

Guide to Benefits

HMSA Participating Provider Dental Program
Individual Dental PPO Platinum
Plan D91

2027

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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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 Coverage Guide ("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 *Contents* at the beginning of the Guide.

Terminology

There are certain words within this Guide that have specific meaning. Terms with specific meaning are capitalized and are defined in one of two places.

- If the term is used frequently in two or more chapters, it is defined in *Chapter 9: Defined Terms* and is formatted in bold and italics.
- If the term is addressed in one chapter only, it is defined in the chapter where it appears.

How To Contact Us

If You have any questions about Your coverage, You can refer to this Guide or call Us at (808) 948-6440 or 1(800) 792-4672 toll-free. 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 recommends. For details on how often these services are covered under this Plan, see *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 *Explanation of Benefits (EOB)* under *Chapter 5: Filing Claims.*

COVERED SERVICE CRITERIA

To determine whether or not 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 of 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 *Choosing a Dentist* under *Chapter 1: Critical Concepts*.
- Another party does not have an obligation to pay. If another party is responsible, payment under this coverage may be affected. See *Chapter 7: Other Party Responsibility*.
- 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 includes access to virtual dental visits delivered by TeleDentistry.com.
If you have a serious and/or painful dental issue and you cannot get in touch with your dentist after hours, you 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 for the PPO network in Hawaii or on the mainland U.S, you can ask your dentist, call us, or visit our online provider directory at hmsadental.com/find-a-dentist.

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 submit prior authorization requests for specific covered services on your behalf.	You are responsible for getting the approval. If you do not receive approval and receive any of the services described in this chapter, benefits may be denied.
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, *Chapter 2: Amounts You May Owe* 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 must pay the dentist in full at the time receive services. We reimburse the eligible charge minus any applicable copayment and deductible. The eligible charge may be less than the dentist's charge.
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.

DEDUCTIBLE

The Deductible is a set dollar amount that You must pay for Covered Services each Calendar Year before reimbursement for dental benefits begins. Only Eligible Charge amounts are used to satisfy the Deductible. The Deductible only applies to basic and major services categories. For example:

- If Your Deductible amount = $25
- And the total charge is $25.00.
- And the Eligible Charge is $20.00
- The amount applied towards Your Deductible = $20

YOUR DEDUCTIBLE

Your Deductible is as follows:

- $25.00 per covered person

Once You have met the Deductible maximum for a Calendar Year, no further Deductibles must be met during the rest of that Calendar Year.

PRIOR COVERAGE DEDUCTIBLE

A Deductible credit will be given to You for dental expenses that were applied toward Your deductible of Your prior dental coverage during the ninety (90) days prior to the effective date of this Plan, but only to the extent those expenses are Eligible Charges under this Plan and are subject to a similar Deductible. Prior coverage Deductible credit only applies at the initial enrollment. You are responsible for providing Us with the information necessary to apply this prior coverage Deductible credit.

COPAYMENT

A Copayment is an amount You owe for most Covered Services. A Copayment is a fixed percentage of the Eligible Charge. Copayment 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.

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 $1,000.00 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 $350 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 $500; and
- The sum of the unused Calendar Year Rollover benefits from prior years does not exceed $1,000.

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	$1,000	$1,000	$1,000	$1,000	$1,000
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)		$350	$0	$350	*$300
Accumulated Rollover Amount		$350	$350	$700	$1,000
Calendar Year Maximum + Accumulated Rollover Amount	$1,000	$1,350	$1,350	$1,700	$2,000

*Only $300 can be added before reaching the Rollover Maximum of $1,000.

The Calendar Year Rollover can be accumulated from one calendar year to the next, up to $1,000 unless:

1. Your total claims paid during a calendar year exceed $500, 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 $350 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 HMSA dental plan to another HMSA 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 and Deductible, 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: Service Limits	Column 2: Descriptions and Service List	Column 3: Copayment
Alphabetical listing of services (both covered and non-covered).	▪ Descriptions of services (both covered and non-covered services). ▪ Applicable *Service Limits.*	A 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

The following guidelines will apply when bitewing radiographs are taken within 12 months of Full Mouth Radiographs (FMX):

- Bitewings taken prior to the FMX, both procedures will be covered.
- Bitewings taken after the FMX, then the bitewings will be denied due to the 1 service in 12-month limitation and the member will be responsible for charges.

Additional panoramic films may be allowed if take by an oral surgeon and the previous film is over twelve (12) months old.

Service List	Descriptions and Service Limits	Copayment
CARIES ARRESTING MEDICAMENT*	Application of medication to stop tooth decay. ***Service Limit:*** Two (2) applications per tooth per year for members – No age limit.	Copayment 0%
CLEANING*	Dental cleaning and polishing (otherwise known as prophylaxis). ***Service Limit:*** Two (2) per Calendar Year.	Copayment 0%
EXAM*	Clinical oral exams. ***Service Limit:*** Two (2) per Calendar Year.	Copayment 0%
PULP VITALITY TESTS	Pulp vitality tests. ***Service Limit:*** One (1) per Calendar Year.	Copayment 0%
X-RAYS	Radiographs and other diagnostic imaging. ***Service Limit:*** • One (1) set of bitewings per Calendar Year; and • One (1) full mouth x-ray every three (3) years, or • One (1) Panoramic x-ray every three (3) years.	Copayment 0%
PERIAPICAL X-RAYS	Periapical x-rays: ***Service Limit:*** Up to six (6) per date of service.	Copayment 20%

*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: 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.
- Deductible applies to these services.

  *High-Cost Procedures incur additional charges which include:
  - 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

Service List	Descriptions and Service Limits	Copayment
ADDITIONAL CROWN PROCEDURE	Additional procedures to construct new crown under existing partial denture framework.	Copayment 20%
CORE BUILD-UP	Core buildup, including pins. Cast or prefabricated post and core combined with core buildup are not paid separately. ***Service Limit:*** Once (1) per tooth per five (5) years.	Copayment 20%
FILLINGS	Amalgam and resin-based composite restorations including polishing. ***Service Limit:*** One (1) restoration per tooth surface every twelve months. Resin-based composite fillings for teeth other than anterior teeth or single, stand-alone, facial surface of bicuspids are considered a *High-Cost Procedure. If you choose this type of restoration for any other bicuspid surface or on a molar tooth, additional charges apply. Age limit does not apply.	Copayment 20%
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.	Copayment 50%
LABIAL VENEER	Labial veneer (resin or porcelain laminate). ***Service Limit:*** For anterior teeth constructed in the laboratory. Subject to review.	Copayment 50%
METAL CROWNS	Crowns made of high noble metal, noble metal, predominantly base metal, and titanium.	Copayment 50%
METAL INLAY/ONLAY	Metallic inlays and onlays.	Copayment 50%

Service List	Descriptions and Service Limits	Copayment
PIN RETENTION	Pin retention- per tooth, in addition to restoration. ***Service Limit:*** Two (2) pins per tooth.	Copayment 20%
PORCELAIN CROWNS	Porcelain/ceramic substrate or porcelain fused to metal crowns. ***Service Limit:*** Once (1) per tooth per five years. *High-Cost Procedure. If you choose this type of restoration for molar teeth, additional charges apply.	Copayment 50%
POST AND CORE	Post and core (cast or prefabricated) in addition to crown. ***Service Limit:*** Once (1) per tooth per five years.	Copayment 20%
PREFABRICATED CROWNS	Crowns made of prefabricated stainless steel or resin. ***Service Limit:*** Age limit does not apply. The 12-month waiting period does not apply.	Copayment 20%
RE-CEMENTATION	Re-cementation of an inlay, onlay, crown, cast or prefabricated post and core is covered after six (6) months of the initial insertion or cementation. ***Service Limit:*** Two (2) re-cementations within a five (5) year period. Twelve-month (12) waiting period between re-cementations.	Copayment 20%
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*.	Copayment 50%
RESIN-BASED COMPOSITE CROWNS	Resin-based composite restoration, anterior, chair side. Age limit does not apply. ***Service Limit:*** Once (1) per tooth per five years. This restoration is considered a *High-Cost Procedure, additional charges apply. The 12-month waiting period does not apply.	Copayment 20%

ENDODONTIC SERVICES (TOOTH ROOTS)

Waiting Periods: The following service waiting period applies to endodontic services.

- Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least twelve (12) consecutive months before coverage for this service category begins.
- Deductible applies to these services.

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:*** Once (1) per tooth per lifetime.	Copayment 50%
ENDODONTIC RETREATMENT	Retreatment of previous root canal therapy. ***Service Limit:*** Once (1) per tooth per lifetime.	Copayment 50%
HEMISECTION	Hemisection includes root removal (but not root canal therapy). ***Service Limit:*** Once (1) per tooth per lifetime.	Copayment 50%
PULP CAP (DIRECT)	Direct pulp cap, not to include the final restoration. ***Service Limit:*** One (1) per tooth in a lifetime.	Copayment 50%
PULP CAP (INDIRECT)	Indirect pulp cap is not covered.	You pay 100% of charges.
PULPOTOMY (THERAPEUTIC)	Therapeutic pulpotomy not to include the final restoration. ***Service Limit*:** Once (1) per tooth in a lifetime.	Copayment 50%

PERIODONTIC SERVICES (GUMS & JAW)

Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least twelve (12) consecutive months before coverage for this service category begins.

- Deductible applies to these services.

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.	Copayment 50%
GINGIVAL FLAP	Gingival flap procedure (which includes root planing). ***Service Limit:*** Once (1) per quadrant per three (3) years.	Copayment 50%
GINGIVECTOMY OR GINGIVOPLASTY	Gingivectomy or gingivoplasty. ***Service Limit:*** Once (1) per quadrant per three (3) years.	Copayment 50%
GRAFT PROCEDURE	Soft tissue graft procedure (including donor site surgery) for correction of rapidly receding gingiva. ***Service Limit:*** Once (1) per tooth per lifetime.	Copayment 50%
GUIDED TISSUE REGENERATION	Guided tissue regeneration (treatment that encourages regeneration of lost periodontal structures). ***Service Limit:*** Once (1) per site per three (3) years.	Copayment 50%
OSSEOUS SURGERY	Osseous surgery (to include flap entry and closure). ***Service Limit:*** Once (1) per site (quadrant) per three (3) years.	Copayment 50%
PERIODONTAL MAINTENANCE*	Periodontal maintenance. ***Service Limit:*** Twice (2) per calendar year in addition to regular cleanings.	Copayment 50%
SCALING* AND ROOT PLANING	Scaling and root planing. ***Service Limit*:** Once (1) every two (2) years.	Copayment 50%
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.

- Replacement of a denture is limited to five years after the placement of a complete or partial denture.
- Deductible applies to these services.

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. ***Service Limit:*** Two (2) per Calendar Year. The 12-month waiting period does not apply.	Copayment 20%
DENTURE – COMPLETE	Complete and immediate maxillary and mandibular dentures (including routine post-delivery care).	Copayment 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.	Copayment 50%
DENTURE REBASE	Denture rebase is covered when at least six months have passed from the date of insertion. ***Service Limit:*** Once (1) per three (3) years. The 12-month waiting period does not apply.	Copayment 20%
DENTURE 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.	Copayment 20%
RELINE PROCEDURES	Denture reline of a complete maxillary/ mandibular denture. Reline procedures are covered when at least six months have passed from the date of insertion. ***Service Limit:*** Once (1) per three (3) years. The 12-month waiting period does not apply.	Copayment 20%
TISSUE CONDITIONING	Tissue conditioning of the maxillary/ mandibular. ***Service Limit:*** Twice (2) per Calendar Year. The 12-month waiting period does not apply.	Copayment 20%

BRIDGES (MISSING TEETH REPLACEMENT)

Service Limit: 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.
- Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least twelve (12) consecutive months before coverage for this service category begins.
- Deductible applies to these services.

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:*** Once (1) every five (5) years. *High-Cost Procedure. If you choose this type of crown for molar teeth, additional charges apply.	Copayment 50%
CROWNS – METAL	Crowns made of full or ¾ cast high noble metal, predominantly base metal, cast noble metal, or titanium.	Copayment 50%
PORCELAIN/ CERAMIC OR COMPOSITE RESIN INLAY/ONLAY	Porcelain/ceramic or composite/resin inlays and onlays. ***Service Limit:*** Once (1) per tooth per five years. This restoration is considered a *High-Cost Procedure, additional charges apply.	Copayment 50%
METAL INLAY/ONLAY	Metallic inlays and onlays. ***Service Limit:*** Once (1) per tooth per five years.	Copayment 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.	Copayment 50%
PONTICS – METAL	Cast high noble metal and metal pontics.	Copayment 50%
RETAINERS	Cast metal for resin bonded fixed prosthesis.	Copayment 50%
RECEMENTATION	Re-cementation of fixed partial dentures is covered after six (6) months of the initial insertion or cementation of the fixed partial denture. ***Service Limit:*** Two (2) re-cementations per fixed partial denture within a five-year period. Twelve-month waiting period between re-cementations.	Copayment 20%
POST AND CORE	Post and core in addition to fixed partial denture retainer indirectly fabricated and prefabricated. ***Service Limit:*** Once (1) every five (5) years. The 12-month waiting period does not apply.	Copayment 20%
CORE BUILD-UP	Core build up for retainer, including any pins. ***Service Limit:*** Once (1) every five (5) years. The 12-month waiting period does not apply.	Copayment 20%

SURGICAL SERVICES (MOUTH, FACE, NECK)

Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least twelve (12) consecutive months before coverage for this service category begins.

- Deductible applies to these services.

Service List	Descriptions and Service Limits	Copayment
ALVEOLOPLASTY	Surgical preparation of ridge for dentures whether or not in conjunction with extractions	Copayment 50%
EXCISION OF BONE TISSUE	Removal of lateral exostosis (maxilla or mandible).	Copayment 50%
EXTRACTIONS – SURGICAL	Surgical extractions and surgical access of an un-erupted tooth.	Copayment 50%
EXTRACTIONS - NONSURGICAL	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. ***Service Limit:*** Once (1) per tooth per lifetime.	Copayment 20%
IMPLANTS	Implant body, surgical placement of implant, removal of implant and maintenance procedures are not covered. The crown for the implant is covered as an alternate service (either a fixed partial denture pontic or a removable partial denture). This service is considered a *High-Cost Procedure, and additional charges apply as explained on *page 5*. Frequency and service limitations of the alternate service apply.	You pay 100% of charges.
INCISIONS	Surgical incision and drainage of abscess of intraoral soft tissue.	Copayment 20%
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.	Copayment 20%
ORAL SURGERY REPAIR	Excision of hyperplastic tissue or pericoronal gingival. Frenectomy, frenotomy, or frenuloplasty.	Copayment 20%

ORTHODONTIC SERVICES (TOOTH ALIGNMENT)

- Deductible applies to these services.

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

- Deductible applies to these services.

Service List	Descriptions and Service Limits	Copayment
ANESTHESIA	Deep sedation/general anesthesia and intravenous conscious sedation/analgesia (but not nitrous oxide).	Copayment 20%
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – PER VISIT	Treatment that relieves pain but it's not curative; services provided do not have distinct procedure codes. Palliative treatment is covered when a painful emergency condition requires immediate treatment for relief. To be considered palliative, the procedure should alleviate but not cure. Coverage is for the emergency treatment (per visit) providing no other eligible services, except diagnostic radiographs, are performed. Service Limit: One (1) palliative service per visit. If submitted in conjunction with definitive procedures palliative treatment will be denied.	Copayment 20%
OFFICE CARE (AFTER HOURS)	Office visits that take place after regularly scheduled hours. scheduled hours. ***Service Limit:*** By Report	Copayment 20%
EMERGENCY DENTAL CARE 24/7	Virtual visit rendered through Teledentistry.com. ***Service Limit:*** Two (2) consultations per calendar year.	Copayment 0%

ENHANCED DENTAL BENEFITS

HMSA dental plan members with eligible medical conditions receive additional dental benefits through the Oral Health for Total Health program. Enrollment in the program is automatic for members who have HMSA medical and dental. Members with only HMSA dental can easily self-enroll online at https://hmsadental.com/members/oral-health-for-total-health/enroll

Coverage for the following services is provided for members who have been diagnosed with one or more of the following conditions: diabetes, coronary artery disease, stroke, chronic obstructive pulmonary disease, end-stage renal disease, metabolic syndrome, and/or who are pregnant:

- Dental cleanings (oral prophylaxis, scaling in the presence of gingival inflammation or periodontal maintenance cleanings), can be any combination of services up to four times per calendar year;
- Periodontal scaling, one per quadrant every 24 months;
- Full-mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered once every 24 months.

Coverage for the following services is provided for members who have been diagnosed with one or more of the following conditions: oral, head, or neck cancers or Sjögren's syndrome:

- Dental cleanings (oral prophylaxis scaling in the presence of gingival inflammation or periodontal maintenance cleanings), can be any combination of services up to four times per calendar year;
- Full-mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit. Covered once every 24 months;
- Fluoride treatment, four times per calendar year;
- Clinical oral exams, four times per calendar year.

For in-network providers, these enhanced services are covered at 100% with no deductibles, coinsurance, copays, or waiting periods. Additionally, the services do not count toward the calendar-year benefit maximum. For out-of-network providers, these enhanced services are covered at 100% with no deductibles, copays, or waiting periods but any coinsurance will apply. Additionally, the services do not count toward the calendar-year benefit maximum. Find out more at hmsa.com/oralhealth.

	Two extra cleanings or periodontal maintenance	Enhanced cleaning to remove excess plaque buildup	Periodontal scaling	Oral health screenings and fluoride treatments
Chronic obstructive pulmonary disease	✓	✓	✓	
Coronary artery disease	✓	✓	✓	
Diabetes	✓	✓	✓	
End-stage renal disease	✓	✓	✓	
Metabolic syndrome	✓	✓	✓	
Oral, head and/or neck cancer	✓	✓		✓
Pregnancy	✓	✓	✓	
Sjögren's syndrome	✓	✓		✓
Stroke	✓	✓	✓	

MISCELLANEOUS SERVICE-SPECIFIC EXCLUSIONS

In addition to these exclusions and the exclusion listed under General Exclusions, each Service Category may also have exclusions.

Service List	Descriptions and Service Limits	Amount You Owe
APPLIANCES	Lost or stolen appliances 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.
CHEMOTHERAPY AGENTS	Localized delivery of chemotherapeutic agents into periodontal pockets	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.
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.
GUM AUGMENTATION	Services for augmentation of the gum ridge are 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.
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.
NITROUS OXIDE	Nitrous oxide is not covered.	You pay 100% of charges.

Service List	Descriptions and Service Limits	Amount You Owe
TEMPOROMANDIBULAR JOINT (TMJ) 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.
TEMPORARY PROCEDURES	Dental procedures that describe temporary or interim services that are essential to the completion of a definitive or final service are not separately billable nor covered by the plan.	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	Amount You Owe
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 non-covered procedure are not covered, including 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 by reason 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.
FEDERAL/STATE TAXES/ SURCHARGES/FEES	Federal or state laws or regulations may require a surcharge tax or other fee that applies to insured/self-funded accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.	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.
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.

Service List	Descriptions and Service Limits	Amount You Owe
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

When You are Eligible for Coverage

To be eligible for coverage as a Member, all of the following must be true:

- You are at least age 65 or older;
- You complete, sign, and submit an enrollment form that is accepted by Us;
- You are a Legal Resident in the state of Hawaii; and
- You pay Your premium in advance.

We reserve the right to request, at any time, documentation that demonstrates in Our sole discretion and to Our satisfaction that You meet the above criteria. Your refusal to provide such documentation or to provide documentation that in HMSA's sole discretion demonstrates the criteria have been met shall result in immediate termination of this coverage.

Categories of Coverage

- Single coverage; You are the only one covered.
- Two-party coverage; You and Your Spouse are covered. Your Spouse must be age 65 or older and listed on Your enrollment form or added later as a new Dependent.

Please note: We must approve any dependents added to this Plan. Each Dependent will have his or her own Effective Date when he or she first becomes eligible for this Plan's coverage.

COVERAGE ACTIVATION

Your coverage will activate on Your Effective Date providing that:

- All initial dues 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.

COVERAGE TERMINATION

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

You may terminate Your coverage at any time by writing Us a letter. Member requests for retroactive termination shall not be granted.

We may end Your coverage at any time if You do not meet the criteria described in *When You are Eligible for Coverage* above or fail to respond within 30 days to Our request that You provide documentation sufficient to demonstrate that You meet the criteria.

If Your coverage ends, You are not eligible to receive benefits under this coverage after the termination date.

End of Month Termination

Unless prohibited by state or federal law, coverage will terminate at the end of the month in which any of the following takes place:

- We end Our Agreement with You by providing You written notice 30 days prior to termination.

Immediate Termination

The following events cause coverage to terminate immediately for the Member and enrolled Spouses.

- Fraudulent use of coverage or intentional misrepresentation or concealment of material facts in Your enrollment form or in any claim for benefits.

If we determine that You have committed fraud or made an intentional misrepresentation or concealment of material facts, We will provide You written notice 30 days prior to termination of Your coverage. During that time, you have a right to appeal our determination of fraud or intentional misrepresentation. For more information on your appeal rights, see Chapter 6: Resolving Disputes.

If Your coverage is terminated for fraud, intentional 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.
    - Conduct which, in Our opinion, seriously jeopardizes Our ability to provide coverage to You, for example, Your refusal to follow prescribed Participating Provider's operational procedures.
    - Engagement in repeated disruptive or threatening behavior or the infliction of bodily harm to others in the provider's office.

Continued Coverage if Member Dies

Upon the death of a Member, his or her spouse, if not eligible for group coverage, may become a Member under an individual payment Plan.

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 at (808) 948-6440 or 1(800) 792-4672 toll-free.

CLAIM SUBMISSION

Notice of Claim

1. 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 stationery. 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 following address(es):

    To submit a Paper Claim

    HMSA Dental
    P.O. Box 69436
    Harrisburg, PA 17106-9436

    To submit an Out-of-state or Out-of-country claim*

    HMSA Dental
    P.O. Box 1320
    Honolulu, HI 96807-1320

    *Out-of-state providers may submit the claim on your behalf, please check with your provider. Please submit the claim to the address above if filing your own claim.

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- 6440 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 17106-9436

Arbitration

HMSA Dental Services
P.O. Box 69437
Harrisburg, PA 17106-9436

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 non-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 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 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, or;
    - 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) 948-5090 or toll free at (800) 462-2085 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) 948-5090 or toll free at (800) 462-2085 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 Your 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 PLAN AND YOU WISH TO CONTEST OUR APPEAL DECISION

If You are enrolled in a self-funded group 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 at:

HMSA Dental Customer Service
P.O. Box 69437
Harrisburg, PA 17106-9437

Within 130 days of HMSA's appeal decision to deny or limit the service or supply.

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 insurance: non-Group insurance: other Group 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.

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 Dental
   Attn: Third Party Liability
   P.O. Box 1320
   Honolulu, Hawaii 96807-1320

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 chapter provides general provisions applicable to Your Plan.

PREMIUMS

You 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.

In the event You 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 You. We are not liable for benefits for services received after the termination date.

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.

AUTHORITY TO TERMINATE, AMEND, OR MODIFY

We have the authority to amend, modify, or terminate the Agreement provided that We give 30 days prior written notice to You 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 Dental
P.O. Box 1320
Honolulu, Hawaii 96807-1320

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.

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.

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.

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 the United States and its territories are based on the Eligible Charge for the same or comparable services rendered in Hawaii.

**Please note:* Eligible charge does not include excise or other tax. You are responsible for all taxes related to the care you receive. If your provider accepts monthly payments to manage your care, you may owe tax on your copayment.

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.

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 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.

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

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

Discrimination is against the law

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

Services HMSA provides

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

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

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

How to file a grievance or complaint

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

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

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

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

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

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

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

(continued on next page)

hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

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Commercial/ACA/Medicare
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H3832_1300_N7KJ3109_27_C
H8481_1300_N7KH3108_27_C
H2561_1300_N7KG3107_27_C

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

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

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

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

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

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

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

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

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

(continued on next page)

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

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

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

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

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

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

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

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

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

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