HMSA Individual Dental PPP Basic

January 2016

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Aloha,

Thanks for choosing HMSA. We've been providing health plans for the people of Hawaii since 1938. Throughout our history, we've worked hard to keep our operating costs low and give you the best value for your health care investment. Our goal is to operate at a break-even level while making sure you get the health care you need.

Today, our operating costs are lower than the national standards under health care reform and we maintain one of the best benefit returns of any health plan in the nation.

This *Guide to Benefits* provides detailed information about your HMSA plan. Please read it carefully and keep it for future reference.

We want to make sure this plan meets your health care needs. If, after reading your *Guide to Benefits*, you decide that you don't want this plan, send us a letter within 10 days. We'll refund your premium and cancel your membership, and you won't be eligible for any benefits.

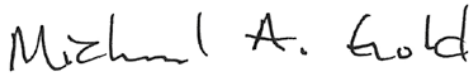
All HMSA plans include the largest statewide network in Hawaii, with 6,500 physicians, hospitals, and other health care providers. And our commitment to excellent customer service means we're ready to help you by phone, online, or in person at our convenient HMSA offices statewide.

As an HMSA member, you also get the following benefits at no additional cost:

- **Well-Being Connect:** Check your well-being, create a customized Well-Being Plan, and track your progress. Sign on to Well-Being Connect through My Account on hmsa.com.
- **HMSA365:** Save money on health and wellness products and services just by showing your HMSA membership card. For details, visit hmsa.com or call 1 (866) 520-6362 toll- free.
- ***Island Scene* magazine:** HMSA's award-winning quarterly magazine features articles on health, fitness, family, and fun in Hawaii. It's mailed to members four times a year.

Thanks again for choosing an HMSA plan. We appreciate your membership and look forward to working with you for your good health and well-being.

Sincerely,



Michael A. Gold
President and Chief Executive Officer
Hawai'i Medical Service Association

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Table of Contents:

Chapter 1: CRITICAL CONCEPTS

1

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 DENTAL GUIDE

This ***Guide*** explains your dental coverage in nine 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

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

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

Definitions

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

How to Contact Us

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

HOW YOU CAN HELP CONTROL YOUR DENTAL COSTS

- Carefully read your guide so that you understand your dental ***Plan*** and how to maximize your coverage.
- Take care of your teeth daily (brush at least twice and floss at least once).
- Schedule and receive regular teeth cleaning and exams as often as your dentist 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: Services & Copayments* as 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 an HMSA Dental Network Provider, or services are for an emergency.
- 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.*

CHOOSING A DENTIST

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

PARTICIPATING DENTIST FACTS	NON-PARTICIPATING 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, refer to *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 are responsible for any difference between the eligible charge and the amount billed by the dentist.
You pay the applicable copayment at the time you receive services.	You pay the provider in full at the time you receive services. We reimburse you any applicable amount after We receive and review a claim.
You pay the applicable deductible at the time you receive services.	You pay the provider in full at the time you receive services. We reimburse you any applicable amount after we receive and review a claim.

SERVICES THAT REQUIRE PRIOR AUTHORIZATION

Prior Authorization is a special approval process to make sure that certain treatments, procedures, or devices meet payment determination criteria before the service is rendered.

If you are under the care of an HMSA participating dental provider or contracting provider, he or she will get approval for you.

Prior authorization is required for the following services and devices. Failure to get our approval will result in a denial of benefits if the services or devices do not meet HMSA's payment determination criteria. **Provider is not responsible for treatment costs or penalties for failure to obtain approval.**

You are responsible for 100% of charges for the services listed below if prior authorization is not obtained before services are rendered:

- Alveoloplasty
- Carriers
- Endodontic Retreatment
- Maxillofacial Prosthetics
- Surgical Access of an Unerupted Tooth
- Placement of a Device to Facilitate Eruption of Impacted Tooth
- Medically Necessary Orthodontia

How to Request Prior Authorization

Ask for prior authorization by writing us at:

HMSA Dental Services
P.O. Box 1187
Elk Grove Village, IL 60009-1187
Fax: (888) 255-0876

If you have questions please call us at:
(808) 948-6440 or 1(800) 792-4672 toll-free

Changes to this Guide's List of Prior Authorization Services

From time to time, we need to update the list of services and supplies that require prior authorization. Changes are needed so that your plan benefits remain current with the way therapies are delivered. Changes may occur at any time during your plan year. If you would like to know if a treatment, procedure or device has been added or deleted from the list in this guide, call us at the telephone number on the back cover of this guide.

Our Response to Your Request for Prior Authorization for Non Urgent Dental Care
If your request for prior authorization is not urgent, HMSA will respond to your request within a reasonable time that is appropriate to the medical circumstances of your case. We will respond within 15 business days after we receive your request. We may extend the response time once for an additional 15 business days if we cannot respond to your request within the first 15 business days and if it is due to circumstances beyond our control. If this happens, we will let you know before the end of the first 15 business days. We will tell you why we are extending the time and the date we expect to have our decision. If we need added details from you, we will let you know and give you at least 45 business days to provide the information.

Our Response to Your Request for Prior Authorization for Urgent Dental Care
Your care is urgent if the time periods that apply to prior authorization for non-urgent care are the following:

- Could seriously risk your life or health or your ability to regain maximum function, or
- In the opinion of your treating physician or dentist, would subject you to severe pain that cannot be adequately managed without the care that is the subject of the request for prior authorization.

HMSA will respond to your request for prior authorization of urgent care as soon as possible given the medical circumstances of your case. It will be no later than 24 hours after all information sufficient to make a determination is provided to us.

If you do not provide enough details for us to determine if or to what extent the care you request is covered, we will notify you within 24 hours after we receive your request. We will let you know what information we need to respond to your request and give you a reasonable time to respond. You will have at least 48 hours to provide the information.

Appeal of Our Prior Authorization Decision
If you do not agree with our prior authorization decision, you may appeal it. See *Chapter 6: Resolving Disputes.*

ACA Provider Nondiscrimination
To the extent an item or service is a Covered Service under this Plan, and consistent with reasonable dental management techniques specified under this Plan with respect to the frequency, method, treatment or setting for an item or service, HMSA shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under Hawaii law. HMSA is not required to accept all types of providers into its network and HMSA has discretion governing provider reimbursement rates that may be subject to quality, performance, or market standards and considerations.

Is the Care Consistent with HMSA's Dental Policies?

To be covered, the care you get must be consistent with the provider's scope of practice, state licensure requirements, and HMSA's dental policies. These are policies drafted by HMSA Dental Directors, many of whom are practicing dentists, with community dental and nationally recognized authorities.

Each policy provides detailed coverage criteria for when a specific dental service meets payment determination criteria. If you have questions about the policies or would like a copy of a policy related to your care, please call us at one of the telephone numbers on the back cover of this guide.

Agreement

The Agreement between HMSA and you is made up of all of the following:

- This Guide to Benefits.
- Any riders and/or amendments.
- The enrollment form submitted to us.

Our Rights to Interpret this Document

We will interpret the provisions of the Agreement and will determine all questions that arise under it. We have the administrative discretion:

- To determine if you meet out written eligibility requirements.
- To determine the amount and type of benefit payable to you or your dependents according to the terms of this agreement.
- To interpret the provisions of this Agreement as is needed to determine benefits, including but not limited to decisions on medical necessity and applicable changes in HMSA's dental policies.
- To make changes as required by Federal law and/or Hawaii State Law.

Our determinations and interpretations, and our decisions on these matters are subject to de novo review as provided in this Guide to Benefits or as allowed by law. If you do not agree with our interpretation or determination, you may appeal. See Chapter 8: Dispute Resolution.
No oral statement of any person shall modify or otherwise affect the benefits, limits and exclusions of this Guide to Benefits, convey or void any coverage, or increase or reduce any benefits under this Agreement.

Questions

If you have any questions, please call us. More details about plan benefits will be provided free of charge. We list our telephone number on the back cover of this guide

Chapter 2: AMOUNTS YOU MAY OWE

2

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

COPAYMENT

A ***Copayment*** is an amount you owe for most covered services. A copayment is a fixed dollar amount. Members ages 19 & older may have the same or higher coinsurance amounts per service. Copayment amounts appear in *Chapter 3: Services & Copayments.*

DEDUCTIBLE

The ***Deductible*** is a set dollar amount that you must pay for covered services each calendar year before reimbursement for dental benefits begin. Only eligible charge amounts are used to satisfy the deductible. For example:

- If your deductible amount is = $25.00
- And the total charge is $25.00
- And the Eligible Charge is $20.00
- The amount applied towards your deductible = $20.00

Your deductible is as follows:

- $25.00 per covered person

Once each covered person has met their deductible for the calendar year, no further deductible must be met during the rest of the calendar year.

The deductible in this policy applies to all services covered under this plan with the exception of orthodontic services.

AMOUNTS EXCEEDING ELIGIBLE CHARGE

In certain circumstances, you may owe the difference between the amount billed by your dentist and the ***Eligible Charge***. This applies if you choose a ★High Cost Procedure. With ★High Cost Procedures, two treatment options exist, however, one is more cost effective than the other. You have a choice whether to receive the ★High Cost Procedure or the more cost effective one. 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 limited to members age 19 and older; benefits for members under age 19 do not include a calendar year maximum. The calendar year maximum for this plan is $1,000.00 per person age 19 and older.

OUT OF POCKET MAXIMUM

The ***Out of Pocket Maximum*** is the maximum dollar amount you will pay toward covered services during a calendar year. Once the out of pocket maximum is met, you are no longer responsible for deductible (if applicable) or copayment amounts unless otherwise noted.

- The out of pocket maximum is $350 per child (up to $700 for two or more children).
- The out of pocket maximum under this plan is limited to members under age 19.
- Benefits for members age 19 and older do not include an out of pocket maximum.
- The out of pocket maximum applies to covered services provided by an in-network provider only.

The following amounts do not apply toward meeting the out of pocket maximum. You are also responsible for these amounts even after you have met the copayment maximum:

- Payments for services subject to a service limit maximum. See *Amounts Exceeding a Service Limit* addressed later in this chapter.
- The difference between the actual charge and the eligible charge that you pay when you receive services from a nonparticipating provider.
- Payments for non-covered services.
- Covered services provided by a non-participating provider do not apply to the out of pocket maximum.

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. The calendar year rollover for this plan is limited to members age 19 and older; rollover does not apply to members under age 19. You may accumulate up to $350 in a calendar year which will roll over and 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 $1,000.00.

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	$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:

- Deductibles
- Co-payments
- Payments for services subject to a maximum once you reach the maximum
- Any amount that exceeds eligible charges as described in this chapter
- Non-covered services
- 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: Services & Copayments* 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: Services & 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. Most Waiting Periods for this Plan are limited to members age 19 and older. For members under age 19, waiting periods only apply to medically necessary orthodontic benefits.

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Chapter 3: SERVICES & COPAYMENTS

3

This chapter describes services both covered and not covered and Copayment amounts. In addition to the information provided in this chapter, also read Chapter 1: Critical Concepts and Chapter 2: Amounts You May Owe to better understand your coverage*. If you are 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 and 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 eligible as a covered benefit. Limitations may also describe circumstances or conditions when a procedure, service or supply is not a covered benefit. In order to identify items excluded from coverage, limitations and benefits should be read in conjunction with the general exclusions table provided later in this chapter.

Some dental services or procedures including their benefit limitations or coverage exclusions may not be listed in the following service tables. If you are unsure if a specific procedure or service is covered or not covered, please call us and we will help you. For your convenience, we list our telephone numbers on the back cover of this guide.

PEDIATRIC DENTAL REQUIREMENTS

This plan includes pediatric dental coverage, an essential health benefit, as required under the federal ***Patient Protection and Affordability Care Act (PPACA)***.

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.

SERVICES PROVIDED BY NONPARTICIPATING PROVIDERS

Benefits for Covered Services described in this guide are reduced when services are provided by providers who are not participating in HMSA's provider network.

SERVICE TABLES & SERVICE CATEGORIES

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

***Please note:* Service Tables, Categories, Limitations and Copayments may differ depending on the member's age at the time the services are performed.**

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

The **SERVICE CATEGORIES** are listed in bold font above the table headings for the service lists, descriptions, service limits and co-payment provisions.

Waiting Periods are indicated below the service category title and may apply to some or all of the services listed in the following service descriptions and limits table. Multiple waiting periods may be applicable and will be detailed above the description and service table.

Refer to *Chapter 2: Amount You May Owe* for more detail on waiting periods.

<table>
<tr><th>COLUMN 1:
SERVICE LIST</th><th>COLUMN 2:
DESCRIPTIONS</th><th>COLUMN 3:
SERVICE LIMITS</th><th colspan="2">COLUMN 4: COPAYMENT</th></tr>
<tr><td rowspan="2">Alphabetical listing of services (both covered and non-covered).</td><td rowspan="2">Descriptions of services (both covered and non-covered services).</td><td>Applicable Service Limits are separated by age:
• Age 0-18
• Prior Authorization services are indicated in bold.</td><td>This section indicates copayments for Participating Dentists (PAR)</td><td>This section indicates copayments for Non-Participating Dentists (NON-PAR)</td></tr>
<tr><td>• Age 19 & Older</td><td colspan="2">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).</td></tr>
</table>

DIAGNOSTIC & PREVENTIVE SERVICES

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
CLEANING*	Dental cleaning and polishing (otherwise known as prophylaxis)	**Age 0 - 18:** Two (2) per calendar year.	10%	20%
		Age 19 & Older: Two (2) per calendar year.		
DIAGNOSTIC CASTS	Cast impression of teeth and jaw	**Age 0 - 18:** Covered.	40%	50%
		Age 19 & Older: Diagnostic casts are not covered	You pay 100% of charges.	
EXAM	Clinical oral exams	**Age 0 - 18:** Two (2) per calendar year.	10%	20%
		Age 19 & Older: Two (2) per calendar year.		
FLUORIDE*	Topical fluoride treatments	**Age 0 - 18:** Two (2) per calendar year.	10%	20%
		Age 19 & Older: Fluoride treatments are not covered.	You pay 100% of charges.	
SEALANTS	Sealant applications for permanent molars	**Age 0 - 18:** Covered for sealant applications for 1st and 2nd permanent molars, but limited to one (1) every 5 years.	10%	20%
		Age 19 & Older: Sealants are not covered.	You pay 100% of charges.	
SPACERS	Passive appliances	**Age 0 - 18:** Covered for fixed unilateral and bilateral spacers, but limited to two (2) per day, up to four (4) every 2 years. Recementation is limited to once (1) per year.	40%	50%
		Age 19 & Older: Spacers are not covered	You pay 100% of charges.	
X-RAYS	Radiographs and other diagnostic imaging	**Age 0 - 18:** •Two (2) sets of bitewings per Calendar Year. •One (1) full-mouth x-ray every 5 years	10%	20%
		Age 19 & Older: •One (1) set of bitewings per Calendar Year •One (1) full-mouth x-ray every three years	10%	20%

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
PANORAMIC X-RAYS	Panoramic radiographic image	**Age 0 - 18:** One (1) Panoramic x-ray every 2 years which cannot be taken in conjunction with a full mouth x-ray.	40%	50%
		Age 19 & Older: One (1) Panoramic x-ray every 3 years which cannot be taken in conjunction with a full mouth x-ray.	40%	50%
CEPHALOMETRIC X-RAYS	Radiographic exam of the head, including mandible, in full lateral view used for making cranial measurements	**Age 0 - 18:** One (1) per day	40%	50%
		Age 19 & Older: Not covered.	You pay 100% of charges.	
INTRAORAL OCCLUSAL X-RAYS	Intraoral occlusal radiographic image(s)	**Age 0 - 18:** One (1) per day.	40%	50%
		Age 19 & Older: Subject to clinical necessity.	40%	50%
PERIAPICAL X-RAYS	Periapical radiographic image(s)	**Age 0 - 18:** Up to five (5) per date of service.	40%	50%
		Age 19 & Older: Subject to clinical necessity. Not to exceed six (6) films per date of service.		
SIALOGRAPHY X-RAYS	Sialography radiographic image(s)	**Age 0 - 18:** One (1) per day.	40%	50%
		Age 19 & Older: Sialography x-rays are not covered.	You pay 100% of charges.	
SKULL AND FACIAL BONE X-RAY	Skull and Facial Bone radiographic image(s)	**Age 0 - 18:** One (1) per day.	40%	50%
		Age 19 & Older: Skull and facial bone x-rays not covered.	You pay 100% of charges.	
PULP VITALITY TEST	Pulp vitality test	**Age 0 - 18:** Pulp vitality tests are not covered	You pay 100% of charges.	
		Age 19 & Older: One per calendar year	10%	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)

Waiting Periods- The following service waiting period applies for repair and replacement services for members age 19 & older:

- **Restorative Services (except for crowns):** Unless otherwise stated, you must have been enrolled in a dental plan offered by us for at least 6 consecutive months before coverage for this service category begins.
- **Repairs:** No sooner than 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.
- Unless otherwise stated, most restorative services are not covered for members age 19 & older.

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
CORE BUILDUP	Core buildup, including pins. Cast or prefabricated post and core combined with core buildup are not paid separately.	**Age 0 - 18:** Limited to permanent teeth only, excluding 3rd molars.	40%	50%
		Age 19 & Older: One (1) per tooth per 5 years for permanent teeth only.	40%	50%
FILLINGS	Amalgam and resin-based composite restorations including polishing.	**Age 0 - 18:** Covered for primary and permanent teeth, limited to: •No sooner than one (1) restoration per tooth surface per calendar year. •Resin-based composite fillings for teeth other than anterior or single, stand-alone, facial surfaces 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 as explained in *Chapter 2: Amounts You May Owe*.	40%	50%

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
		Age 19 & Older: Covered for primary and permanent teeth, limited to: •No sooner than one (1) restoration per tooth surface per calendar year. •Resin-based composite fillings for teeth other than anterior or single, stand-alone, facial surfaces 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 as explained in *Chapter 2: Amounts You May Owe*.	40%	50%
METAL CROWNS	Crowns made of high noble metal, noble metal, predominantly base metal and titanium.	**Age 0 - 18:** Covered, but limited to: •One (1) per tooth every 5 years for permanent teeth excluding 3rd molars. •Endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of clinical crown (anterior). **Limited to Full Cast Noble Metal.**	60%	70%
		Age 19 & Older: Metal crowns are not covered.	You pay 100% of charges.	

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
PIN RETENTION	Pin retention per tooth, in addition to restoration	**Age 0 - 18:** Covered, but limited to permanent teeth.	40%	50%
		Age 19 & Older: Covered, but limited to two (2) times per tooth as a lifetime maximum	40%	50%
PORCELAIN CROWNS	Porcelain/ceramic substrate or porcelain fused to metal crowns	**Age 0 - 18:** Covered for porcelain fused to metal crowns, but limited to: •One (1) per tooth every 5 years for permanent teeth, excluding 3rd molars. •Endodontic treatment, loss of one major cusp (posterior), or loss of not less than 40% of clinical crown (anterior) Limited to Noble Metal.	60%	70%
		Age 19 & Older: Porcelain crowns are not covered.	You pay 100% of charges.	
POST AND CORE	Post and core (cast or prefabricated) in addition to crown	**Age 0 - 18:** Covered for permanent teeth, excluding 3rd molars.	40%	50%
		Age 19 & Older: Covered once (1) every 5 years.	40%	50%
PREFABRICATED CROWNS-PRIMARY TEETH	Crowns made of prefabricated stainless steel	**Age 0 - 18:** Covered for primary teeth only, one (1) per tooth per year.	40%	50%
		Age 19 & Older: Covered.	40%	50%
PREFABRICATED CROWNS-PERMANENT TEETH	Crowns made of prefabricated stainless steel	**Age 0 - 18:** Covered for permanent teeth excluding 3rd molars.	40%	50%
		Age 19 & Older: One (1) per tooth per year.	40%	50%

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
RECEMENTATION	Recementation of an inlay, onlay or crown, is covered after six (6) months of the initial insertion or cementation	**Age 0 - 18:** Covered for primary and permanent teeth, including 3rd molars, but limited to one (1) tooth per day.	40%	50%
		Age 19 & Older: Covered after six (6) months of the initial insertion or cementation. Two (2) recementations within a 5 year period.	40%	50%
RESIN-BASED COMPOSITE CROWNS	Crowns made of resin, resin with high noble metal, noble metal, or predominantly base metal	**Age 0 - 18:** Resin-based composite crowns are not covered.	You pay 100% of charges.	
		Age 19 & Older: This restoration is considered a ★High Cost Procedure. If you choose this type of restoration for molar teeth, additional charges apply as explained in *Chapter 2: Amounts You May Owe*.	40%	50%
TEMPORARY CROWNS	Usually a preformed artificial crown, which is fitted over a damaged tooth as an immediate protective device.	**Age 0 - 18:** Covered, but limited to fractured tooth emergencies in cases involving endodontic treatment, loss of at least one major cusp (posterior), or loss of no less than 40% of the clinical crown (anterior) and for permanent teeth, excluding 3rd molars.	60%	70%
		Age 19 & Older: Temporary crowns are not covered.	You pay 100% of charges.	

ENDODONTIC SERVICES (TOOTH ROOTS)

Waiting Periods- The following service waiting period applies for repair and replacement services for members age 19 & older:

- **Pulpotomy (therapeutic):** Unless otherwise stated, you must have been enrolled in a dental plan offered by us for at least 6 consecutive months before coverage for this service category begins.
- Unless otherwise stated, most endodontic services are not covered for members age 19 & older.

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
APEXIFICATION / RE-CALCIFICATION	Treatment used to seal an open apex	**Age 0 - 18:** Covered for permanent teeth excluding 3rd molars. Includes initial, interim and final visit, but limited to one (1) per tooth per lifetime.	40%	50%
		Age 19 & Older: Apexification / recalcification is not covered.	You pay 100% of charges.	
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	**Age 0 - 18:** One (1) per tooth in a lifetime.	40%	50%
		Age 19 & Older: Endodontic therapy is not covered.	You pay 100% of charges.	
ENDODONTIC RETREATMENT	Retreatment of previous root canal therapy	**Age 0 - 18:** Covered for retreatment of previous root canal therapy, in accord with our dental policies. One (1) retreatment per tooth per lifetime. **Prior Authorization is required.**	40%	50%
		Age 19 & Older: Endodontic retreatment is not covered.	You pay 100% of charges.	

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
PARTIAL PULPOTOMY	Partial pulpotomy for apexogenesis; permanent tooth with incomplete root development	**Age 0 - 18:** Covered for permanent tooth with incomplete root development. Services are limited to one (1) per tooth per day per lifetime.	40%	50%
		Age 19 & Older: Partial pulpotomy is not covered.	You pay 100% of charges.	
PULPOTOMY (THERAPEUTIC)	Therapeutic pulpotomy not to include the final restoration	**Age 0 - 18:** Covered for primary teeth. Includes therapeutic pulpotomy, but not the final restoration. Services are limited to one (1) per tooth per day per lifetime.	40%	50%
		Age 19 & Older: Therapeutic pulpotomy is covered, once (1) per tooth per lifetime.	40%	50%

PERIODONTIC SERVICES (GUMS & JAW)

- Benefits for all periodontal services are limited to two (2) quadrants per date of service.
- Unless otherwise stated, all periodontic services are not covered for members age 19 & older.

Service List	Descriptions	Service Limits	Copayment	
FULL MOUTH DEBRIDEMENT	Removal of subgingival and/or supragingival plaque and calculus; removal of contused and devitalized tissue from a wound surface	**Age 0 - 18:** Covered for the removal of heavy plaque and calculus to enable a comprehensive evaluation.	40%	50%
		Age 19 & Older: Full mouth debridement is not covered.	You pay 100% of charges.	
PERIODONTAL MAINTENANCE*	Therapy for preserving the state of health of the periodontium	**Age 0 - 18:** Two (2) per calendar year in addition to regular cleaning.	40%	50%
		Age 19 & Older: Periodontal maintenance is not covered.	You pay 100% of charges.	
SCALING AND ROOT PLANING*	Treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others	**Age 0 - 18:** Once (1) every 2 years.	40%	50%
		Age 19 & Older: Scaling and root planing is not covered.	You pay 100% of charges.	

DENTURES (ARTIFICIAL TEETH)

Waiting Periods- The following service waiting period applies to dentures for members age 19 & older:

- **Repair, Adjustments, Reline and Replacement (Broken Teeth):** Unless otherwise stated, you must have been enrolled in a dental Plan offered by us for at least 6 consecutive months before coverage for this service category begins.
- Unless otherwise stated, most restorative services are not covered for members age 19 & older.

Replacement of a denture is covered 5 years after the placement of a complete or partial denture.

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
ADJUSTMENTS	Denture adjustments are covered when at least six months have passed from the date of insertion	**Age 0 - 18:** Covered for full and partial dentures, but limited to once (1) per day.	40%	50%
		Age 19 & Older: Denture adjustments are covered when at least 6 months have passed from the date of insertion not to exceed two (2) per calendar year.	40%	50%
DENTURE – COMPLETE	Complete maxillary and mandibular dentures (including routine post-delivery care).	**Age 0 - 18:** Covered for complete maxillary and mandibular dentures (including routine post- delivery care), but limited to one (1) per arch every 5 years.	60%	70%
		Age 19 & Older: Complete dentures are not covered.	You pay 100% of charges.	

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
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.	**Age 0 - 18:** Covered for complete and immediate maxillary and mandibular dentures (including routine post-delivery care), but limited to one (1) per arch every 5 years.	60%	70%
		Age 19 & Older: Partial dentures are not covered.	You pay 100% of charges.	
DENTURE – IMMEDIATE	Immediate maxillary and mandibular dentures (including routine post-delivery care)	**Age 0 - 18:** Covered for immediate maxillary and mandibular dentures (including routine post- delivery care), but limited to one (1) per arch every 5 years.	60%	70%
		Age 19 & Older: Immediate dentures are not covered.	You pay 100% of charges.	
DENTURE REBASE	Denture rebase is covered when at least six months have passed from the date of insertion not to exceed once every three (3) years. The 12-month waiting period **does not** apply.	**Age 0 - 18:** Covered for complete and partial replacement of resin base material.	40%	50%
		Age 19 & Older: Covered when at least 6 months have passed from date of insertion not to exceed once (1) every 3 years.	40%	50%

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
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.	**Age 0 - 18:** Covered for complete repairs, partial denture base, partial denture cast framework, repair or replace broken clasp, and adding tooth to partial denture, but limited to one (1) per day.	40%	50%
		Age 19 & Older: Repairs are covered no sooner than six (6) months from date of insertion or cementation.	40%	50%
RELINE PROCEDURE	Denture reline of a complete or partial maxillary/ mandibular denture	**Age 0 - 18:** Covered for denture reline of a complete maxillary/mandibular denture after one (1) year following the initial fitting of a new denture. Services are limited to once (1) every 2 years.	40%	50%
		Age 19 & Older: Covered when at least 6 months have passed from date of insertion, not to exceed one (1) reline every 3 years.	40%	50%
REPLACEMENT (BROKEN TEETH)	Replacement of broken teeth part of a removable appliance	**Age 0 - 18:** Covered for denture teeth replacement for broken or missing teeth on complete or partial dentures, but limited to three (3) teeth per day.	40%	50%
		Age 19 & Older: Once (1) per calendar year.	40%	50%
TISSUE CONDITIONING	Tissue conditioning of the maxillary/ mandibular ridges	**Age 0 - 18:** Tissue conditioning is not covered.	You pay 100% of charges	
		Age 19 & Older: Covered prior to impression for reline or denture. Two (2) per arch per calendar year.	40%	50%

SURGICAL SERVICES (MOUTH, FACE, NECK)

Unless otherwise stated, most surgical services are not covered for members age 19 & older.

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
ALVEOLOPLASTY	Surgical preparation of ridge for dentures whether or not in conjunction with extractions	**Age 0 - 18:** Covered. **Prior Authorization is required.**	40%	50%
		Age 19 & Older: Alveoloplasty is not covered.	You pay 100% of charges.	
BIOPSY OF BONY TISSUE	Process of removing bony tissue for histologic evaluation	**Age 0 - 18:** Covered.	Copayment determined on an individual basis.	
		Age 19 & Older: Biopsies of hard tissue are not covered.	You pay 100% of charges.	
BIOPSY OF SOFT TISSUE	Process of removing soft tissue for histologic evaluation	**Age 0 - 18:** Covered.	Copayment determined on an individual basis.	
		Age 19 & Older: Biopsies of soft tissue are not covered.	You pay 100% of charges.	
DEVICE TO AID ERUPTION OF IMPACTED TOOTH	An orthodontic device to guide eruption of an unerupted tooth after surgical procedure	**Age 0 - 18:** Covered, but limited to permanent teeth only, excluding 3rd molars. **Prior Authorization is required.**	40%	50%
		Age 19 & Older: Device(s) to aid in the eruption of impacted teeth is not covered.	You pay 100% of charges.	
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	**Age 0 - 18:** Covered but limited to one (1) per tooth for all primary and permanent teeth. Extractions related to orthodontic services are not covered.	40%	50%
		Age 19 & Older: Covered.	40%	50%

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
EXTRACTIONS - SURGICAL	Surgical extractions and surgical access of an unerupted tooth	**Age 0 - 18:** Covered but limited to one (1) per tooth for all primary and permanent teeth. Extractions related to orthodontic services are not covered. **Prior Authorization is required.**	60%	70%
		Age 19 & Older: Surgical extractions are not covered.	You pay 100% of charges.	
INCISIONS	Surgical incision and drainage of abscess of intraoral soft tissue	**Age 0 - 18:** Covered for surgical incision and drainage of abscess of intraoral soft tissue for all primary and permanent teeth	40%	50%
		Age 19 & Older: Incisions are not covered.	You pay 100% of charges.	
REMOVAL OF CYST OR TUMOR	Removal of benign odontogenic cyst or tumor	**Age 0 - 18:** Covered.	40%	50%
		Age 19 & Older: Removal of cyst(s) or tumor(s) is not covered.	You pay 100% of charges.	
OTHER SURGICAL SERVICES	Excision of hyperplastic tissue or pericoronal gingival but limited to frenectomy, frenotomy, or frenuloplasty	**Age 0 - 18:** Covered.	40%	50%
		Age 19 & Older: Other surgical services are not covered.	You pay 100% of charges.	
OROANTRAL FISTULA CLOSURE	Procedure performed for closure of an opening between the maxillary sinus and oral cavity	**Age 0 - 18:** Covered.	Copayment determined on an individual basis.	
		Age 19 & Older: Oroantral fistula closures are not covered.	You pay 100% of charges.	
RADICAL EXCISION	Removal of benign lesion up to 1.25 cm	**Age 0 - 18:** Covered.	40%	50%
		Age 19 & Older: Radical excisions are not covered.	You pay 100% of charges	

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
SURGICAL ACCESS OF UNERUPTED TOOTH	Surgical exposure of an impacted tooth not intended for extraction	**Age 0 - 18:** Covered, but limited to permanent teeth only, excluding 3rd molars. Prior Authorization is required.	40%	50%
		Age 19 & Older: Surgical access of unerupted teeth is not covered.	You pay 100% of charges.	
TOOTH REIMPLANTATION	Tooth implantation and/or stabilization of an accidentally displaced or evulsed tooth	**Age 0 - 18:** Covered.	40%	50%
		Age 19 & Older: Tooth reimplantation is not covered.	You pay 100% of charges.	

MAXILLOFACIAL PROSTHETICS

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
MAXILLOFACIAL PROSTHETIC DEVICES	Restoration and/or replacement of the stomatognathic (jaws) and craniofacial (facial) structures with prostheses	**Age 0 - 18:** **Prior Authorization is required**	60%	70%
		Age 19 & Older: Maxillofacial prosthetic devices are not covered.	You pay 100% of charges.	

ORTHODONTIC SERVICES (TOOTH ALIGNMENT)

Waiting Periods- The following service waiting period applies to medically necessary orthodontic services for members under age 19 only.

- Unless otherwise stated, you must have been enrolled in a dental plan offered by us for at least 24 consecutive months before coverage for this service category begins.
- 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.
- Orthodontic services are not a covered service for member age 19 & older. Refer to *Chapter 2: Amount You May Owe* for more detail on waiting periods.

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
MEDICALLY NECESSARY ORTHODONTIC TREATMENT	Orthodontic treatment required to repair cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored.	**Age 0 - 18:** Covered for the following services when treatment is required to repair of cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored: •Panoramic and cephalometric X-Rays •Interceptive treatment of the primary or transitionary dentition •Comprehensive treatment of the transitional, adolescent and adult dentition. **Prior Authorization is required.**	Copayment 60% up to Out of Pocket Maximum, refer to *Chapter 2: Amounts You May Owe* for details.	You pay 100% of charges
		Age 19 & Older: Not Covered	You pay 100% of charges.	
NON-MEDICALLY NECESSARY ORTHODONTIC TREATMENT	Orthodontic treatment for the prevention and correction of irregular teeth and/or jaw relationships (including any repair or replacement of orthodontic appliances) and does not qualify as medically necessary.	**Age 0 - 18:** Non-medically necessary Orthodontic Treatments are not covered.	You pay 100% of charges.	
		Age 19 & Older: Non-medically necessary Orthodontic Treatments are not covered.	You pay 100% of charges.	

ANESTHESIA, EMERGENCY, & AFTER HOURS CARE

Service List	Descriptions	Service Limits	Copayment PAR	Copayment NON-PAR
ANESTHESIA	Deep sedation/general anesthesia and intravenous conscious sedation/analgesia	**Age 0 - 18:** Covered for deep sedation/general anesthesia and intravenous conscious sedation/analgesia, but limited to the following: •Covered only for covered dental services •Administered in a hospital setting •Services cannot be safely performed in an office setting due to underlying medical conditions •Services cannot be safely performed in a dental office due to an uncooperative patient, or extensive oral treatment is necessary to prevent dental or medical complications	40%	50%
		Age 19 & Older: Covered when medically necessary for covered oral surgical services.	40%	50%
CONSULTATION	Diagnostic services performed by a dentist other than the requesting dentist	**Age 0 - 18:** Limited to one (1) per day for endodontic, oral and maxillofacial and pediatric dental specialties.	40%	50%
		Age 19 & Older: Consultations are not covered.	You pay 100% of charges.	
HOSPITAL CALL	Diagnostic services performed by a dentist in a hospital setting	**Age 0 - 18:** Covered, one (1) per day.	40%	50%
		Age 19 & Older: Hospital calls are not covered.	You pay 100% of charges.	

Service List	Descriptions	Service Limits	Copayment	
			PAR	NON-PAR
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	Palliative (emergency) treatment of dental pain	**Age 0 - 18:** Limited to one (1) per visit.	40%	50%
		Age 19 & Older: Covered when medically necessary however, payment for emergency dental services may be denied if a Dentist's report does not support the need for immediate attention. Refer to *Chapter 1: Critical Concepts* for more details.	40%	50%
OFFICE CARE (AFTER HOURS)	Office visits that take place after regularly scheduled hours	**Age 0 - 18:** Covered if the dentist has to return to the office for an unscheduled emergency visit after the office has closed for the day.	40%	50%
		Age 19 & Older: Covered on an individual basis.	40%	50%

ENHANCED DENTAL BENEFITS

Members diagnosed with diabetes, coronary artery disease, oral cancer and women who are pregnant will be provided additional and specific support through HMSA's Enhanced Dental Benefits.

Coverage for the following dental-care services are provided for each member who is eligible to receive Enhanced Dental Benefits and has been diagnosed with diabetes, coronary artery disease or who is pregnant:

- Dental cleanings (oral prophylaxis or periodontal maintenance cleanings) once (1) every 3 months.
- Periodontal scaling once (1) for each quadrant every 24 months when this service is necessary and appropriate.
- Members are subjected to eligible plan benefits and applicable waiting periods prior to obtaining Enhanced Dental Benefits.

Coverage for the following dental care services is provided for each member who is eligible to receive Enhanced Dental Benefits and has been diagnosed with oral cancer:

- Dental cleanings (oral prophylaxis or periodontal maintenance cleanings) once (1) every 3 months.
- Fluoride treatment, once (1) every 3 months.
- Pre-diagnostic cancer screening, once (1) every 6 months.

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

DIAGNOSIS	CLEANING OR PERIODONTAL MAINTENANCE VIST EVERY THREE MONTHS	PERIODONTAL SCALING ONCE PER QUADRANT EVERY 24 MONTHS	PREDIAGNOSTIC ORAL CANCER SCREENING EVERY 6 MONTHS	FLUORIDE TREATMENT EVERY 3 MONTHS
DIABETES	✓	✓		
CORONOARY ARTERY DISEASE	✓	✓		
PREGNANCY	✓	✓		
ORAL CANCER*	✓		✓	✓

*Oral cancer benefit available for members who have had a previous diagnosis of oral cancer.

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	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.
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.
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, you are not responsible for those charges.	You pay zero (0)% of charges.
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).	You pay 100% of charges.
LABIAL VENEERS	Labial veneers (resin or porcelain laminate).	You pay 100% of charges.
NITROUS OXIDE	Nitrous oxide is not covered for members age 19 & older.	You pay 100% of charges.
MAXILLOFACIAL PROSTHESIS	Maxillofacial prosthetics (artificial replacement of maxillofacial anatomical parts such as ears, eyes, orbits, nose, or cranium) are not covered for members age 19 & older.	You pay 100% of charges.
PORCELAIN/ CERAMIC OR	Porcelain/ceramic or	You pay 100% of charges.

SERVICE LIST	DESCRIPTIONS	AMOUNT YOU OWE
COMPOSITE RESIN INLAY/ONLAY	composite/resin inlays and onlays is not a benefit.	
PULP CAP (INDIRECT)	Indirect pulp cap is not covered.	You pay 100% of charges.
TEMPORARY BRIDGES	Interim prosthesis that are used over a limited period of time after which they are replaced with a more definitive restoration.	You pay 100% of charges.
TEMPOROMANDIBULAR JOINT DYSFUNCTION	Any service associated with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaws), including dental splints are not covered.	You pay 100% of charges.
WHITENING	External or internal bleaching of teeth is not covered.	You pay 100% of charges.

GENERAL EXCLUSIONS

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

LIST	DESCRIPTION	AMOUNT YOU OWE
APPOINTMENTS	Broken or missed appointments are not covered.	You pay 100% of charges.
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.
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.
CONVENIENT TREATMENTS, SERVICES OR SUPPLIES	Treatments, services or supplies that are prescribed, ordered or recommended primarily for your comfort or convenience or the comfort or convenience of your provider.	You pay 100% of charges.
COSMETIC	Services that are primarily intended to improve your natural appearance but do not restore or materially improve a physical function are not covered. Services that are prescribed for psychological or psychiatric reasons are not covered. You are not covered for complications of recent or past cosmetic surgeries, services or supplies.	You pay 100% of charges.
DENTIST DOESN'T ORDER	Services that are not rendered, supervised, or directed by a Dentist are not covered.	You pay 100% of charges.

LIST	DESCRIPTION	AMOUNT YOU OWE
EFFECTIVE DATE	Services received before the effective dates 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 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.
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.
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.
OCCLUSAL ADJUSTMENT	Revising or altering the functional relationships between upper and lower teeth.	You pay 100% of charges.

LIST	DESCRIPTION	AMOUNT YOU OWE
OCCLUSAL ORTHOTIC DEVICE	Occlusal orthotic device (also known as occlusal splint therapy) is not covered.	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.
PROSTHETIC PRECISION ATTACHMENTS	Prosthetic attachments are two interlocking devices, one that is fixed to an abutment/retainer or crown and the other is integrated into a fixed or removable prosthesis. Prosthetic attachments are not covered.	You pay 100% of charges.
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.
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.
TEMPORARY DENTURES	Interim prostheses that are used over a limited period of time after which they are replaced with a more definitive restoration are not covered.	You pay 100% of charges.
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

4

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

WHO IS ELIGIBLE

If you purchase this coverage from **Healthcare.gov**, you must meet the eligibility criteria used by Healthcare.gov.

If you purchase this coverage directly from HMSA, you must meet **al**l of the following:

- Enrolling during an open enrollment period or qualify for a special enrollment period in accord with federal law.
- You are not incarcerated.
- You meet one of these requirements:
    - You are a resident of the State of Hawaii.
    - You intend to reside in the State of Hawaii.
    - You have entered the State of Hawaii with a job commitment.
    - You are seeking employment in the State of Hawaii.
- Your parent or caretaker resides in Hawaii and you reside with the parent or caretaker. If you meet the above residency standards, you may enroll your ***Dependent*** who lives outside Hawaii in this Plan if you claim that dependent on your tax return.
- You complete, sign and submit an enrollment form that is accepted by us.

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 above criteria have been met shall result in immediate termination of this coverage.

Categories of Coverage

There are different categories of coverage you may hold.

- With single coverage; you are the only one covered.
- With family coverage you and your spouse and/or eligible dependent children have coverage. Each covered family member must be listed on the member's enrollment form or added later as a new dependent.

Please note: If you buy this coverage directly from HMSA, 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

This coverage takes effect and you are eligible to receive benefits on your effective date, provided the following requirements have been met:

- Your initial dues were paid;
- We accepted your enrollment form and provided you written notice of your effective date. By submitting the enrollment form, you also accept and agree to the provisions of our constitution and bylaws now in force and as amended in the future; and
- Your eligibility for coverage under this guide subject to all applicable waiting periods.

What You Should Know about Enrolling Your Child(ren)

In general, you may enroll a child if the Child meets all of these requirements:

- The child is under 26 years of age, and
- The child is your son, daughter, stepson or stepdaughter, your legally adopted child or a child placed with you for adoption, a child for whom you are the court-appointed guardian, or an eligible foster child (defined as an individual who is placed with you by an authorized placement agency or by judgment, decree, or other court order).

In addition, you may enroll children who meet all of the criteria in one of these categories:

- Children with special needs.
- Children who are newborns or adopted.

CHILDREN WHO ARE NEWBORNS OR ADOPTED

You may enroll a newborn or adopted child, effective as of the date listed below, if you comply with requirements described below and enroll the child in accord with our usual enrollment process:

- The birth date of a newborn provided you comply with our usual enrollment process within 31 days of the child's birth.
- The date of adoption, provided you comply with our usual enrollment process within 31 days of the date of adoption
- The birth date of a newborn adopted child provided we receive notice of your intent to adopt the newborn within 31 days of the child's birth date.
- The date the child is placed with you for adoption, provided we receive notice of placement when you assume a legal obligation for total or partial support of the child with anticipation of adoption.

CHILDREN WITH SPECIAL NEEDS

You may enroll your child, if he or she is disabled by providing us with written documentation acceptable to us demonstrating that:

- Your child is incapable of self-sustaining support because of a physical or mental disability.
- Your child's disability existed before the child turned 26 years of age.
- Your child relies primarily on you for support and maintenance as a result of his or her disability.
- Your child is enrolled with us under this coverage or another HMSA coverage and has had continuous healthcare coverage with us since before the child's 26th birthday.

You must provide this documentation to us within 31 days of the child's 26th birthday and subsequently at our request but not more frequently than annually

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

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

Any amount otherwise payable to the Member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian. If you would like more information about how we handle QMCSOs, call HMSA's Customer Service. Our phone number is listed on the back cover of this guide.

COVERAGE TERMINATION

If you purchased this coverage from Healthcare.gov, you may end your coverage at any time by notifying Healthcare.gov.

If you purchased this coverage directly from HMSA, 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 if you purchased this coverage directly from us, 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, or fail to make payments to us when due.

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

End of Month Termination

Your coverage will end at the end of the month in which any of these take place:

- You choose to end this coverage. In this case, you must provide us written notice of your intent to terminate 30 days before the termination date.
- You fail to make payments to us when due.

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.
- For the member, upon termination of this Agreement. If the member's coverage ends, coverage for all other enrolled family members will also end.
- For the member's spouse, upon the dissolution of marriage to the Member. You must inform us, in writing, of the dissolution of the marriage.
- For the member's child, when the child fails to meet the criteria outlined earlier in this chapter under who is eligible. You must inform us, in writing, if a child no longer meets the eligibility requirements. You must notify us on or before the first day of the month following the month the child no longer meets the requirements. For example, if your child turns 19 on June 1; you would need to notify us by July 1. If you fail to inform us that your child is no longer eligible, and we make payments for services on his or her behalf, you must reimburse us for the amount we paid.

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

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

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 ends.
- You agree to reimburse us for any payments we made under this coverage.
- We retain our full legal rights, including but not limited to, the right to initiate a civil action based on fraud, concealment or misrepresentation.
- Engagement in repeated disruptive or threatening behavior or the infliction of bodily harm to others in the provider's office.

Rejoining Individual Dental Plans
If you cancel your coverage, you cannot re-enroll in an Individual Dental Plan for 24 months unless you were enrolled within the past 60 days in another HMSA dental plan which includes crowns, bridges and dentures as covered. You must also meet the requirements listed in the section eligibility for coverage above. Your enrollment form is subject to approval by HMSA. If we accept your enrollment form and dues, we will give you a new membership card and a new effective date. You and each of your dependents must again meet any applicable Individual Dental Plan waiting periods based on a new effective date.

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Chapter 5: FILING CLAIMS

5

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 non-participating Dentists in the state of Hawaii file claims for you, there are limited circumstances when you will be required to file a claim. If you have any questions after reading this chapter, please contact your personnel department, or call us. Our telephone numbers appear on the back cover of this guide.

CLAIM SUBMISSION

Notice of Claim

1. Submit your claim no later than 90 days from the last day on which you received the services. Complete a separate claim for each covered family member and each provider. Claims received by us more than one year after the last day on which you received services are not eligible for payment.
2. Enclose a signed letter with your claim that includes all of the following information:
   - A phone number where you can be reached during the day.
   - The subscriber number that appears on your member card (the card issued to you by us that you present to Your Dentist at the time you receive services).
   - Information about other coverage you may have (if applicable). For information about other coverage, see *Chapter 7: Other Party Responsibility.*
3. Enclose an itemized statement from Your Dentist (often called a provider statement). It is helpful to us if the provider statement is in English, or accompanied by an English translation on the service provider's stationary. The provider statement must include all of the following information:
   - Provider's full name and address.
   - Patient's name.
   - Date(s) you received service(s).
   - Date of the Injury or beginning of illness or injury.
   - The charge for each service in U.S. currency.
   - Description of each service.
   - Diagnosis or type of illness or injury.
   - Where you received the service (office, outpatient, hospital, etc.).
   - A claim without a provider statement cannot be paid. Statements you prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.
4. Send your claim to the address listed on the back cover of this guide.

Explanation of Benefits (EOB)
An Explanation of Benefits (EOB) is a statement that explains how we processed a claim based on the services performed, the actual charge, and 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 notify you 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 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

6

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. To be considered, 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) 538-8966

Mailing Address for Appeals:

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

Arbitration:

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

EXPEDITED APPEALS REQUIREMENTS

To request an expedited appeal, please call us at the phone numbers provided above. 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.

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 regarding 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 one of the following:

- Any person you authorize to act on your behalf provided you follow our procedures which include filing an authorization 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.
- 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 an 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 prior authorization or a service or supply, it is the date of our denial of coverage for the service or supply.
- The subscribers 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 your request and supporting documents for your records. They will not be returned to you.

INFORMATION AVAILABLE FROM US

If your appeal relates to a claim for benefits or a request for prior authorization, 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 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

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.

Unless You qualify for expedited external review of Our appeal decision, before requesting review, you must exhaust HMSA's internal appeals process before requesting external review, 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 or dental records relevant to the subject of the IRO review. For release of medical records copies of the authorization form are available from HMSA by calling (808) 948-5090, or toll free at (800) 462-2085. Copies of the authorization form to release dental records are available from HMSA by calling (808) 948-6440 or toll free at 1 (8000 792-4672. Copies are also available on HMSA.com
- A complete and signed conflict of interest form. If you are appealing a medical benefit, the conflict of interest form is available from HMSA by calling (808) 948-5090, or toll free at (800) 462-2085 or on HMSA.com. If you are appealing dental benefits the conflict of interest form is available from HMSA by calling (808) 948-6440, or toll free at 1 (800) 792-4672. Copies are also available 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 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
- 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 dentist 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 provides the following:

- 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 from 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 the start of arbitration, both parties (you and we) must agree on designation of 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 accordance 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 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' 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.

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Chapter 7: OTHER PARTY RESPONSIBILITY

7

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 sponsored insurance, non-group sponsored 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 must 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 when the combination of the primary Plan's payment and this Plan's payment exceed the Eligible Charge. 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 of Benefit 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. The following are four common coordination rules:

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

Dependent Child Coordination of Benefit Rules

The following are coordination rules that apply to Dependent children (note that if none of the following rules apply, the parent's coverage with the earliest continuous Effective Date pays first):

- For a child who is covered by both parents who are not separated or divorced and have joint custody, the coverage of the parent whose birthday occurs first in a Calendar Year pays first.
- For a child who is covered by separated or divorced parents and a court decree provides which parent has health insurance responsibility, the appointed parent's coverage pays first.
- For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, and then the coverage of the parent with custody pays first. The payment order for this Dependent child is as follows:

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

AUTOMOBILE ACCIDENTS

If your injuries or Illness are due to a motor vehicle accident or other event for which we believe motor vehicle insurance coverage reasonably appears available under Hawaii Revised Statutes Chapter 431, Article 10C, or any other motor vehicle insurance coverage, then that motor vehicle coverage will pay before this coverage. You are responsible for any cost sharing payments required under such motor vehicle insurance coverage. We do not cover such cost sharing payments. Payment under this coverage for an Injury covered by motor vehicle insurance is subject to the rules set forth below.

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

Guidelines

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

Worker's Compensation or Motor Vehicle Insurance

If you have dental coverage under Worker's Compensation or motor vehicle insurance for illness or injury, please note the following:

- If you have or may have coverage under Worker's Compensation insurance, such coverage will apply instead of the coverage under this guide. Dental expenses arising from illness or injury covered under Worker's Compensation insurance are excluded from coverage under this guide.
- If you are or may be entitled to dental benefits from your automobile coverage, you must exhaust those benefits first, before receiving benefits from us.

THIRD PARTY LIABILITY

Third party liability grants us the right to be reimbursed if you are injured or become ill and either of the following is true:

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

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

1. Timely Notice and Proof Requirements
   You must give us timely notice in writing if any of the following are true:
   - You have any knowledge of any potential claim against any third party or other source of recovery in connection with the illness or injury.
   - There is any written claim or demand (including legal proceeding) against any third party or against other source of recovery in connection with the illness or injury.
   - There is any recovery of damages (including any settlement, judgment, award, insurance proceeds, or other payment) against any third party or other source of recovery in connection with the illness or injury. To give timely notice, your notice must be no later than 30 calendar days after the occurrence of each of the events stated above.
2. You must promptly sign and deliver to Us all liens, assignments, and other documents we deem necessary to secure our rights to recover payments, and you hereby authorize and direct any person or entity making or receiving any payment on account of such illness or injury to pay to us so much of such payment as necessary to discharge Your reimbursement obligations described above.
3. You must promptly provide us any and all information reasonably related to our investigation of our liability for coverage and our determination of our rights to recover payments. We may ask you to complete an Injury/Illness report form, and provide us dental records and other relevant information.
4. You must not release, extinguish, or otherwise impair our rights to recover our payments, without our express written consent.
5. You must cooperate in protecting our rights under these rules. This includes giving notice of our lien as part of any written claim or demand made against any third party or other source of recovery in connection with the illness or injury.
6. Notice Required.

Any written notice required by these rules must be sent to:

HMSA
Attn: 8 CA/Other Party Liability
P.O. Box 860
Honolulu, Hawaii 96808-0860

Our Rights

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

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

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

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

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

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

To the extent that we are not reimbursed for the total we pay or have paid related to your illness or injury, we have a right of subrogation (substituting us to your rights of recovery) for all causes of action and all rights of recovery you have against any third party or other source of recovery in connection with the illness or injury.

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

For any payment made by us under these rules, you are still responsible for your copayments, deductibles, timeliness in submission of claims, and other obligations under this guide. Nothing in this Third Party Liability section shall limit our ability to coordinate benefits as described elsewhere in this chapter.

Chapter 8: GENERAL PROVISIONS

8

This chapter provides general provisions applicable to your plan.

PEDIATRIC DENTAL REQUIREMENTS

This plan includes pediatric dental coverage, an *essential health benefit*, as required under the federal *Patient Protection and Affordability Care Act (PPACA)*.

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 you.

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 you 30 days prior written notice 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 is 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

Dental Network Providers are not agents or employees of ours, nor are we (or any of our employees) an employee or agent of any Dental Network Provider. We are not an insurer against nor liable for the negligence or other wrongful act or omission of any Dental Network Provider or his or her employee or other person or for any act or omission of anyone covered by this plan.

CIRCUMSTANCES BEYOND OUR CONTROL

In the event of a major disaster, epidemic, war, insurrection or other circumstances beyond our control, we will make a good faith effort to provide or arrange for covered services. However, we will not be responsible for any delay or failure in providing services due to lack available facilities or personnel.

NOTICE ADDRESS

Any written notice to us required by this guide should be sent to:

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

Any notice from us to you will be acceptable when addressed to you at your address as it appears in our records.

MEDICAID ENROLLMENT

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

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

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.

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Chapter 9: DEFINED TERMS

9

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

Agreement - The legal document between you and us that contains all of the following:

- This guide.
- Any riders and/or amendments.
- The enrollment form submitted to us by you.
- The Agreement that exists between us and 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.

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

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

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

Dentist - A doctor of dental medicine (D.M.D.) or doctor of dental surgery (D.D.S.). In addition, the Dentist must be both of the following:

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

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

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

Eligible Charge - The amount we use to determine our payment and the amount you owe for a service that is covered according to the provisions of the Agreement between us and the Dental Network Provider. We determine Eligible Charge according to the provisions of the Agreement between us and the Dental Network Provider and based on the following:

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

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

Essential Health Benefits - PPACA ensures health plans offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral (dental) and vision care.

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 - This document and any applicable amendment which describes the dental coverage you have under this Plan.

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

HMSA Directory of Participating Providers- A complete list of HMSA participating providers.

Healthcare.gov - Federal online health insurance marketplace managed by the U.S. Centers for Medicare and Medicaid Services**.**

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.

Medically Necessary Orthodontic Treatment - Orthodontic treatment required to repair cleft lip and palate or other severe facial birth defects or injury for which the function of speech, swallowing, or chewing shall be restored.

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

Non- Medically Necessary Orthodontic Treatment - Orthodontic treatment for the prevention and correction of irregular teeth and/or jaw relationships (including any repair or replacement of orthodontic appliances) and does not qualify as medically necessary.

Non-Participating Provider - A dental provider that is not contracted with us nor has any contracts with our affiliated networks.

Out of Pocket Maximum - The maximum amount you will pay for covered dental services under this plan.

Participating Provider - A dental provider that is participating with us or participating in one of our affiliated networks.

Patient Protection and Affordable Care Act also known as the Affordable Care Act or ACA – is the health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The law includes numerous health related provisions for insurance carriers to increase the quality and control healthcare costs for individuals.

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 enrollment form of this Payment Determination Criteria are contained in the Patient's Bill of Rights and Responsibilities, Hawaii

Revised Statutes § 432E-1.4. The current language of this statutory provision will be provided upon request. Request should be submitted to HMSA's Customer Service Department.

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

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

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

You may ask your physician to contact us to determine whether the services you need meets our payment determination criteria or are excluded from coverage before you receive the care.

Plan - The specific dental coverage described in this guide and which is offered to you and which you pay premium toward.

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

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

You, Your - You and your enrolled spouse and/or child(ren) who are eligible for coverage under this plan.

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HMSA CENTERS

Convenient evening and Saturday hours:

HMSA Center @ Honolulu
818 Keeaumoku St.
Monday through Friday, 8 a.m.- 6 p.m. | Saturday, 9 a.m.- 2 p.m.

HMSA Center @ Pearl City
Pearl City Gateway | 1132 Kuala St., Suite 400
Monday through Friday, 9 a.m.- 7 p.m. | Saturday, 9 a.m.- 2 p.m.

HMSA Center @ Hilo
Waiakea Center | 303A E. Makaala St.
Monday through Friday, 9 a.m.- 7 p.m. | Saturday, 9 a.m.- 2 p.m.

OFFICES

Visit your local HMSA office Monday through Friday, 8 a.m. - 4 p.m.:

Kailua-Kona, Hawaii Island | 75-1029 Henry St., Suite 301
Kahului, Maui | 33 Lono Ave., Suite 350
Lihue, Kauai | 4366 Kukui Grove St., Suite 103

PHONE

948-6440 on Oahu

If you're calling from the U.S. Mainland, please call 1 (800) 792-4672. If you need to call a local Hawaii telephone number from the Mainland, the area code is 808.

MAIL

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

HMSA's mission is to provide the people of Hawaii access to a sustainable, quality health care system that improves the overall health and well-being of our state.

hmsa®

hmsa.com/dental

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