$89.54**	**$0.00**	

NOTE(S)
37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[redacted]
Claim Number: [redacted]
In-Network Provider

PHYS THERAPY	97110	09/18/23	$42.00	$23.66	$23.19	$0.00	37.15CO
PHYS THERAPY	97530	09/18/23	$55.00	$40.80	$39.98	$0.00	37.15CO
PHYS THERAPY	97112	09/18/23	$45.00	$26.91	$26.37	$0.00	37.15CO
		TOTALS:	**$142.00**	**$91.37**	**$89.54**	**$0.00**	

[CONTINUE]

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	Date of Service	Amount the provider billed the plan	Total cost (amount the plan approved)	Plan's share	Your share	Codes

NOTE(S)

37.15CO - AFTER ANY APPLICABLE DEDUCTIBLE AND COINSURANCE WERE APPLIED, THE AMOUNT HMSA PAID WAS REDUCED DUE TO FEDERAL MANDATORY PAYMENT REDUCTION RULES.

[redacted]

[CONTINUE]

[redacted]

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