Guide to Benefits

HMSA Group Dental PPO Plan

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Chapter 1: Critical Concepts

This chapter explains important concepts that affect Your coverage. In many instances, You will be referred to other chapters for additional details about a concept.

USING YOUR GUIDE TO BENEFITS

This Guide explains your dental coverage in nine (9) chapters. Each chapter explains a different aspect of your coverage.

Review Entire Document

While You might refer to some chapters more often than others, keep in mind that all chapters are important. You should familiarize yourself with the entire Guide. For a quick view of all chapter topics, see *Table of Contents* at the beginning of the Guide.

Terminology

The terms You and Your mean you and your family members eligible for this coverage. We, Us and Our refer to HMSA.

The term Provider means an approved Dentist or other practitioner who provides you with dental care services. Your provider may also be the place where you get your services, such as routine dental care services or specialized dental services.

Definitions

Throughout this guide, terms appear in *Bold Italics* the first time they are defined. Terms are also defined in Chapter 9: Defined Terms

How To Contact Us

If You have any questions about Your coverage, you can refer to this Guide or call Us. Telephone numbers appear on the back cover of this Guide. If Your question is regarding a dispute, see *Chapter 6: Resolving Disputes*.

HOW YOU CAN HELP CONTROL YOUR DENTAL COSTS

- Carefully read Your Guide so that You understand Your dental Plan and how to maximize Your coverage.
- Take care of Your teeth daily (brush at least twice and floss at least once).
- Schedule and receive regular teeth cleaning and exams as often as Your Dentist recommend. For details on how often these services are covered under this Plan, see *page Chapter 3: Services & Copayments*.
- Don't let a minor dental problem become a major one.
- Be an active participant in Your treatment so You can make informed decisions about Your dental care. Talk with Your Dentist and ask questions. Understand the treatment program and any risks, benefits, alternatives, and costs associated with it.
- Take time to read and understand Your Explanation of Benefits (EOB). This report shows how We determined payment. Make sure You are billed only for those services You received. For details regarding the EOB, see *Chapter 5: Filing Claims*.

COVERED SERVICE CRITERIA

To determine whether a specific service is covered under Your Plan and eligible for payment by Us, all of the following criteria must be met:

- The service is listed as covered in *Chapter 3: Services & Copayments* Please note: Even if a service is covered, you may be responsible for a portion of costs. For more information, See *Chapter 2: Amounts You May Owe*.
- The service is not specifically excluded. Even if a service is not specifically listed in *Chapter 3* as an exclusion, it is not considered covered unless the care meets all the criteria listed in this section.
- The service meets *Payment Determination Criteria* (see *Chapter 9: Defined Terms*). You may ask Your provider to contact Us to determine if the care You seek meets Payment Determination Criteria. We should be contacted before You receive the care in question.
- The service is consistent with Our dental policies. Call Us if You have questions.
- The service is ordered by and received from or arranged by a Dentist. In general, you should receive services from a Participating Dentist whenever possible. For more information about Participating Dentists, see *section Choosing a Dentist*.
- Another party does not have an obligation to pay. If another party is responsible, payment under this coverage may be affected. See *Chapter 7*.
- The service is not subject to a *waiting period*.
- The service has not exceeded a stated service limitation. See *Chapter 3: Services & Copayments*.

24/7 Emergency Dental Care

Your HMSA Dental plan now includes virtual dental visits delivered by TeleDentistry.com as a covered benefit – at no extra cost!

Emergency rooms are not typically equipped to handle dental emergencies. If you have a serious and/or painful dental issue and you cannot get in touch with your dentist after hours, you now have 24/7 access to a dentist by phone or video call. This valuable benefit can save you both time and money.

- The service is available to you on island or on the Mainland, you'll be connected to a dentist who'll help resolve the problem and write prescriptions if necessary. The TeleDentistry.com dentist can refer you to an in-network HMSA dentist or your regular dentist for further care as needed.
- Visit hmsadental.com/teledentistry or call (866) 256-1871.

CHOOSING A DENTIST

Under this Plan, you can seek care from almost any *Dentist*. To keep Your costs as low as possible, you should go to a Participating Dentist whenever possible. For a listing of Participating Dentists, refer to the HMSA's Directory of Participating Dentists. Please note: the directory is subject to change and may not reflect the most current information about a Dentist. To confirm a Dentist's status, you can ask Your Dentist, call Us, or visit www.hmsa.com.

Participating Dentist Facts	Nonparticipating Dentist Facts
We have contracts with Participating Dentists. We recognize and approve Participating Dentists. HMSA also contracts with a third party to provide dental benefits through their network.	We do not contract with nonparticipating Dentists.
We credential Participating Dentists. We look at many factors including licensure, professional history, and type of practice.	We do not credential nonparticipating Dentists.
They agree to comply with Our payment policies.	They do not agree to comply with Our payment policies.
They agree to file claims for Covered Services on Your behalf.	You are responsible for ensuring that claims are filed. If the Dentist does not file for You, you must file yourself. See *Chapter 5: Filing Claims*.
They agree to accept Our *Eligible Charge* as payment in full for Covered Services, (with the exception of **High-Cost* Procedures). For information related to **High-Cost* Procedures, see *page* 5 under Amounts Exceeding *Eligible Charge*. You are not responsible for any difference between the Eligible Charge and the amount billed by the Dentist (unless the Covered Service is considered a **High-Cost* Procedure).	They do not agree to accept the *Eligible Charge* as payment in full. You are responsible for any difference between the Eligible Charge and the amount billed by the Dentist.
You pay the applicable Copayment at the time You receive services.	You pay the provider in full at the time You receive services. We reimburse You any applicable amount after We receive and review a claim.
You pay the applicable Deductible at the time You receive services.	You pay the provider in full at the time You receive services. We reimburse You any applicable amount after We receive and review a claim.

Chapter 2: Amounts You May Owe

In general, your payment obligation for a service that is covered is a fraction of total costs. However, in most cases, you are responsible for a portion of costs. This chapter explains the various charges for which You may be responsible.

COPAYMENT
A Copayment is an amount you owe for most covered services. A Copayment is a fixed percentage of the Eligible Charge. Member Responsibility amounts appear in *Chapter 3: Services & Copayments*.

AMOUNTS EXCEEDING ELIGIBLE CHARGE
In certain circumstances, you may owe the difference between the amount billed by Your Dentist and the *Eligible Charge* (for a definition of Eligible Charge, see *Chapter 9: Defined Terms*). This applies if You receive services from a nonparticipating Dentist or choose a **High-Cost Procedure*. With **High-Cost* Procedures, two treatment options exist, but one is more cost effective than the other. You have a choice to receive the **High-Cost* Procedure or the more cost effective one. However, if You choose the **High-Cost* Procedure, You are responsible for both of the following amounts:

- The Copayment of the most cost-effective procedure and
- Any difference between the amount the Dentist bills for the **High-Cost* Procedure and the Eligible Charge for the more cost-effective procedure.
- Porcelain crowns on molar teeth are considered a **High-Cost* Procedure

AMOUNTS EXCEEDING CALENDAR YEAR MAXIMUM
The Calendar Year Maximum is the maximum dollar amount We will pay toward Covered Services during a Calendar Year. **The Calendar Year Maximum under this Plan is $1500.00 per person.**

CALENDAR YEAR ROLLOVER

A Rollover is a portion of Your unused Calendar Year Maximum that may be carried over to the next calendar year, thereby increasing the dollar amount available to pay for Covered Services during the calendar year. You can accumulate up to $500 in a calendar year which will be added to your Calendar Year Maximum no later than March 15th of the following year, provided the following conditions are met:

- You are a member of the plan on the last day of the calendar year.
- You receive at least one (1) Covered Service during the calendar year while covered under this Plan.
- Your total claims paid during the calendar year does not exceed $700; and
- The sum of the unused Calendar Year Rollover benefits from prior years does not exceed $1,250.

Here's an example of how the Calendar Year Rollover benefit works.

Calendar Year	One (1)	Two (2)	Three (3)	Four (4)	Five (5)
Calendar Year Maximum	$1,500	$1,500	$1,500	$1,500	$1,500
Covered Service Received	Yes	Yes	Yes	Yes	Yes
Total Claims Paid during Calendar Year	$275	$880	$200	$200	$400
Calendar Year Rollover (based on prior year qualification)		$500	$0	$500	*$250
Accumulated Rollover Amount		$500	$500	$1,000	$1,250
Calendar Year Maximum + Accumulated Rollover Amount	$1,500	$2,000	$2,000	$2,500	$2,750

*Only $250 can be added before reaching the Rollover Maximum of $1,250.

The Calendar Year Rollover can be accumulated from one calendar year to the next, up to $1,250 unless:

1. Your total claims paid during a calendar year exceed $700, or
2. No claims for Covered Services are incurred during a calendar year.

If either of the above instances occurs, there will be no additional Calendar Year Rollover for that calendar year. If total claims paid during any one calendar year exceed the Calendar Year Maximum, the excess amount will be deducted from the Rollover Amount available for that calendar year. No additional Calendar Year Rollover will be earned for that calendar year and the Rollover Amount available for the next calendar year will be reduced by the amount deducted for the excess claim amount.

If coverage under this benefit is first provided during a partial calendar year, the Calendar Year Rollover will be calculated as if coverage was provided for a full calendar year. For example:

- Coverage begins 11/1, and
- One Covered Service claim for $100 occurs 12/15, and
- The claim is filed and approved prior to 3/1 of the following year, and
- Premiums are paid and up to date; therefore
- A $500 Calendar Year Rollover will be available for use in the following year.

To assure accurate calculation of the Calendar Year Rollover, claims should be submitted in a timely manner, as described in *Chapter 5: Filing Claims*.

The following expenses are not included when calculating the Total Claims Paid:

1. Deductibles;
2. Co-payments;
3. Payments for services subject to a maximum once you reach the maximum;
4. Any amount that exceeds eligible charges as described in this chapter;
5. Non-covered services; or
6. Orthodontic benefits.

WHEN YOUR CALENDAR YEAR ROLLOVER BENEFIT ENDS

You will lose Your right to any Calendar Year Rollover or Accumulated Rollover Amount when You lose eligibility for coverage in Your Plan. The Accumulated Rollover Amount can be used only while You are enrolled in Your Plan and while Your Plan continues to offer the Calendar Year Rollover benefit. This means that if You change from one Group Sponsor's dental plan to another Group Sponsor's dental plan, or if Your Plan is terminated, you lose Your right to any rollover benefit that has not been used.

AMOUNTS EXCEEDING A SERVICE LIMIT

A Service Limit restricts a Covered Service in some way, such as: dollar amount: how often You can receive a service: an age restriction, or some other limitation. Service Limits appear in *Chapter 3: Services & Copayments.* If You have reached the Calendar Year Maximum, you are not eligible for additional payment from Us, even if You have not reached a specific Service Limit. If You exceed the Service Limit for a specific procedure (e.g., two cleanings) You are not eligible for additional payment from Us for that service even if You have not reached the Calendar Year Maximum.

If You were covered by Us under a different dental coverage immediately prior to this dental coverage, any limitations related to procedure frequency as described in *Chapter 3* will carry forward under this coverage.

Charges for services not covered

You are responsible for 100% of charges for any service that is not covered by Your Plan. See *Chapter 3: Service and Copayments.*

Waiting periods

You are responsible for 100% of charges for any service that is subject to a waiting period if You have not met the waiting period. See *Chapter 3:* under *Dentures, Bridges, and Restorative Services (Crowns)*.

Chapter 3: Services & Copayments

This chapter describes services both covered and not covered and Copayment amounts. In addition to the information in this chapter, to better understand Your coverage, also read *Chapter 1: Critical Concepts and Chapter* 2: Amounts You May Owe. If after reading this chapter You are still unsure whether or not a service is covered, please call Us and We will assist You.

ABOUT THIS CHAPTER

Your dental coverage provides benefits for procedures, services or supplies that are listed in the following service tables. You will note that some of the benefits have limitations. These limitations describe additional criteria, circumstances or conditions that are necessary for a procedure, service, or supply to be a covered benefit. These limitations may also describe circumstances or conditions when a procedure, service or supply is not a covered benefit. These limitations and benefits should be read in conjunction with the *General Exclusions* table later in this chapter, in order to identify all items excluded from coverage.

NON-ASSIGNMENT

Benefits for Covered Services described in this Guide cannot be transferred or assigned to anyone. Any attempt to assign this coverage or rights to payment will be void.

SERVICE TABLES & SERVICE CATEGORIES

Information in this chapter is formatted within tables. Each table represents a Service Category. Each Service Category Groups related services. For example, all restorative procedures appear in one table. When an entire Service Category is subject to the same Service Limit, the limit appears immediately after the heading for the section category.

The following explains the type of information that appears in each of the three columns of the Service Tables found throughout this chapter.

Column 1: Services List	Column 2: Descriptions and Service Limits	Column 3: Copayment
Alphabetical listing of services (both Covered and non-Covered).	• Descriptions of services (both Covered and non-Covered Services). • Applicable *Service Limits*.	The Copayment is an amount You owe for most Covered Services. You may be responsible for charges in addition to the Copayment. See *Chapter 2: Amounts You May Owe* for a list of other charges for which You may be responsible. If a service is not covered, the amount You owe for the non-Covered Service will appear in the Amount Not Covered field on the Member Explanation of Benefits (EOB).

DIAGNOSTIC & PREVENTIVE SERVICES

Service List	Descriptions and Service Limits	Copayment
CLEANING*	Dental cleaning and polishing (otherwise known as prophylaxis). *Service Limit:* Two (2) per Calendar Year.	0%
EXAM	Clinical oral exams. *Service Limit:* Two (2) per Calendar Year.	0%
FLUORIDE*	Topical fluoride treatments. *Service Limit:* You must be age 18 or younger. Two (2) per Calendar Year.	0%
PULP VITALITY TESTS	Pulp vitality tests. *Service Limit:* One (1) per Calendar Year.	0%
SEALANTS	Sealant applications for permanent molars. *Service Limit:* You must be age 16 or younger. Once per molar in a lifetime. Considered a basic service.	30%
SPACERS	Passive appliances. *Service Limit:* You must be age 13 or younger. One (1) per arch per lifetime. Recementation once per Calendar Year. Considered a basic service.	30%
X-RAYS	Radiographs and other diagnostic imaging. *Service Limit:* *One (1) set of bitewings per Calendar Year; and *One (1) full mouth x-rays every three (3) years, or *One (1) Panoramic x-ray every three (3) years.	0%
PERIAPICAL X-RAYS	Periapical x-rays: *Service Limit: Up to (6) per date of service*	30%

*You may be eligible for additional services under the Enhanced Dental Benefit program. Please refer to the *Enhanced Dental Benefits* section within this chapter for additional details.

RESTORATIVE SERVICES (FILLINGS & CROWNS)

Service Limit: Unless otherwise stated, the services listed in this Restorative service category require that you are age 15 or older. In addition, the following service limits apply for repair and replacement services:

- **Repairs**: No sooner than six (6) months after a cementation or placement of a crown. This limitation applies to all services in this service category with the exception of fillings.
- **Replacement Services:** No sooner than three (3) years after the placement of a prefabricated stainless steel or prefabricated resin crown, or five (5) years or more after the placement of any other type of restorative procedure (inlays, onlays, crowns, porcelain veneers, and bridges).
- **Crowns:** Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least 12 consecutive months before coverage for this service category begins.

Service List	Descriptions and Service Limits	Copayment
ADDITIONAL CROWN PROCEDURE	Additional procedures to construct new crown under existing partial denture framework.	30%
CORE BUILDUP	Core buildup, including pins. Cast or prefabricated post and core combined with core buildup are not paid separately. Limited to once every five (5) years.	30%
FILLINGS	Amalgam and resin-based composite restorations including polishing. *Service Limit:* No sooner than one (1) restoration per tooth surface every twelve months. Age limit does not apply.	30%
PORCELAIN/ CERAMIC, OR COMPOSITE RESIN INLAY/ONLAY	Porcelain/ceramic or composite/resin inlays and onlays. *Service Limit:* This restoration is considered a *High-Cost Procedure, additional charges apply as explained on *page 5*.	50%
LABIAL VENEER	Labial veneer (resin or porcelain laminate). *Service Limit:* For anterior teeth constructed in the laboratory. Subject to review.	50%
METAL CROWNS	Crowns made of high noble metal, noble metal, predominantly base metal and titanium.	50%
METAL INLAY/ONLAY	Metallic inlays and onlays.	50%

Service List	Descriptions and Service Limits	Copayment
PIN RETENTION	Pin retention- per tooth, in addition to restoration.	30%
PORCELAIN CROWNS	Porcelain/ceramic substrate or porcelain fused to metal crowns. *Service Limit: *High-Cost* Procedure. If you choose this type of restoration for molar teeth, additional charges apply as explained on *page 5*.	50%
POST AND CORE	Post and core (cast or prefabricated) in addition to crown. Limited to once every five (5) years.	30%
PREFABRICATED CROWNS	Crowns made of prefabricated stainless steel or resin. Age limit does not apply. The 12-month waiting period does not apply.	30%
RECEMENTATION	Recementation of an inlay, onlay, crown, cast or prefabricated post and core are covered after six (6) months of the initial insertion or cementation. *Service Limit:* Two recementations within a five-year period. Twelve-month service limit between recementations.	30%
RESIN CROWNS	Crowns made of resin, resin with high noble metal, noble metal, or predominantly base metal. *Service Limit: *High-Cost* Procedure. If you choose this type of restoration for molar teeth, additional charges apply. See *Chapter 2: Amounts You May Owe*.	50%
RESIN-BASED COMPOSITE CROWNS	Resin-based composite restoration, anterior, chairside. Age limit does not apply. *Service Limit:* This restoration is considered a **High-Cost* Procedure, additional charges apply as explained in *Chapter 2: Amounts You May Owe*. The 12-month waiting period does not apply.	30%
TEMPORARY CROWNS	Temporary crowns are not covered.	You pay 100% of charges.

ENDODONTIC SERVICES (TOOTH ROOTS)

Service List	Descriptions and Service Limits	Copayment
ENDODONTIC THERAPY	Complete root canal therapy including all appointments necessary to complete the treatment, clinical procedures, and follow-up care for anterior, bicuspid, or molar teeth. *Service Limit:* One (1) per permanent tooth in a lifetime.	30%
ENDODONTIC RETREATMENT	Retreatment of previous root canal therapy. *Service Limit:* One (1) retreatment per tooth per lifetime.	30%
HEMISECTION	Hemisection includes root removal (but not root canal therapy).	30%
PULP CAP (DIRECT)	Direct pulp cap, not to include the final restoration. *Service Limit:* One (1) per tooth in a lifetime.	30%
PULP CAP (INDIRECT)	Inidrect pulp cap is not covered.	You pay 100% of charges.
PULPOTOMY (THERAPEUTIC)	Therapeutic pulpotomy not to include the final restoration. *Service Limit*: One (1) per tooth in a lifetime.	30%

PERIODONTIC SERVICES (GUMS & JAW)
Service Limit: You must be age 18 or older.

Service List	Descriptions and Service Limits	Copayment
AUGMENTATION OF GUM RIDGE	Gum ridge augmentation is not covered.	You pay 100% of charges.
CHEMOTHERAPY AGENTS	Localized delivery of chemotherapeutic agents into periodontal pockets.	You pay 100% of charges.
CROWN LENGTHENING	Clinical crown lengthening of hard tissue on teeth that have been fractured or have extensive caries. *Service Limit:* You must be age 18 or older.	30%
GINGIVAL FLAP	Gingival flap procedure (which includes root planing). *Service Limit:* You must be age 18 or older. Once every three (3) years.	30%
GINGIVECTOMY OR GINGIVOPLASTY	Gingivectomy or gingivoplasty. *Service Limit:* You must be age 18 and older. Once every three (3) years.	30%
GRAFT PROCEDURE	Soft tissue graft procedure (including donor site surgery) for correction of rapidly receding gingiva. *Service Limit:* You must be age 18 or older. Once per tooth, per lifetime.	30%
GUIDED TISSUE REGENERATION	Guided tissue regeneration (treatment that encourages regeneration of lost periodontal structures). Service Limit: Once per site every three (3) years.	30%
OSSEOUS SURGERY	Osseous surgery (to include flap entry and closure). *Service Limit:* You must be age 18 or older. Once every three (3) years.	30%
PERIODONTAL MAINTENANCE*	Periodontal maintenance. *Service Limit:* Available if you are age 18 or older and limited to twice per calendar year.	30%
SCALING* AND ROOT PLANING	Scaling and root planing. *Service Limit*: Once every two (2) years.	30%
STABILIZATION OF TOOTH MOBILITY	Procedures used for the primary purpose of reducing tooth mobility (including crown-type restorations) are not covered.	You pay 100% of charges.

*You may be eligible for additional services under the Enhanced Dental Benefit program. Please refer to the *Enhanced Dental Benefits* section within this chapter for additional details.

DENTURES (ARTIFICIAL TEETH)

Service Limit: Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least 12 consecutive months before coverage for this service category begins. You must be age 15 or older. Replacement of a denture is limited to five years after the placement of a complete or partial denture.

Service List	Descriptions and Service Limits	Copayment
ADJUSTMENTS	Denture adjustments are covered when at least six (6) months have passed from the date of insertion not to exceed two per Calendar Year. The 12-month waiting period does not apply.	30%
DENTURE – COMPLETE	Complete and immediate maxillary and mandibular dentures (including routine post-delivery care).	50%
DENTURE – PARTIAL	Maxillary or mandibular partial denture resin base, framework with resin denture bases, flexible base, or removable unilateral partial denture made of one-piece cast metal (including routine post-delivery care and any conventional clasps, rests, and teeth; and six-month post insertion care and adjustments).	50%
DENTURE REBASE	Denture rebase is covered when at least six months have passed from the date of insertion not to exceed once every three (3) years. The 12-month waiting period does not apply.	30%
REPAIR	Repair for broken complete denture base, replacement of missing or broken teeth (complete denture), repair of broken partial denture base, repair or replacement of a broken clasp and rest, adding a clasp to existing partial denture, and replacement of broken missing teeth. *Service Limit:* Repairs are covered no sooner than six months from the date of insertion or cementation. The 12-month waiting period does not apply.	30%
RELINE PROCEDURES	Denture reline of a complete maxillary/mandibular denture. *Service Limit:* Reline procedures are covered when at least six months have passed from the date of insertion not to exceed one reline every three (3) years. The 12-month waiting period does not apply.	30%
TEMPORARY DENTURES	Interim prostheses that are used over a limited period of time after which they are replaced with a more definitive restoration are not covered.	You pay 100% of charges.
TISSUE CONDITIONING	Tissue conditioning of the maxillary/mandibular. *Service Limit:* Twice per Calendar Year. The 12-month waiting period does not apply.	30%

BRIDGES (MISSING TEETH REPLACEMENT)

Service Limit: You must be age 15 or older. Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least 12 consecutive months before coverage for this service category begins. Coverage for bridge replacements is available no sooner than five (5) years after the placement of a bridge or any other type of restorative procedure (inlays, onlays, crowns, porcelain veneers, and bridges). Repair of bridges is covered after six (6) months of initial insertion or cementation.

Service List	Descriptions and Service Limits	Copayment
CROWNS - RESIN/ PORCELAIN	Crowns made of indirect resin-based composite, resin with high noble metal, porcelain fused to metal, resin with predominantly base metal, and resin with noble metal. Service Limit: Coverage for these procedures is available no more than once every five (5) years. *Service Limit: *High-Cost* Procedure. If you choose this type of crown for molar teeth, additional charges apply as explained in *Chapter 2: Amounts You May Owe*.	50%
CROWNS - METAL	Crowns made of full or ¾ cast high noble metal, predominantly base metal, cast noble metal, or titanium.	50%
PORCELAIN/ CERAMIC OR COMPOSITE RESIN INLAY/ONLAY	Porcelain/ceramic or composite/resin inlay and onlays. *Service Limit:* This restoration is considered a **High-Cost* Procedure, additional charges apply as explained in *Chapter 2: Amounts You May Owe*.	50%
METAL INLAY/ONLAY	Metallic inlays and onlays.	50%
PONTICS - RESIN/ PORCELAIN	Indirect resin-based composite, porcelain fused to metal, resin with high noble metal, resin with noble metal, and resin with predominantly base metal pontics. *Service Limit: *High-Cost* Procedure. If you choose this type of pontic for molar teeth, additional charges apply as explained in *Chapter 2: Amounts You May Owe*.	50%
PONTICS - METAL	Cast high noble metal and metal pontics.	50%
PROSTHETIC PRECISION ATTACHMENTS	Prosthetic attachments are two interlocking devices, one that is fixed to an abutment/retainer or crown and the other is integrated into a fixed or removable prosthesis. Prosthetic attachments are not covered.	You pay 100% of charges.
RETAINERS	Cast metal for resin bonded fixed prosthesis.	50%
RECEMENTATION	Recementation of fixed partial dentures is covered after six (6) months of the initial insertion or cementation of the fixed partial denture. *Service Limit:* Two recementations per fixed partial denture within a five-year period. Twelve-month waiting period between recementations.	30%

Service List	Descriptions and Service Limits	Copayment
TEMPORARY BRIDGES	Interim prosthesis that are used over a limited period of time after which they are replaced with a more definitive restoration.	You pay 100% of charges.
POST AND CORE	Post and core in addition to fixed partial denture retainer indirectly fabricated and prefabricated. Limited to once every five (5) years. The 12-month waiting period does not apply.	30%
CORE BUILD UP	Core build up for retainer, including any pins. Limited to once every five (5) years. The 12-month waiting period does not apply.	30%

SURGICAL SERVICES (MOUTH, FACE, NECK)

Service List	Descriptions and Service Limits	Copayment
ALVEOLOPLASTY	Surgical preparation of ridge for dentures whether or not in conjunction with extractions.	30%
EXCISION OF BONE TISSUE	Removal of lateral exostosis (maxilla or mandible).	30%
EXTRACTIONS	Surgical extractions and surgical access of an unerupted tooth. Nonsurgical extractions include extraction of coronal remnants, deciduous tooth, erupted tooth, or exposed root (elevation and/or forceps removal). Both include local anesthesia, suturing (if needed), and routine post-operative care.	30%
IMPLANTS	Surgical placement of implant fixture; restoration of the implant fixture including abutment and crown; removal of implant and maintenance procedures. *Service Limit*: You must be age 15 or older and you must have been enrolled in a dental Plan offered by us for at least 12 consecutive months before coverage for this service begins.	50%
INCISIONS	Surgical incision and drainage of abscess of intraoral soft tissue.	30%
OCCLUSAL ADJUSTMENT	Revising or altering the functional relationships between upper and lower teeth.	You pay 100% of charges.
OCCLUSAL ORTHOTIC DEVICE	Occlusal orthotic device (also known as occlusal splint therapy) is not covered.	You pay 100% of charges.
REMOVAL OF CYST OR TUMOR	Removal of benign odontogenic cyst or tumor.	30%
REPAIR	Excision of hyperplastic tissue or pericoronal gingival. Frenectomy, frenotomy, or frenuloplasty.	30%

ORTHODONTIC SERVICES (TOOTH ALIGNMENT)

Service List	Descriptions and Service Limits	Copayment
TREATMENT	Orthodontic treatment (including any repair or replacement of orthodontic appliances) is not covered.	You pay 100% of charges.

ANESTHESIA, EMERGENCY, & AFTER-HOURS CARE

Service List	Descriptions and Service Limits	Copayment
ANESTHESIA	Deep sedation/general anesthesia and intravenous conscious sedation/analgesia (but not nitrous oxide).	30%
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	Palliative (emergency) treatment of dental pain. Service Limit: The emergency treatment is for symptoms of sufficient severity that a layperson could reasonably expect, in the absence of dental treatment, to result in placing the member's health or condition in jeopardy. Payment for emergency dental services may be denied if a Dentist's report does not support the need for immediate attention. Please also see *Chapter 1: Critical Concepts* under *Choosing A Dentist*.	30%
OFFICE CARE (AFTER HOURS)	Office visits that take place after regularly scheduled hours.	30%
EMERGENCY DENTAL CARE 24/7	Virtual visit rendered through Teledentistry.com Service Limit: Two consultations per calendar year	0%

ENHANCED DENTAL BENEFITS

Members diagnosed with diabetes, coronary artery disease, stroke, oral, and head & neck cancers, Sjögren's Syndrome, Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Metabolic Syndrome, and women that are pregnant will be provided additional and specific support through HMSA's Oral Health for Total Health program which offers enhanced dental benefits. Any applicable waiting periods will apply.

Coverage for the following dental-care services is provided for each member who is enrolled in Oral Health for Total Health and has been diagnosed with diabetes, coronary artery disease, stroke, Chronic Obstructive Pulmonary Disease, End Stage Renal Disease, Metabolic Syndrome, or who is pregnant:

- Dental cleanings (oral prophylaxis, scaling in the presence of gingival or periodontal maintenance cleanings) one (1) every 3 months.
- Periodontal scaling covered at 100% - one (1) for each quadrant every 24 months.

Coverage for the following dental care services is provided for each member who is enrolled in Oral Health for Total Health has been diagnosed with oral, and head & neck cancers or Sjögren's Syndrome:

- Dental cleanings (oral prophylaxis scaling in the presence of gingival or periodontal maintenance cleanings) one (1) every 3 months
- Fluoride treatment, one (1) every 3 months
- Pre-diagnostic cancer screening, one (1) every 6 months

For these benefits, deductible, coinsurance and calendar-year benefit maximum provisions that would otherwise apply towards your dental plan do not apply for in-network services. Out-of- network services will follow the plan's current out-of-network benefits; however, they will not apply to the deductible and calendar-year benefit maximum provision.

Eligible medical conditions	Two additional preventive visits, plus:	
	Periodontal scaling covered 100%**	Cancer screenings; fluoride treatments
Chronic obstructive pulmonary disease*	✓	
Coronary artery disease	✓	
Diabetes	✓	
End-stage renal disease*	✓	
Metabolic syndrome*	✓	
Oral, head, and neck cancers		✓
Pregnancy	✓	
Sjögren's syndrome		✓
Stroke	✓	

*Starting Jan. 1, 2023

MISCELLANEOUS SERVICE SPECIFIC EXCLUSIONS

The following tables set forth circumstances or conditions when a procedure, service or supply is not a covered benefit or is limited. These tables should be read in conjunction with the above service tables in order to identify all items that are excluded from coverage or limited.

If you are unsure if a specific procedure or service is covered or not covered, please call us and we will help you.

Service List	Descriptions and Service Limits	Copayment
APPLIANCES	Maxillofacial prosthetics (artificial replacement of maxillofacial anatomical parts such as ears, eyes, orbits, nose, or cranium) are not covered.	You pay 100% of charges.
BITE GUARDS	Bite guards whether or not used to reduce occlusal trauma (bruxism) due to tooth grinding or jaw clenching are not covered.	You pay 100% of charges.
CONTROLLED RELEASE DEVICES	Controlled release devices whether or not used for the controlled release of therapeutic agents into diseased crevices around your teeth are not covered.	You pay 100% of charges.
CONGENITAL DEFORMITY	Correction of congenital deformity is not covered.	You pay 100% of charges.
INCIDENTAL PROCEDURES	Incidental services or procedures that are incurred during the normal course of providing care such as, but not limited to, infection control, etc., are not covered however, if such services are billed separately, the Member is not responsible for those charges.	You pay Zero (0) % of charges.
NITROUS OXIDE	Nitrous oxide is not covered.	You pay 100% of charges.
MAXILLOFACIAL PROSTHESIS	Maxillofacial prosthetics (artificial replacement of maxillofacial anatomical parts such as ears, eyes, orbits, nose, or cranium) are not covered.	You pay 100% of charges.
TEMPOROMANDIBULAR JOINT DYSFUNCTION	Any service associated with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaws), including dental splints are not covered.	You pay 100% of charges.
WHITENING	External or internal bleaching of teeth is not covered	You pay 100% of charges.

GENERAL EXCLUSIONS

The exclusions listed here are general exclusions that apply to your coverage. You are also subject to service-specific exclusions listed previously in this chapter.

Service List	Descriptions and Service Limits	Copayment
APPOINTMENTS	Broken or missed appointments are not covered.	You pay 100% of charges.
CALENDAR YEAR MAXIMUM	Charges that exceed the Calendar Year Maximum are not covered.	You pay 100% of charges.
COVERED BY ANOTHER PLAN	Any service for which you received payment under any other dental Plan, certificate, or rider offered by us or another carrier are not covered.	You pay 100% of charges.
COMPLICATIONS OF NONCOVERED PROCEDURE	Complications of a noncovered procedure are not covered, including complications of recent or past cosmetic surgeries, services or supplies.	You pay 100% of charges.
CONVENIENT TREATMENTS, SERVICES OR SUPPLIES	Treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience or the comfort or convenience of your provider.	You pay 100% of charges.
COSMETIC	Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function are not covered. Services that are prescribed for psychological or psychiatric reasons are not covered. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.	You pay 100% of charges.
DENTIST DOESN'T ORDER	Services that are not rendered, supervised, or directed by a Dentist are not covered.	You pay 100% of charges.
EFFECTIVE DATE	Services received before the Effective Date are not covered.	You pay 100% of charges.
FALSE STATEMENTS	Services are not covered if you are eligible for care only because of a fraudulent statement or other intentional misrepresentation that you made in an enrollment form for membership or in any claim to us. If we pay you or your provider before learning of any false statement, you are responsible for reimbursing us.	You pay 100% of charges.
GUM AUGMENTATION	Services for augmentation of the gum ridge are not covered.	You pay 100% of charges.
GOVERNMENT PROVIDES COVERAGE	Services for an Illness or Injury that are provided without charge to you by any federal, state, territorial, municipal, or other government instrumentality or agency are not covered.	You pay 100% of charges.

Service List	Descriptions and Service Limits	Copayment
HYGIENISTS' NOT IN COMPLIANCE WITH HAWAII STATUTE	Services provided by persons who do not have a dental hygienist license or who may be licensed but do not practice under the supervision of a Dentist are not covered.	You pay 100% of charges.
IMMEDIATE FAMILY MEMBER	Services provided by your parent, child, spouse, or yourself are not covered.	You pay 100% of charges.
MILITARY DUTY	Services or supplies that are required to treat an Illness or Injury received while you are on active status in the military are not covered.	You pay 100% of charges.
MILITARY HOSPITAL	Treatment for an Illness or Injury related to military service when you receive treatment in a hospital operated by an agency of the United States government is not covered.	You pay 100% of charges.
NO CHARGE	Services for an Illness or Injury that would have been provided without charge or collection but for the fact that you have coverage under this Guide.	You pay 100% of charges.
PAYMENT RESPONSIBILITY IS OTHERS	Services for which someone else has the legal obligation to pay for, and when, in the absence of this coverage, you would not be charged. Services or supplies for an Illness or Injury caused or alleged to be caused by a third party and/or you have or may have a right to receive payment or recover damages in connection with the Illness or Injury. Illness or Injury for which you may recover damages or receive payment without regard to fault.	You pay 100% of charges.
SERVICE LIMIT	Charges that exceed a Service Limit.	You pay 100% of charges.
SERVICES NOT DESCRIBED	Services not specifically excluded when they are not otherwise described as covered in this chapter.	You pay 100% of charges.
TERMINATION DATE	Services received after the termination date are not covered.	You pay 100% of charges.
WAR OR ARMED AGGRESSION	To the extent permitted by law, services or supplies required in the treatment of an Illness or Injury that results from a war or armed aggression, whether or not a state of war legally exists.	You pay 100% of charges.

Chapter 4: Eligibility & Enrollment

This chapter provides information about enrollment opportunities, eligibility requirements, and options if Your coverage ends.

WHO IS ELIGIBLE
You are eligible for coverage under this Plan if You are:

- The Member.
- The Member's Spouse (i.e., the Member's husband or wife as the result of a marriage that is legally recognized in the state of Hawaii).
- The Member's Child(ren) who meet all of the following requirements:

– The child is under 26 years of age; and

– The son, daughter, stepson or stepdaughter of the employee; a legally adopted individual; an individual who is placed with the employee for legal adoption by the employee; a child for whom the employee is the courtappointed guardian; or an eligible foster child (defined as an individual who is placed with the employee by an authorized placement agency or by judgment, decree, or other court order).

– The Member's child who is disabled. In this case, You must provide Us with acceptable written documentation of the child's disability within 31 days of the child turning 26 years of age and subsequently at Our request but not more frequently than annually. The documentation must demonstrate to Us that all of the following is true:

  - Your child is incapable of self-sustaining support because of a physical or mental disability.
  - Your child's disability existed before he or she reached age 26.
  - Your child relies primarily on You for support and maintenance as a result of his or her disability.
  - Your child is enrolled with Us under this coverage or another HMSA coverage and has had continuous health care coverage with Us since before the child reached age 26.

If an enrolled Child no longer meets the above requirements, You must notify Us. For details, see Coverage *Termination*.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS
Qualified Medical Child Support Orders (QMCSOs) are court orders that meet certain federal guidelines and require a person to provide health benefits coverage for a child. To be a Qualified Medical Child Support Order, the order cannot require a health benefit Plan to provide any type or form of payment, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act with respect to a Group Sponsor Plan.

Claims for a child covered by a Qualified Medical Child Support Order may be made by:

- The child; or
- The child's custodial parent; or
- The child's court-appointed guardian.

Any amount otherwise payable to the Member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian. If You would like more information about how We handle QMCSOs, You may request a free copy of Our procedures governing QMCSO determinations.

COVERAGE ACTIVATION
Your coverage will activate on Your Effective Date providing that:

- All initial premiums were paid; and
- We accepted Your enrollment form by giving written notice to You of Your Effective Date. Your Effective Date is the date on which You are accepted as covered by this Plan as recorded by Us, thereby activating Your eligibility for coverage under this Guide subject to all applicable waiting periods.

ENROLLMENT OPPORTUNITIES
You may enroll for coverage when You are first eligible, during Annual Enrollment, or following a qualified event.

FIRST ELIGIBLE
You may enroll when You are first eligible according to Your Group Sponsor's rules for eligibility. If You do not enroll when You first become eligible or by the first day of the month immediately following the first four consecutive weeks of employment, You will not be able to enroll until the next Annual Enrollment Period. However, if You show Us to Our satisfaction that there was unusual and justifiable cause, You may have the opportunity to enroll sooner.

ANNUAL ENROLLMENT
You may enroll during the Annual Enrollment Period by naming yourself and Your Spouse and/or Child(ren) on the enrollment form. If You do not sign up during the Annual Enrollment Period, You will not have an opportunity again until the next Annual Enrollment Period. An exception to this rule exists if You have an unusual and justifiable cause. In such cases, You may be eligible to enroll sooner if We accept the cause.

QUALIFYING EVENTS (BIRTH, ADOPTION, MARRIAGE)
You may enroll for coverage within 31 days of a qualifying event. You must enroll Your spouse or child(ren) by naming him or her on the enrollment form or other form and submitting it within 31 days of the date Your spouse or child becomes eligible. If You do not enroll with 31 days of the event, You may enroll at the next enrollment opportunity during the Annual Enrollment period. Following are examples of qualifying events:

- Birth.
- Adoption. In cases of adoption, We must receive notice of the event within 31 days of adoption placement (the date You assume a legal obligation for total or partial support of the child in anticipation of adoption).
- Marriage.
- Loss of coverage by Your Spouse under another Plan.

CHILDREN WHO ARE NEWBORNS OR ADOPTED

- You may enroll a newborn or adopted Child, effective as of the date listed below, if You comply with requirements described below and enroll the Child in accord with Our usual enrollment process:
- The birth date of a newborn providing You comply with Our usual enrollment process within 31 days of the Child's birth.
- The date of adoption, providing You comply with Our usual enrollment process within 31 days of the date of adoption.
- The birth date of a newborn adopted Child, providing We receive notice of Your intent to adopt the newborn within 31 days of the Child's birth date.
- The date the Child is placed with You for adoption, providing We receive notice of placement when You assume a legal obligation for total or partial support of the Child with anticipation of adoption.

COVERAGE TERMINATION
Some events end coverage at the end of the month, while others cause coverage to terminate immediately.

End of Month Termination
Unless prohibited by state or federal law, the following events will cause coverage to terminate at the end of the month in which any of the following takes place:

- For the Member: upon Your retirement, termination of employment, severance from the Group Sponsor, or termination of this Agreement. If the Member's coverage ends, coverage for all other enrolled family Members will also end.
- For the Member's Spouse: upon the dissolution of marriage to the Member. You must inform Us, in writing, of the dissolution of the marriage.
- For the Member's Child: when the child fails to meet the criteria outlined earlier in this chapter under *Who's Eligible*. You must inform Us, in writing, if a child no longer meets the eligibility requirements. You must notify Us on or before the first day of the month following the month the child no longer meets the requirements. For example, let's say that Your child turns 26 on June 1, You must notify Us by July 1. If You fail to inform Us that Your child is no longer eligible, and We make payments for services on his or her behalf, You must reimburse Us for the amount We paid.

Immediate Termination
The following events cause coverage to terminate immediately for the Member and any enrolled Spouse and children:

- Fraudulent use of coverage or misrepresentation or concealment of material facts in Your enrollment form. If Your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:
  - We will not pay for any services or supplies provided after the date the coverage is terminated.
  - You agree to reimburse Us for any payments We made under this coverage.
  - We will retain Our full legal rights. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- Engagement in repeated disruptive or threatening behavior or the infliction of bodily harm to others in the provider's office.

COBRA CONTINUATION
When Your coverage ends under this Agreement, You may have the opportunity to continue Your Group Sponsor coverage for a limited time under the Consolidated Omnibus Budget Reconciliation Act (COBRA). This Act applies to Group Sponsors with 20 or more employees. If it is determined that You are not eligible for COBRA coverage, You may be eligible for one of Our individual Plans. Please call Us for more information. \

Qualifying Events
COBRA entitles You and Your spouse and/or children if already covered, to continue this coverage if coverage is lost due to a qualifying event. Qualifying events include:

- Group or Group Sponsor from whom You retired files bankruptcy under federal law.
- Death of the employee covered under this coverage. If it is determined that the employee's Spouse is not eligible for Group coverage, the Spouse may become a Member under an individual Plan offered by HMSA. In this case, all Dependent children of such deceased Member may continue to be enrolled as though they were Dependents of such new Member.
- Divorce or legal separation.
- The Child no longer meets Our eligibility rules.
- Enrollment in Medicare.
- Termination of employment for reasons other than gross misconduct, or if Your work hours are reduced to the point that You are no longer eligible for coverage.
- Dependents covered as domestic partners are not eligible for COBRA coverage.

Requirements for COBRA Continuation of Coverage
Continuation under this provision is subject to You requesting it and paying any required premium within the election period.

The qualified covered person must elect to continue coverage under the Plan within 60 days of the later of:

- The date the notification of election rights is sent, or
- The date coverage under the Plan terminates.

Otherwise, the option to elect COBRA shall end on the date 60 days following the date Your coverage under the Plan terminated.

If an employee with Dependent coverage requests continuation of coverage under this section, such request shall include Dependent coverage, unless the employee asks that it be dropped. In like manner, such a request on the part of the covered spouse of an employee shall include coverage for all dependents of the employee that were covered.

Coverage Continued
The coverage continued for a covered person under this provision shall be the same as provided under the Plan for other covered persons in the same benefit class in which such covered person would have been covered had his coverage not been terminated.

Termination of COBRA Continuation Coverage
Once in effect, COBRA continuation coverage for a covered person under this section shall terminate on the earliest of the following dates:

- The date on which the Group Sponsor ceases to maintain any Group Sponsor health Plan (including successor plans);
- At the end of the last period for which premium contributions for such coverage have been made, if You or other responsible person does not make, when due, the required premium contribution;
- The date the maximum period of COBRA continuation of coverage ends. In the case of qualifying event above, this date shall be the date 18 months after the date of that qualifying event; unless You or any of Your Dependents is totally disabled at the time of, or within 60 days after, Your termination or reduction in hours, in which case this date shall be 29 months after the qualifying event. In all other cases, such date shall be the date 36 months after the date of that qualifying event which applies;
- The date You become eligible under any other similar Group Sponsor health Plan or any other federal or state provided health insurance coverage.
- The date the qualified beneficiary becomes eligible for Medicare, Medicaid, or any other federal or state provided health insurance coverage. With respect to a covered employee under a Group Sponsor health Plan, a qualified beneficiary means any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the Plan as either of the following:
    - o The Spouse of the covered employee; or
    - o The Dependent Child of the covered employee.

If You lose Your coverage under this Plan and wish to continue under COBRA, You must do all the following:

Contact Your Group Sponsor Immediately
You should contact Your Group Sponsor immediately if You think You are eligible for COBRA. If notice is not provided on time, COBRA coverage will not be available to You.

1. You are entitled to receive a COBRA election form within 44 days if the qualifying event is a termination of employment or reduction in hours. If the qualifying event is divorce, legal separation, or a child who no longer meets eligibility requirements, the form and notice must be provided to You within 14 days after You notify Your Group Sponsor of the event.
2. You or Your spouse is responsible for notifying Your Group Sponsor of Your divorce or legal separation, or if a child loses eligibility status under Our rules for coverage.
3. If You or Your spouse believes You have had a qualifying event and You have not received Your COBRA election form on a timely basis, please contact Your Group Sponsor.

Complete and Submit Election Form
You or Your Dependents must complete and submit an election form to notify Your Group Sponsor of either of the following:

1. Coverage for You or Your Dependents is being continued for 18 months under COBRA and it is determined under Title XVI of the Social Security Act that You or Your Dependent was disabled on the date of, or within 60 days of, the event which would have caused coverage to terminate. In this case, You or Your Dependent must notify Your Group Sponsor of such determination. Notice must be provided within 60 days of the determination of disability. Notice must also be given within 30 days of any notice that You or Your Dependent is no longer disabled.

2. Coverage for a Dependent would terminate due to Your divorce, a legal separation, or the Dependent ceasing to be a Dependent under this Plan. In this case, You or Your Dependent must provide notice to Your Group Sponsor of the event. This notice must be given within 60 days after the later of the occurrence of the event or the date coverage would terminate due to the occurrence of the event.

Pay Premium
If You or Your Dependents are entitled to and elect COBRA continuation coverage, You must pay Your Group Sponsor the premiums for the continuing coverage which may be up to 102% of the full cost of the coverage. In the case of a disabled individual whose coverage is being continued for 29 months, You or Your Dependents may be required to pay up to 150% of the full cost of the coverage for any month after the 18th month. Within 45 days of the date, You elect COBRA coverage You must pay an initial COBRA premium to cover from the date of Your qualifying event to the date of Your election. You will be notified of the amount of the premiums You must pay thereafter.

If You fail to make the initial payment or any subsequent payment in a timely fashion (a 30-day grace period applies to late subsequent payments), Your COBRA coverage will terminate.

Add Child(ren)
If during the period of COBRA coverage, a child is born to You or placed with You for adoption, and You are on COBRA because You terminated employment or had a reduction in hours, the child can be covered under COBRA and can have election rights of his or her own. Please be aware that Dependent children of domestic partners are not eligible for COBRA continuation coverage.

Chapter 5: Filing Claims

This chapter explains what to do when Your Dentist does not submit a written request for payment (claim). In the rare event You are required to file Your own claim, follow the directions outlined in this chapter. Because all Participating and even most nonparticipating Dentists in the state of Hawaii file claims for You, there are limited circumstances when You will be required to file a claim. If You have any questions after reading this chapter, please contact Your personnel department, or call Us. Our telephone numbers appear on the back cover of this Guide.

CLAIM SUBMISSION
Notice of Claim

1. Complete a separate claim for each covered family Member and each provider. Claims received by Us more than one year after the last day on which You received services are not eligible for payment.
2. Enclose a signed letter with Your claim that includes all of the following information:
    - A phone number where You can be reached during the day;
    - The subscriber number that appears on Your Member Card (the card issued to You by Us that You present to Your Dentist at the time You receive services); and
    - Information about other coverage You may have (if applicable). For information about other coverage, see *Chapter 7: Other Party Responsibility*.
3. Enclose an itemized statement from Your Dentist (often called a provider statement). It is helpful to Us if the provider statement is in English or accompanied by an English translation on the service provider's stationary.

    The provider statement must include all of the following information:
    - Provider's full name and address.
    - Patient's name.
    - Date(s) You received service(s).
    - Date of the Injury or beginning of Illness or Injury.
    - The charge for each service in U.S. currency.
    - Description of each service.
    - Diagnosis or type of Illness or Injury.
    - Where You received the service (office, outpatient, hospital, etc.).
    - A claim without a provider statement cannot be paid. Statements You prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.
4. Send Your claim to the address listed on the back cover of this Guide.

Explanation of Benefits (EOB)
An Explanation of Benefits (EOB) is a statement that explains how We processed a claim based on the services performed; the actual charge: any adjustments to the actual charge: Our *Eligible Charge:* the amount We paid, and the amount You owe.

Timeframe for Claim Determination
If We receive all the necessary information and can make a claim determination, We will send You an EOB within 30 days of the date We receive Your claim. However, if We require additional information to make a decision about Your claim or are unable to make a decision due to circumstances beyond Our control, We will extend the time for an additional 15 days. We will let You know within the initial 30-day period why We are extending the time and when You can expect Our decision. If We require additional information, You will have at least 45 days to provide Us the information.

Payment
If applicable, a check will be enclosed with Your EOB. Checks must be cashed or deposited before the check's expiration date. A service charge will apply for requests to reissue expired checks. A schedule of the current service charges is available from Us upon request.

The following rules apply for any payment by Us for services rendered by a nonparticipating Dentist:

- Checks are not assignable.
- In Our sole discretion, We will make a check payable directly to the Dentist: Member: Member's spouse or child: or in the case of the Member's death, to his or her executor: administrator: provider: spouse, or relative.
- In no event will Our payment exceed the amount We would pay to a comparable Participating Dentist for like services rendered.

Denials
If any of Your claim(s) is denied, the EOB will provide an explanation for the denial. If, for any reason, You believe We wrongly denied a claim or coverage request, please call Us for assistance. If You are not satisfied with the information You receive, and You wish to pursue a claim for coverage, You may request an appeal. See *Chapter 6: Resolving Disputes*.

Chapter 6: Resolving Disputes

This chapter describes how to dispute a determination made by Us related to coverage, reimbursement, some other decision or action by Us, or any other matter related to the Agreement. For Us to consider an appeal, the appeal must be in accordance with the rules outlined in this chapter. Call Us if You have any questions regarding appeals.

IMPORTANT CONTACT INFORMATION RELATED TO DISPUTES

Phone Numbers
(808) 948- 6640 or toll free at 1 (800) 792-4672

Fax Number
(808) 538-8996

Mail Address
Appeals
HMSA Dental Services
P.O. Box 69437
Harrisburg, PA 17106-9437

Arbitration
HMSA Dental Services
P.O. Box 69437
Harrisburg, PA 17106-9437

EXPEDITED APPEALS REQUIREMENTS
To request an expedited appeal, call Us. We will respond to an expedited appeal as soon as possible taking into account Your dental condition but not later than 72 hours after all information sufficient to make a determination is provided to Us.

Expedited appeals are appropriate when a no expedited appeal would result in any of the following:

- Seriously jeopardizing Your life or health.
- Seriously jeopardizing Your ability to gain maximum functioning.
- Subjecting You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.
- You may request expedited external review of our initial decision if you have requested an expedited internal appeal and the adverse benefit determination involves a medical condition for which the completion of an expedited internal appeal would meet the requirements above. The process for requesting an expedited external review is discussed below.

NONEXPEDITED APPEALS REQUIREMENTS
You must send a written request for appeal by facsimile or by mail to the address listed at the beginning of this chapter. Requests which do not comply with the requirements of this chapter will not be recognized or treated as an appeal by Us.

Send the request within one (1) year from the date of the action, matter, or decision You are contesting. In the case of coverage or reimbursement disputes, this is one (1) year from the date We first informed You of the denial or limitation of Your claim, or of the denial of coverage for any requested service or supply. Send complete claim or coverage information in regard to Your appeal.

We will respond to an appeal for pre-service requests within 30 days of Our receipt of complete appeal information. We will respond to an appeal for post-service requests within 60 calendar days of Our receipt of complete appeal information.

PERSONS AUTHORIZED TO APPEAL
Either You or Your Authorized Representative may request an appeal. Authorized Representatives may be either of the following:

- Any person You authorize to act on Your behalf provided You follow Our procedures which include filing a form with Us. Call Us to obtain a form to authorize a person to act on Your behalf;
- A court appointed guardian or an agent under a health care proxy;
- A person authorized by law to provide substituted consent for You or to make health care decisions on Your behalf; or
- A family member or Your treating health care professional if You are unable to provide consent.
- Request for appeal from an Authorized Representative who is a Dentist must be in writing unless requesting expedited appeal.

WHAT YOUR REQUEST MUST INCLUDE
To be recognized as an appeal, Your request must include all of this information:

- The date of Your request
- Your name and telephone number (so we may contact You)
- The date of the service We denied or date of the contested action or decision. For precertification of a service or supply, it is the date of Our denial of coverage for the service or supply.
- The subscriber's number from Your member card.
- The provider name.
- A description of the facts related to Your request and why you believe Our action or decision was in error.
- Any other details about Your appeal. This may include written comments, documents, and records You would like Us to review.
- You should keep a copy of the request for your records. It will not be returned to You.

INFORMATION AVAILABLE FROM US
If Your appeal relates to a claim for benefits or a request for precertification, We will provide upon Your request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim as defined by the Employee Retirement Income Security Act.

If Our appeal decision denies Your request or any part of it, We will provide an explanation, including the specific reason for denial, references to the dental plan terms on which Our decision is based, a statement of Your external review rights, and other information regarding Our denial.

OPTIONS WHEN YOU DISAGREE
You must exhaust all internal appeals options available to You before requesting review by an Independent Review Organization selected by the Insurance Commissioner, requesting arbitration, or filing a lawsuit.

If You are enrolled in a Group Sponsor Plan that is not self-funded or an individual plan and You wish to contest Our appeal decision, You must do one of the following:

- Request review by an Independent Review Organization selected by the Insurance Commissioner if You are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational.

- For all other issues:
    - Request arbitration before a mutually selected arbitrator,
    - File a lawsuit under section 502(a) of ERISA.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION (IRO)
If you choose review by an Independent Review Organization, You must submit Your request to the Insurance Commissioner within 130 days of HMSA's decision to deny or limit the service or supply.

Before requesting review, You must have exhausted HMSA's internal appeals process or show that HMSA violated federal rules related to claims and appeals unless the violation was 1) de minimis; 2) non-prejudicial; 3) attributable to good cause or matters beyond HMSA's control; 4) in the context of an ongoing good-faith exchange of information; and 5) not reflective of a pattern or practice of non-compliance.

Your request must be in writing and include:

- A copy of HMSA's final internal appeal decision.
- A completed and signed authorization form releasing Your medical records relevant to the subject of the IRO review. Copies of the authorization form are available from HMSA by calling (808) 948-6440, or toll free at (800) 792-4672, or on HMSA.com.
- A complete and signed conflict of interest form. Copies of the conflict-of-interest form are available from HMSA by calling (808) 948-6440, or toll free at (800) 792-4672, or on HMSA.com.
- A check for $15.00 made out to the Insurance Commissioner. It will be refunded to You if the IRO overturns HMSA's decision. You are not required to pay more than $60.00 in any calendar year.

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, HI 96813
Telephone: (808) 586-2804

You will be informed by the Insurance Commissioner within 14 business days if Your request is eligible for external review by an IRO.

You may submit additional information to the IRO. It must be received by the IRO within 5 business days of the receipt of notice that Your request is eligible. Information received after that date will be considered at the discretion of the IRO.

The IRO will issue a decision within 45 calendar days of the IRO's receipt of Your request for review.

The IRO decision is final and binding except to the extent HMSA or You have other remedies available under applicable federal or state law.

EXPEDITED IRO REVIEW
You may request expedited IRO review if:

- The timeframe for completion of an expedited internal appeal would seriously jeopardize the enrollee's life, health, or ability to gain maximum functioning or would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination and You have requested expedited internal appeal at the same time.
- The timeframe for completion of a standard external review would seriously jeopardize the enrollee's ability to gain maximum functioning, or would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination; or
- If the final adverse determination concerns an admission, availability of care, continued stay, or health care service for which the enrollee received emergency services; provided that the enrollee has not been discharged from a facility for health care services related to the emergency services.

Expedited IRO review is not available if the treatment or supply has been provided. The IRO will issue a decision as expeditiously as Your condition requires but in no event more than 72 hours after the IRO's receipt of Your request for review.

External Review of Decisions Regarding Experimental or Investigational Services
You may request IRO review of an HMSA determination that the supply or service is experimental or investigational.

Your request may be oral if Your treating physician certifies, in writing, that the treatment or supply would be significantly less effective if not promptly started.

Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from Your physician that:

- Standard health care services or treatments have not been effective in improving Your condition.
- Standard health care services or treatments are not medically appropriate for You; or
- There is no available standard health care service or treatment covered by Your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

Your treating dentist must certify in writing that the service recommended is likely to be more beneficial to you, in the dentist's opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment. The IRO will issue a decision as expeditiously as Your condition requires but in no event more than 7 calendar days of the IRO's receipt of Your request for review.

ARBITRATION

If You choose arbitration, You must submit a written request for arbitration to the address shown at the beginning of this chapter. Your request for arbitration will not affect Your rights to any other benefits under this plan. You must have fully complied with HMSA's appeals procedures described above and We must receive Your request for arbitration within one year of the decision rendered on appeal. In arbitration, one person (the arbitrator) reviews the positions of both parties and makes the final decision to resolve the issue. No other parties may be joined in the arbitration. The arbitration is binding, and the parties waive their right to a court trial and jury.

Before arbitration starts, both parties (You and We) must agree on the person to be the arbitrator. If We both cannot agree within 30 days of Your request for arbitration, either party may ask the First Circuit Court of the State of Hawaii to appoint an arbitrator.

The arbitration hearing shall be in Hawaii. The arbitration shall be conducted in accord with the Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the rules of Dispute Prevention and Resolution, Inc., to the extent not inconsistent with this *Chapter 6: Resolving Disputes,* and such other arbitration rules as both parties agree upon. The arbitrator may hear and determine motions for summary disposition pursuant to HRS §658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

The arbitrator will make a decision as quickly as possible and will give both parties a copy of this decision. The decision of the arbitrator is final and binding. No further appeal or court action can be taken except as provided under the Hawaii Uniform Arbitration Act.

HMSA will pay the arbitrator's fee. You must pay Your attorney's or witness's fees; if You have any, and We must pay ours. The arbitrator will decide who will pay all other costs of the arbitration.

HMSA waives any right to assert that You have failed to exhaust administrative remedies because You did not select arbitration.

IF YOU ARE ENROLLED IN A SELF FUNDED GROUP SPONSOR PLAN AND YOU WISH TO CONTEST OUR APPEAL DECISION

If You are enrolled in a self-funded Group Sponsor plan, You are not eligible for review by an IRO selected by the Insurance Commissioner. You must either request review by an IRO randomly selected by HMSA if You are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness, or a determination by HMSA that the service or treatment is experimental or investigational; request arbitration as described above; or file a lawsuit against HMSA under section 502(a) of ERISA.

If you choose review by an IRO, you must submit your request in writing to HMSA within 130 days of HMSA's appeal decision to deny or limit the service or supply at:

HMSA Member Advocacy and Appeals
P.O. Box 1958
Honolulu, HI 96805-1958

Within 6 business days following the date of receipt of your request, we will notify you in writing that your appeal is eligible for external review.

We will assign an IRO to review your appeal. The IRO will inform you of its decision within 45 days after the IRO received the assignment from us.

Chapter 7: Other Party Responsibility

There may be situations when another party is responsible for a portion or the entire cost of Your services. This chapter explains those circumstances.

WHEN YOU HAVE MORE THAN ONE DENTAL PLAN

You may have other dental insurance coverage that provides coverage that is the same or similar to this Plan. If You have such coverage, We will coordinate with the other coverage(s) to determine payment under this Plan.

Other coverage includes Group Sponsor insurance: non-Group Sponsor insurance: other Group Sponsor benefit Plans: Medicare or other governmental benefits, and the dental benefits coverage in Your automobile insurance (whether issued on a fault or no-fault basis).

Should You have more than one dental Plan, to ensure accurate and timely coordination of benefits, You follow the instructions outlined here.

Notice to Us

Inform Us of Your other dental coverage (also let Us know if Your other coverage ends or changes). If We need additional information, You will receive a letter from Us. If You do not provide Us with the information, We need to coordinate Your benefits, Your claims may be delayed or denied.

Indicate that You have other dental coverage when You fill out a claim form by completing the appropriate boxes on the form. If Your Dentist is filing the claim on Your behalf, make sure Your Dentist knows to inform Us.

Notice to Your Provider

Inform Your provider by giving him or her information about the other dental coverage at the time services are rendered.

How Much We Pay

You may have other insurance coverage that provides benefits which are the same or similar to this Plan. When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's payment. As the secondary Plan, this Plan's payment will not exceed the amount this Plan would have paid if it had been Your only coverage. Additionally, when this Plan is secondary, benefits will be paid only for those services or supplies covered under this Plan.

If there is an applicable benefit maximum under this Plan, the service or supply for which payment is made by either the primary or the secondary Plan shall count toward that benefit maximum. For example, this Plan covers one set of bitewing x-rays per Calendar Year, if this Plan is secondary and Your primary Plan covers one set of bitewing x-rays per Calendar Year, the x-rays for one set of bitewings covered under the primary Plan will count toward the yearly benefit maximum and this Plan will not provide benefits for a second set of bitewing x-rays within the Calendar Year.

General Coordination Rules

There are certain rules We follow to help Us determine which Plan pays first when there is other insurance or coverage that provides the same or similar coverage as this Plan. A comprehensive listing of Our coordination of benefits rules is available upon request. Following are four common coordination rules:

- The coverage without coordination of benefits rules pays first.
- The coverage You have as an employee pays before the coverage You have as a spouse or Dependent child.
- The coverage You have as the result of Your active employment pays before coverage You hold as a retiree or under which You are not actively employed.
- When none of the general coordination rules apply (including those not described above), the coverage with the earliest continuous effective date pays first.

Dependent Child Coordination Rules

- Following are coordination rules that apply to Dependent children (note that if none of the following rules apply the parent's coverage with the earliest continuous effective date pays first):
- For a child who is covered by both parents who are not separated or divorced and have joint custody, the coverage of the parent whose birthday occurs first in a Calendar Year pays first.
- For a child who is covered by separated or divorced parents and a court decree says which parent has health insurance responsibility, that parent's coverage pays first.
- For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this Dependent child is as follows:

    1) Custodial parent.
    2) Other non-custodial parent.
    3) Spouse of custodial parent.
    4) Spouse of other non-custodial parent.

AUTOMOBILE ACCIDENTS

If Your injuries or illness are due to a motor vehicle accident or other event for which We believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, or any other motor vehicle insurance coverage, then that motor vehicle coverage will pay before this coverage.

You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Payment under this coverage for an Injury covered by motor vehicle insurance is subject to the rules set forth below.

You must provide Us a list of expenses paid by the motor vehicle insurance. The list must show the date expenses were incurred, the provider of service, and the amount paid by motor vehicle insurance We cannot process a claim without this information.

Guidelines

Once You submit a list of expenses to Us, We will review the list of expenses to verify that the motor vehicle insurance coverage available under Hawaii Revised Statutes Chapter 431, Article 10C, or any other motor vehicle insurance, is exhausted. Upon Our verification of exhaustion, You are eligible for Covered Services in accord with this Guide.

Worker's Compensation or Motor Vehicle Insurance
If You have dental coverage under Worker's Compensation or motor vehicle insurance for Illness or Injury, please note the following:

- If You have or may have coverage under Worker's Compensation insurance, such coverage will apply instead of the coverage under this Guide. Dental expenses arising from Illness or Injury covered under Worker's Compensation insurance are excluded from coverage under this Guide.
- If You are or may be entitled to dental benefits from Your automobile coverage, You must exhaust those benefits first, before receiving benefits from Us.

THIRD PARTY LIABILITY
Third party liability grants Us the right to be reimbursed if You are injured or become ill and either of the following is true:

- The Illness or Injury is caused or alleged to have been caused by someone else and You have or may have a right to recover damages or receive payment in connection with the Illness or Injury.
- You have or may have a right to recover damages or receive payment without regard to fault.

Your cooperation is necessary for Us to determine Our liability for coverage and to protect Our rights to recover Our payments. We will provide benefits in connection with the Illness or Injury in accordance with the terms of this Guide if You cooperate with Us by following the rules set forth below. If You do not cooperate with Us, Your claims may be delayed or denied, and We shall be entitled to reimbursement of payments made on Your behalf to the extent that Your failure to cooperate has resulted in erroneous payments of benefits or has prejudiced Our rights to recover payments.

1. Timely Notice and Proof Requirements

   You must give Us timely notice in writing if any of the following are true:

   - You have any knowledge of any potential claim against any third party or other source of recovery in connection with the Illness or Injury.
   - There is any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the Illness or Injury.
   - There is any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection.

     with the Illness or Injury. To give timely notice, Your notice must be no later than 30 calendar days after the occurrence of each of the events stated above.

2. You must promptly sign and deliver to Us all liens, assignments, and other documents We deem necessary to secure Our rights to recover payments, and You hereby authorize and direct any person or entity making or receiving any payment on account of such Illness or Injury to pay to Us so much of such payment as necessary to discharge Your reimbursement obligations described above.

3. You must promptly provide Us any and all information reasonably related to Our investigation of Our liability for coverage and Our determination of Our rights to recover payments. We may ask You to complete an Injury/Illness report form and provide Us dental records and other relevant information.

4. You must not release, extinguish, or otherwise impair Our rights to recover Our payments, without Our express written consent.

5. You must cooperate in protecting Our rights under these rules. This includes giving notice of Our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the Illness or Injury.

6. Notice Required

   Any written notice required by these rules must be sent to:
   HMSA
   Attn: 8 CA/Other Party Liability
   P.O. Box 860
   Honolulu, Hawaii 96808-0860

Our Rights

If You have complied with the rules set forth in the *Third-Party Liability* section, We will pay benefits in connection with the Illness or Injury to the extent that the treatment would otherwise be a covered benefit payable under this Guide. However, We shall have a right to be reimbursed for any benefits We provide from any recovery received from or on behalf of any third party or other source of recovery in connection with the Illness or Injury, including, but not limited to, proceeds from any of the following:

- Settlement, judgment, or award.
- Motor vehicle insurance including liability insurance or Your underinsured or uninsured motorist coverage.
- Workplace liability insurance.
- Property and casualty insurance.
- Dental malpractice coverage.
- Other insurance.

We shall have a first lien on such recovery proceeds, up to the amount of total benefits We pay or have paid related to the Illness or Injury. You must reimburse Us for any benefits paid, even if the recovery proceeds obtained (by settlement, judgment, award, insurance proceeds, or other payment) do not specifically include dental expenses or are:

- Stated to be for general damages only;
- For less than the actual loss or alleged loss suffered by You due to the Illness or Injury;
- Obtained on Your behalf by any person or entity, including Your estate, legal representative, parent, or attorney;
- Without any admission of liability, fault, or causation by the third party or payor.

Our lien will attach to and follow such recovery proceeds even if You distribute or allow the proceeds to be distributed to another person or entity. Our lien may be filed with the court, any third party or other source of recovery money, or any entity or person receiving payment regarding the Illness or Injury.

If We are entitled to reimbursement of payments made on Your behalf under these rules, and We do not promptly receive full reimbursement pursuant to Our request, We shall have a right of set-off from any future payments payable on Your behalf under this Guide.

To the extent that We are not reimbursed for the total We pay or have paid related to Your Illness or Injury, We have a right of subrogation (substituting Us to Your rights of recovery) for all causes of action and all rights of recovery You have against any third party or other source of recovery in connection with the Illness or Injury.

Our rights of reimbursement, lien, and subrogation described above, are in addition to all other rights of equitable subrogation, constructive trust, equitable lien and/or statutory lien We may have for reimbursement of these payments, all of which rights are preserved and may be pursued at Our option against You or any other appropriate person or entity.

For any payment made by Us under these rules, You are still responsible for Your Copayments, Deductibles, timeliness in submission of claims, and other obligations under this Guide.

Nothing in this Third-Party Liability section shall limit Our ability to coordinate benefits as described elsewhere in this chapter.

Chapter 8: General Provisions

This provides general provisions applicable to Your Plan.

PREMIUMS
You or Your Group Sponsor must pay premiums to Us on or before the first day of the month in which coverage under this Plan is to be provided. We have the right to change the monthly premium following 30 days written notice to Your Group Sponsor.

In the event You or Your Group Sponsor fail to pay monthly premiums on or before the due date, We may terminate coverage, unless all premiums are brought current within ten (10) days of Our providing written notice of default to Your Group Sponsor and the state of Hawaii Department of Labor and Industrial Relations. We are not liable for benefits for services received after the termination date. This includes benefits for services You receive if You are enrolled in this coverage under either of the following provisions:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA).
- The Uniformed Services Employment and Reemployment Rights Act (USERRA).

COVERAGE TERMS
By submitting the enrollment form, You accept and agree to the provisions of Our constitution and bylaws now in force and as amended in the future. You also appoint Your Group Sponsor as Your administrator for premium payment and for sending and receiving all notices to and from Us concerning the Plan.

AUTHORITY TO TERMINATE, AMEND, OR MODIFY
Your Group Sponsor has the authority to amend, modify, or terminate this coverage at any time. If Your Group Sponsor terminates this coverage, You are not eligible for coverage under this Plan after the termination date. Any amendment or modification proposed by Your Group Sponsor must be in writing and accepted by Us in writing. We have the authority to amend, modify, or terminate the Agreement provided that We give 30 days prior written notice to Your Group Sponsor regarding the change.

RIGHT TO INTERPRET
We will interpret the provisions of the Agreement and will determine all questions that arise under it. We have the administrative discretion to do all of the following:

- Determine whether You meet Our written eligibility requirements.
- Determine the amount and type of benefits payable to You or Your Dependents according to the terms of this Agreement.
- Interpret the provisions of this Agreement as is necessary to determine benefits, including determinations of dental necessity.

Our determinations and interpretations, and Our decisions on these matters are subject to de novo review by an impartial reviewer as provided in this Guide or as allowed by law. If You disagree with Our interpretation or determination, You may appeal. See *Chapter 6: Resolving Disputes*.

No oral statement or verbal representations of any person shall modify or otherwise affect the benefits, limitations, and exclusions of this Guide, convey or void any coverage, or increase or reduce any benefits under this Agreement.

CONFIDENTIAL INFORMATION
Your dental records and information about Your care are confidential. We do not use or disclose Your dental information except as permitted or required by law. You may be required to provide information to Us about Your dental treatment or condition. In accordance with law, We may use or disclose Your dental information (including providing this information to third parties) for the purposes of payment activities and health care operations such as quality assurance, disease management, provider credentialing, administering the Plan, complying with government requirements, and research or education.

GOVERNING LAW
To the extent not superseded by the laws of the United States, this coverage will be construed in accord with and governed by the laws of the State of Hawaii. Any action brought because of a claim against this coverage will be litigated in the state or federal courts located in the State of Hawaii and in no other.

RELATIONSHIP BETWEEN PARTIES
Participating Dentists are not agents or employees of Ours, nor are We (or any of Our employees) an employee or agent of any Participating Dentist. We are not an insurer against nor liable for the negligence or other wrongful act or omission of any Participating Dentist or his or her employee or other person or for any act or omission of anyone covered by this Plan.

CIRCUMSTANCES BEYOND OUR CONTROL
In the event of a major disaster, epidemic, war, insurrection or other circumstances beyond Our control, We will make a good faith effort to provide or arrange for Covered Services. However, We will not be responsible for any delay or failure in providing services due to lack available facilities or personnel.

NOTICE ADDRESS
Any written notice to Us required by this Guide should be sent to:

HMSA
P.O. Box 860
Honolulu, Hawaii 96808-0860

Any notice from Us to You will be acceptable when addressed to You at Your address as it appears in Our records.

MEDICAID ENROLLMENT
Notwithstanding anything contained herein, any payment hereunder shall be made in accordance with any assignment of rights made by or on behalf of You as required by Medicaid or any other State Plan for dental assistance approved under Title XIX of the Social Security Act. Payments for benefits under this Plan will be made in accordance with any State Law which provides for acquisition.

Medicaid is a form of public assistance sponsored jointly by the federal and state governments providing dental assistance for eligible persons whose income falls below a certain level. The Hawaii Department of Human Services pursuant to Title XIX of the federal Social Security Act administers this program.

ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) provides that You will be entitled to do all of the following:

- Examine all Plan documents and copies of documents (such as annual reports) filed by the Plan with the United States Department of Labor. You may examine these documents without charge at the Plan administrator's office or at specified locations.
- Obtain copies of Plan documents from the Plan administrator upon written request. The Plan administrator may request a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if Your Group Sponsor has 100 or more participants in Your Plan. The Plan administrator is required by law to furnish You with a copy of this summary annual report.

In addition to creating rights for You and other participants, ERISA imposes duties upon the people responsible for the operation of Your employee benefit Plan. The people responsible are called fiduciaries of the Plan. Fiduciaries have a duty to operate Your employee benefit Plan prudently and in the interest of You and Your family Members. HMSA and the Plan administrator (Your Group Sponsor) are fiduciaries under this Agreement; however, HMSA's duties are limited to those described in this Agreement, and the Plan administrator is responsible for all other duties under ERISA. No one, including Your Group Sponsor, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a covered benefit or exercising Your rights under ERISA. If Your claim for a covered benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to request an appeal and reconsideration of Your claim. Under ERISA, there are steps You can take to enforce the above rights.

For instance, if You request Plan documents from the Plan administrator and do not receive it within 30 days, a federal court may require the Plan administrator to provide the materials and pay You up to $110 a day until You receive the document, unless the document was not sent because of matters reasonably beyond the control of the Plan administrator.

If You have a claim for benefits that is denied or ignored (in whole or in part), You may file suit in state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person or entity You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous. If You have any questions about Your Plan, You should contact the Plan administrator, i.e., Your Group Sponsor. If You have questions about this statement or about Your rights under ERISA, You should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20010.

PRIVACY POLICIES AND PRACTICES FOR MEMBER FINANCIAL INFORMATION

Notice of Our privacy policies and practices for personal financial information required by law*- HMSA and Our affiliated organizations throughout the state of Hawaii have established the following policies and practices:

- Maintain physical, electronic, and procedural safeguards to protect the privacy, confidentiality, and integrity of personal information.
- Ensure that those in Our workforce who have access to or use Your personal information need that information to perform their jobs and have been trained to properly handle personal information. Our employees are fully accountable to management for following Our policies and practices.
- Require that third parties who access Your personal information on Our behalf comply with applicable laws and agree to HMSA's strict standards of confidentiality and security.

Effective July 1, 2002, HMSA is required by state law to provide an annual notice of Our privacy policies and practices for personal financial information to Members that are enrolled in Our individual health plans. This section contains information regarding how We collect and disclose personal financial information about Our Members to Our affiliates and to nonaffiliated third parties. This applies to former as well as current HMSA Members.

*Privacy of Consumer Financial Information, H.R.S. Chapter 431, Article 3A

Collection of personal financial information- HMSA collects personal financial information about You that is necessary to administer Your health Plan. We may collect personal financial information about You from sources such as enrollment forms and other forms that You complete, and Your transactions with Us, Our affiliates, or others.

Sharing of personal financial information- HMSA may share with Our affiliates and with nonaffiliated third parties any of the personal financial information that is necessary to administer Your health Plan, as permitted by law.

Nonaffiliated third parties are those entities that are not part of the family of organizations controlled by HMSA. We do not otherwise share Your personal financial information with anyone without Your permission.

Chapter 9: Defined Terms

This chapter provides definitions for many of the terms used in two or more chapters throughout this Guide To Benefits.

Agreement - *The legal document between You and Us that contains all of the following:*

- This *Guide To Benefits (Guide).*
- Any riders and/or amendments.
- The enrollment form submitted to Us by You.
- The Agreement that exists between Us and Your Group Sponsor.

Calendar Year - A period of time used in determining provisions such as Service Limits. The first Calendar Year for anyone covered by this Plan begins on that person's Effective Date and ends on December 31 of that same year. Thereafter, Calendar Year begins January 1 and ends December 31 of that year.

Child - Means any of the following: your son, daughter, stepson, or stepdaughter, you're legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or your eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judge, decree, or court-order).

Coordination of Benefits (COB) - Applies when you are covered by more than on insurance policy providing benefits for like services.

Covered Service - Dental services or supplies that are listed as covered in *Chapter 3: Services & Copayments.* In addition to being listed as covered, for a Covered Service to qualify for payment by Us under this Plan, it must meet the criteria listed in *Chapter 1: Critical Concepts* under *Covered Services Criteria*.

Dentist - A Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.). In addition, the Dentist must be both of the following:

- Certified or licensed by the proper government authority to render services within the lawful scope of his or her respective license.
- Approved by Us.

Dependent - The Member's spouse and/or eligible child(ren).

Effective Date - The date upon which You are first eligible for coverage under this Plan.

Eligible Charge – The lower of either the provider's actual charge or the amount We establish as the maximum allowable fee. HMSA's payment, and Your Copayment, are based on the eligible charge. The Eligible Charge for nonparticipating Dentists is less than the Eligible Charge for the same service provided by a Participating Dentist. We determine Eligible Charge according to the provisions of the Agreement between Us and the Participating Dentist and based on the following:

- The lower of the amount billed by the Dentist on a submitted claim; or
- The discounted charge negotiated by Us; or
- An amount We establish as the Maximum Allowable Charge. Maximum Allowable Charges are listed in Our Schedule of Maximum Allowable Charges. We reserve the right to annually adjust the charges listed in the Schedule of Maximum Allowable Charges. In adjusting charges, We consider all of the following:
  - Increases in the cost of dental and non-dental services in Hawaii over the previous year.
  - The relative difficulty of the service compared to similar services.
  - Changes in technology which may have affected the difficulty of the service.
  - Payment for the service under federal, state, and other private insurance programs.
  - The impact of changes in the charge on Our health Plan rates.

Eligible Charge for Covered Services rendered outside Hawaii is based on the Eligible Charge for the same or comparable services rendered in Hawaii.

Emergency Dental Care 24/7- Virtual dental visits delivered exclusively by TeleDentistry.com. Visit hmsadental.com/teledentistry or call (866) 256-1871.

Explanation of Benefits (EOB) – A statement that explains how we processed a claim based on services performed, the actual charge, any adjustments to the actual charge, our *Eligible Charge*, the amount we paid, and the amount you owe.

Group - The Member's employer or Group sponsor. Members of a Group Sponsor share a common relationship with one another, such as employment or Membership in an organization. The Group Sponsor executes the Group Sponsor Plan Agreement with Us and by obtaining dental coverage through the Group Sponsor, the Member designates the Group Sponsor as the administrator for this coverage.

Guide To Benefits - This document and any applicable amendment which describes the dental coverage You have under this Plan. Guide to Benefits is abbreviated throughout the document as "Guide."

HMSA – Hawai'i Medical Service Association, an independent licensee of the Blue Cross and Blue Shield Association.

Illness or Injury - Any bodily disorder, bodily Injury, disease, or condition.

Legal Resident – Legal Resident means (1) every individual domiciled in the state of Hawaii, and (2) every other individual whether domiciled in the state of Hawaii or not, who resides in the state. To "reside" in the state means to be in the state of Hawaii for other than a temporary or transitory purpose. Every individual who is in the state of Hawaii for more than two hundred days of the taxable year in the aggregate shall be presumed to be a resident of the state of Hawaii.

Member - The person who meets applicable eligibility requirements and who executes the enrollment form that is accepted, in writing, by Us.

Payment Determination Criteria - Criteria We apply to all services. Only those Covered Services that meet Payment Determination Criteria are eligible for payment under this Plan. To meet Payment Determination Criteria, a service must meet all of the following criteria:

(a) For the purpose of treating a dental condition.

(b) The most appropriate delivery or level of service considering potential benefits and harms to the patient.

(c) Known to be effective in improving dental health outcomes; provided that:

1. Effectiveness is determined first by scientific evidence;

2. If no scientific evidence exists, then by professional standards of care; and

3. If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion, and

(d) Cost-effective for the dental condition being treated compared to alternative dental interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

Services that are not known to be effective in improving dental health outcomes include, but are not limited to, services that are experimental or investigational.

Definitions of terms and additional information regarding application of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Request should be submitted to HMSA's Customer Service Department.

The fact that a Dentist or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets Payment Determination Criteria, even if it is listed as a Covered Service.

Participating providers may not bill or collect charges for services or supplies that do not meet HMSA's Payment Determination Criteria unless a written acknowledgement of financial responsibility, specific to the service, is obtained from You or Your legal representative prior to the time services are rendered.

Participating providers may, however, bill You for services or supplies which are excluded from coverage without obtaining a written acknowledgement of financial responsibility from You or Your representative. More than one procedure, service, or supply may be appropriate for the diagnosis and treatment of Your condition. In that case, We reserve the right to approve only the least costly treatment, service, or supply.

You may ask Your physician to contact Us to determine whether the services You need meets Our Payment Determination Criteria or are excluded from coverage before You receive the care.

Plan - The specific dental coverage described in this Guide, and which is offered to You by Your Group or Group Sponsor and which You pay premium toward.

Teledentistry- The use of electronic information, imaging and communication technologies, such as interactive audio, and video to provide dental care delivery, diagnosis, consultation, treatment, transfer of dental information and education.

Prior Authorization – Dental services including but not limited to crowns and orthodontia services for pediatric members are only covered if prior authorized by HMSA. Typically, the dental provider will obtain this prior authorization, but it is your responsibility to ensure the prior authorization is obtained before the services are rendered. Services that are not preauthorized when required are not payable by HMSA.

Teledentistry- The use of electronic information, imaging and communication technologies, such as interactive audio, and video to provide dental care delivery, diagnosis, consultation, treatment, transfer of dental information and education.

Us, We, Our - Terms that refer to Hawai'i Medical Service Association (HMSA), an independent licensee of the Blue Cross and Blue Shield Association.

Waiting Period - Once enrolled under this plan, an identified period of time that must be accommodated prior to covered services being eligible for coverage under the plan.

You, Your - You, the Member of the Group, and Your enrolled Spouse and/or Child(ren) who are eligible for coverage under this Plan.

Serving you

Meet with knowledgeable, experienced health plan advisers. We'll answer questions about your health plan, give you general health and well-being information, and more. Visit hmsa.com for directions.

HMSA Center @ Honolulu
818 Keeaumoku St.
Monday–Friday, 8 a.m.–5 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

HMSA Center @ Kahului
Puunene Shopping Center | 70 Hookele St.
Monday–Friday, 9 a.m.–6 p.m. | Saturday, 9 a.m.–2 p.m.

Customer Relations representatives are also available in person at our Kauai office, Monday–Friday, 8 a.m.-4 p.m.:

Lihue, Kauai
4366 Kukui Grove St., Suite 103 | Phone: (808) 245-3393

Contact HMSA. We're here with you.

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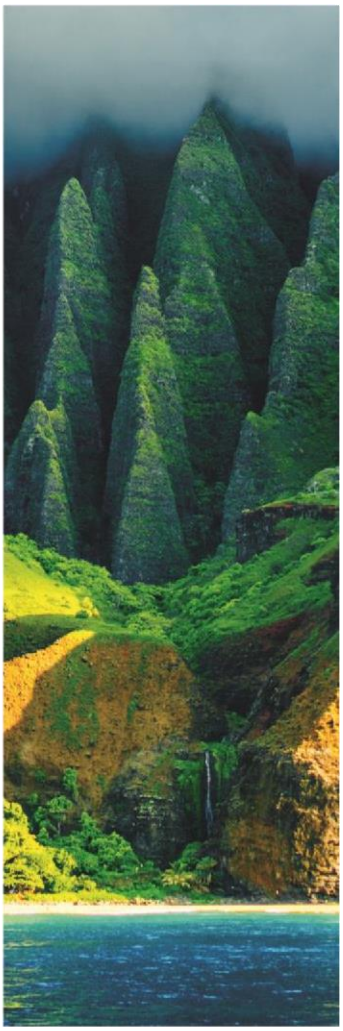

Together, we improve the lives of our members and the health of Hawaii.
Caring for our families, friends, and neighbors is our privilege.

hmsa