

HMSA's Individual Dental Plus Plan – PPP

Guide to Benefits January 2012



W

e are happy to have you in Hawai'i Medical Service Association's PPP Individual Dental Plus Plan. We have received and accepted your enrollment form and initial payment of dues. You are eligible for the PPP Individual Dental Plus Plan coverage beginning on the effective date shown on your member card.

To be sure that the PPP Individual Dental Plus Plan meets your needs, you have 10 days to read this Guide To Benefits and decide if you want to keep this coverage. We will give you a full refund of your dues if, during this 10-day period, you write to tell us that you do not want this coverage. Of course, you will not be eligible for any benefits if we refund your dues.

We hope that you will be satisfied with your PPP Individual Dental Plus Plan coverage and welcome you as a Hawai'i Medical Service Association (HMSA) member.

Robert P. Hiam
President and Chief Executive Officer
Hawai'i Medical Service Association

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Chapter 1:

Critical Concepts

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

USING YOUR GUIDE TO BENEFITS

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

Review Entire Document

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

Terminology

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

- If the term is used frequently in two or more chapters, it is defined in *0 Defined Terms* and is formatted in bold and italics.
- If the term is addressed in one chapter only, it is defined in the chapter where it appears.

How To Contact Us

If You have any questions about Your coverage, You can refer to this Guide or call Us. Telephone numbers appear on the back cover of this Guide. If Your question is regarding a dispute, see page 29.

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 *page 8*.
- 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 *page 28*.

COVERED SERVICE CRITERIA

To determine whether or not a specific service is covered under Your Plan and eligible for payment by Us, all of the following criteria must be met:

- The service is listed as covered in *Chapter 3: Services & Copayments*. Please note: Even if a service is covered, You may be responsible for a portion of costs. For more information, see *Chapter 2: Amounts You May Owe*.
- The service is not specifically excluded. Even if a service is not specifically listed in *Chapter 3* as an exclusion, it is not considered covered unless the care meets all of the criteria listed in this section.
- The service meets *Payment Determination Criteria* (see *0 Defined Terms* on *page 45*). You may ask Your provider to contact Us to determine if the care You seek meets Payment Determination Criteria. We should be contacted before You receive the care in question.
- The service is consistent with Our dental policies. Call Us if You have questions.
- The service is ordered by and received from or arranged by a Dentist. In general, You should receive services from a Participating Dentist whenever possible. For more information about Participating Dentists, see *page 3*.
- Another party does not have an obligation to pay. If another party is responsible, payment under this coverage may be affected. See *Chapter 7*.
- The service is not subject to a waiting period.
- The service has not exceeded a stated service limitation. See *Chapter 3: Services & Copayments*.

CHOOSING A DENTIST

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

Participating Dentist Facts	Nonparticipating Dentist Facts
We have contracts with Participating Dentists. We recognize and approve Participating Dentists. HMSA also contracts with a third party to provide dental benefits through their network.	We do not contract with nonparticipating Dentists.
We credential Participating Dentists. We look at many factors including licensure, professional history, and type of practice.	We do not credential nonparticipating Dentists.
They agree to comply with Our payment policies.	They do not agree to comply with Our payment policies.
They agree to file claims for Covered Services on Your behalf.	You are responsible for ensuring that claims are filed. If the Dentist does not file for You, You must file yourself. See page 27.
They agree to accept Our <i>Eligible Charge</i> as payment in full for Covered Services, (with the exception of ★High Cost Procedures). For information related to ★High Cost Procedures, see page 5 under Amounts Exceeding <i>Eligible Charge</i> . 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 <i>Eligible Charge</i> 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.

Amounts You May Owe

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

COPAYMENT

A Copayment is an amount You owe for most Covered Services. A Copayment is a fixed percentage of the Eligible Charge. Copayment amounts appear in *Chapter 3: Services & Copayments*.

AMOUNTS EXCEEDING ELIGIBLE CHARGE

In certain circumstances, You may owe the difference between the amount billed by Your Dentist and the *Eligible Charge* (for a definition of Eligible Charge, see *page 43*). This applies if You receive services from a nonparticipating Dentist or choose a ★*High Cost Procedure*. With ★*High Cost Procedures*, two treatment options exist, but one is more cost effective than the other. You have a choice to receive the ★*High Cost Procedure* or the more cost effective one. However, if You choose the ★*High Cost Procedure*, You are responsible for both of the following amounts:

- The Copayment of the most cost effective procedure and
- Any difference between the amount the Dentist bills for the ★*High Cost Procedure* and the Eligible Charge for the more cost effective procedure.

AMOUNTS EXCEEDING CALENDAR YEAR MAXIMUM

The Calendar Year Maximum is the maximum dollar amount We will pay toward Covered Services during a Calendar Year. The Calendar Year Maximum under this Plan is \$1000.00 per person.

CALENDAR YEAR ROLLOVER

A Rollover is a portion of Your unused Calendar Year Maximum that may be carried over to the next calendar year, thereby increasing the dollar amount available to pay for Covered Services during the calendar year. You can accumulate up to \$350 in a calendar year which will be added to your Calendar Year Maximum no later than March 15th of the following year, provided the following conditions are met:

- You are a member of the plan on the last day of the calendar year;

- You receive at least one (1) Covered Service during the calendar year while covered under this Plan;
- Your total claims paid during the calendar year does not exceed \$500; and
- The sum of the unused Calendar Year Rollover benefits from prior years does not exceed \$1,000.

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

Calendar Year	One (1)	Two (2)	Three (3)	Four (4)	Five (5)
Calendar Year Maximum	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000
Covered Service Received	Yes	Yes	Yes	Yes	Yes
Total Claims Paid during Calendar Year	\$275	\$880	\$200	\$200	\$400
Calendar Year Rollover (based on prior year qualification)		\$350	\$0	\$350	*\$300
Accumulated Rollover Amount		\$350	\$350	\$700	\$1,000
Calendar Year Maximum + Accumulated Rollover Amount	\$1,000	\$1,350	\$1,350	\$1,700	\$2,000

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

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

1. Your total claims paid during a calendar year exceed \$500, or
2. No claims for Covered Services are incurred during a calendar year.

If either of the above instances occurs, there will be no additional Calendar Year Rollover for that calendar year.

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

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

- Coverage begins 11/1, and
- One Covered Service claim for \$100 occurs 12/15, and
- The claim is filed and approved prior to 3/1 of the following year, and
- Premiums are paid and up-to-date; therefore
- A \$350 Calendar Year Rollover will be available for use in the following year.

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

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

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

5. Non-covered services; or
6. Orthodontic benefits.

WHEN YOUR CALENDAR YEAR ROLLOVER BENEFIT ENDS

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

AMOUNTS EXCEEDING A SERVICE LIMIT

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

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

Charges For Services Not Covered

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

Waiting Periods

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

Services & Copayments

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

ABOUT THIS CHAPTER

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

NON-ASSIGNMENT

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

SERVICE TABLES & SERVICE CATEGORIES

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

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

Column 1: Services List	Column 2: Descriptions and Service Limits	Column 3: Copayment
Alphabetical listing of services (both covered and noncovered).	<ul style="list-style-type: none"> ▪ Descriptions of services (both covered and noncovered services). ▪ Applicable <i>Service Limits</i>. 	<p>A copayment is an amount You owe for most Covered Services.</p> <p>You may be responsible for charges in addition to the Copayment. See <i>page 5</i> 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).</p>

DIAGNOSTIC & PREVENTIVE SERVICES

Service List	Descriptions and Service Limits	Copayment (<i>also see pgs. 5-7</i>)
CLEANING	Dental cleaning and polishing (otherwise known as prophylaxis). <i>Service Limit:</i> Two (2) per Calendar Year.	Copayment 0%
EXAM	Clinical oral exams. <i>Service Limit:</i> Two (2) per Calendar Year.	Copayment 0%
FLUORIDE	Topical fluoride treatments. <i>Service Limit:</i> You must be age 18 or younger. Two (2) per Calendar Year.	Copayment 0%
PULP VITALITY TESTS	Pulp vitality tests. <i>Service Limit:</i> One (1) per Calendar Year.	Copayment 0%
SEALANTS	Sealant applications for permanent molars. <i>Service Limit:</i> You must be age 16 or younger. Once per molar in a lifetime Considered a basic service.	Copayment 20%
SPACERS	Passive appliances. <i>Service Limit:</i> You must be age 13 or younger. One (1) per arch per lifetime. Recementation once per Calendar Year. Considered a basic service.	Copayment 20%
X-RAYS	Radiographs and other diagnostic imaging. <i>Service Limit:</i> <ul style="list-style-type: none"> ▪ One (1) set of bitewings per Calendar Year ; and ▪ One (1) full-mouth x-ray every three (3) years, or One (1) Panoramic x-ray every three (3) years. 	Copayment 0%
PERIAPICAL X-RAYS	<ul style="list-style-type: none"> ▪ Periapical x-rays: <i>Service Limit:</i> As needed. Considered basic service.	Copayment 20%

RESTORATIVE SERVICES (FILLINGS & CROWNS)

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

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

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
ADDITIONAL CROWN PROCEDURE	Additional procedures to construct new crown under existing partial denture framework.	Copayment 20%
CORE BUILDUP	Core buildup, including pins. Cast or prefabricated post and core combined with core buildup are not paid separately. Limited to once every five (5) years.	Copayment 20%
FILLINGS	Amalgam and resin-based composite restorations including polishing. <i>Service Limit:</i> No sooner than one (1) restoration per tooth surface every twelve months. Resin-based composite fillings for teeth other than anterior teeth or single, stand-alone, facial surface of bicuspid 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 on page 5. Age limit does not apply.	Copayment 20%
PORCELAIN/CERAMIC, OR COMPOSITE RESIN INLAY/ONLAY	Porcelain/ceramic or composite/resin inlays and onlays. <i>Service Limit:</i> This restoration is considered a ★High Cost Procedure, additional charges apply as explained on page 5.	Copayment 50%
LABIAL VENEER	Labial veneer (resin or porcelain laminate). <i>Service Limit:</i> For anterior teeth constructed in the laboratory. Subject to review.	Copayment 50%
METAL CROWNS	Crowns made of high noble metal, noble metal, predominantly base metal and titanium.	Copayment 50%
METAL INLAY/ONLAY	Metallic inlays and onlays.	Copayment 50%
PIN RETENTION	Pin retention in addition to restoration. <i>Service Limit:</i> Up to two (2) pins per tooth done on the same day.	Copayment 20%

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
PORCELAIN CROWNS	Porcelain/ceramic substrate or porcelain fused to metal crowns. <i>Service Limit:</i> ★High Cost Procedure. If you choose this type of restoration for molar teeth, additional charges apply as explained on page 5.	Copayment 50%
POST AND CORE	Post and core (cast or prefabricated) in addition to crown. Limited to once every five (5) years.	Copayment 20%
PREFABRICATED CROWNS	Crowns made of prefabricated stainless steel or resin. Age limit does not apply. The 12 month waiting period does not apply.	Copayment 20%
RECEMENTATION	Recementation of an inlay, onlay, crown, cast or prefabricated post and core is covered after six (6) months of the initial insertion or cementation. <i>Service Limit:</i> Two recementations within a five year period. Twelve-month waiting period between recementations.	Copayment 20%
RESIN CROWNS	Crowns made of resin, resin with high noble metal, noble metal, or predominantly base metal. <i>Service Limit:</i> ★High Cost Procedure. If you choose this type of restoration for molar teeth, additional charges apply. See page 5.	Copayment 50%
RESIN-BASED COMPOSITE CROWNS	Resin-based composite restoration, anterior, chairside. Age limit does not apply. <i>Service Limit:</i> This restoration is considered a ★High Cost Procedure, additional charges apply as explained on page 5. The 12 month waiting period does not apply.	Copayment 20%
TEMPORARY CROWNS	Temporary crowns are not covered.	You pay 100% of charges.

ENDODONTIC SERVICES (TOOTH ROOTS)

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
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. <i>Service Limit:</i> One (1) per permanent tooth in a lifetime.	Copayment 20%
ENDODONTIC RETREATMENT	Retreatment of previous root canal therapy. <i>Service Limit:</i> One (1) retreatment per tooth per lifetime.	Copayment 20%
HEMISECTION	Hemisection includes root removal (but not root canal therapy).	Copayment 20%
PULP CAP (DIRECT)	Direct pulp cap, not to include the final restoration. <i>Service Limit:</i> One (1) per tooth in a lifetime.	Copayment 20%
PULP CAP (INDIRECT)	Indirect pulp cap is not covered.	You pay 100% of charges.
PULPOTOMY (THERAPEUTIC)	Therapeutic pulpotomy not to include the final restoration. <i>Service Limit:</i> One (1) per tooth in a lifetime.	Copayment 20%
RUBBER DAM	Surgical procedure to isolate tooth with a rubber dam.	Copayment 20%

PERIODONTIC SERVICES (GUMS & JAW)

Service Limit: You must be age 18 or older.

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
AUGMENTATION OF GUM RIDGE	Gum ridge augmentation is not covered.	You pay 100% of charges.
CHEMOTHERAPY AGENTS	Localized delivery of chemotherapeutic agents into periodontal pockets.	You pay 100% of charges.
CROWN LENGTHENING	Clinical crown lengthening of hard tissue on teeth that have been fractured or have extensive caries. <i>Service Limit:</i> You must be age 18 or older.	Copayment 20%
GINGIVAL FLAP	Gingival flap procedure (which includes root planing). <i>Service Limit:</i> You must be age 18 or older. No sooner than once every three (3) years.	Copayment 20%
GINGIVECTOMY OR GINGIVOPLASTY	Gingivectomy or gingivoplasty. <i>Service Limit:</i> You must be age 18 and older. No sooner than once every three (3) years.	Copayment 20%
GRAFT PROCEDURE	Soft tissue graft procedure (including donor site surgery) for correction of rapidly receding gingiva. <i>Service Limit:</i> You must be age 18 or older. Limited to once per tooth, per lifetime.	Copayment 20%
GUIDED TISSUE REGENERATION	Guided tissue regeneration (treatment that encourages regeneration of lost periodontal structures). <i>Service Limit:</i> Once per site every three (3) years.	Copayment 20%
OSSEOUS SURGERY	Osseous surgery (to include flap entry and closure). <i>Service Limit:</i> You must be age 18 or older. No sooner than once every three (3) years.	Copayment 20%
PERIODONTAL MAINTENANCE	Periodontal maintenance. <i>Service Limit:</i> Available if you are age 18 or older, and limited to twice per calendar year.	Copayment 20%
SCALING AND ROOT PLANING	Scaling and root planing. <i>Service Limit:</i> Once every two (2) years.	Copayment 20%
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.

DENTURES (ARTIFICIAL TEETH)

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

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
ADJUSTMENTS	Denture adjustments are covered when at least six (6) months have passed from the date of insertion not to exceed two per Calendar Year. The 12-month waiting period does not apply.	Copayment 20%
DENTURE – COMPLETE	Complete and immediate maxillary and mandibular dentures (including routine post-delivery care).	Copayment 50%
DENTURE – PARTIAL	Maxillary or mandibular partial denture resin base, framework with resin denture bases, flexible base, or removable unilateral partial denture made of one piece cast metal (including routine post delivery care and any conventional clasps, rests and teeth; and six-month post insertion care and adjustments.	Copayment 50%
DENTURE REBASE	Denture rebase is covered when at least six months have passed from the date of insertion not to exceed once every three (3) years. The 12-month waiting period does not apply.	Copayment 20%
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. <i>Service Limit:</i> Repairs are covered no sooner than six months from the date of insertion or cementation . The 12-month waiting period does not apply.	Copayment 20%
RELINE PROCEDURES	Denture reline of a complete maxillary/ mandibular denture. <i>Service Limit:</i> Reline procedures are covered when at least six months have passed from the date of insertion not to exceed one reline every three (3) years. The 12-month waiting period does not apply.	Copayment 20%
TEMPORARY DENTURES	Interim prostheses that are used over a limited period of time after which they are replaced with a more definitive restoration are not covered.	You pay 100% of charges.
TISSUE CONDITIONING	Tissue conditioning of the maxillary/ mandibular. <i>Service Limit:</i> Twice per Calendar Year. The 12-month waiting period does not apply.	Copayment 20%

BRIDGES (MISSING TEETH REPLACEMENT)

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

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
CROWNS - RESIN/ PORCELAIN	Crowns made of indirect resin-based composite, resin with high noble metal, porcelain fused to metal, resin with predominantly base metal, and resin with noble metal. Service Limit: Coverage for these procedures is available no more than once every five (5) years. <i>Service Limit:</i> ★High Cost Procedure. If you choose this type of crown for molar teeth, additional charges apply as explained on page 5.	Copayment 50%
CROWNS - METAL	Crowns made of full or ¾ cast high noble metal, predominantly base metal, cast noble metal, or titanium.	Copayment 50%
PORCELAIN/ CERAMIC OR COMPOSITE RESIN INLAY/ONLAY	Porcelain/ceramic or composite/resin inlays and onlays. <i>Service Limit:</i> This restoration is considered a ★High Cost Procedure, additional charges apply as explained on page 5.	Copayment 50%
METAL INLAY/ONLAY	Metallic inlays and onlays.	Copayment 50%
PONTICS - RESIN/ PORCELAIN	Indirect resin-based composite, porcelain fused to metal, resin with high noble metal, resin with noble metal, and resin with predominantly base metal pontics. <i>Service Limit:</i> ★High Cost Procedure. If you choose this type of pontic for molar teeth, additional charges apply as explained on page 5.	Copayment 50%
PONTICS - METAL	Cast high noble metal and metal pontics.	Copayment 50%
PROSTHETIC PRECISION ATTACHMENTS	Prosthetic attachments are two interlocking devices, one that is fixed to an abutment/retainer or crown and the other is integrated into a fixed or removable prosthesis. Prosthetic attachments are not covered.	You pay 100% of charges.
RETAINERS	Cast metal for resin bonded fixed prosthesis.	Copayment 50%
RECEMENTATION	Recementation of fixed partial dentures is covered after six (6) months of the initial insertion or cementation of the fixed partial denture. <i>Service Limit:</i> Two recementations per fixed partial denture within a five year period. Twelve-month waiting period between recementations.	Copayment 20%

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
TEMPORARY BRIDGES	Interim prosthesis that are used over a limited period of time after which they are replaced with a more definitive restoration.	You pay 100% of charges.
POST AND CORE	Post and core in addition to fixed partial denture retainer indirectly fabricated and prefabricated. Limited to once every five (5) years. The 12 month waiting period does not apply.	Copayment 20%
CORE BUILD UP	Core build up for retainer, including any pins. Limited to once every five (5) years. The 12 month waiting period does not apply.	Copayment 20%

SURGICAL SERVICES (MOUTH, FACE, NECK)

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
ALVEOLOPLASTY	Surgical preparation of ridge for dentures whether or not in conjunction with extractions	Copayment 20%
EXCISION OF BONE TISSUE	Removal of lateral exostosis (maxilla or mandible).	Copayment 20%
EXTRACTIONS	Surgical extractions include biopsy of hard and soft tissue (bone, tooth) and surgical access of an unerupted tooth. Nonsurgical extractions include extraction of coronal remnants, deciduous tooth, erupted tooth or exposed root (elevation and/or forceps removal). Both include local anesthesia, suturing (if needed), and routine post-operative care.	Copayment 20%
IMPLANTS	Implant body, surgical placement of implant, removal of implant and maintenance procedures are not covered. The crown for the implant is covered as an alternate service (either a fixed partial denture pontic or a removable partial denture). This service is considered a *High Cost Procedure and additional charges apply as explained on page 5. Age, frequency and service limitations of the alternate service apply.	You pay 100% of charges.
INCISIONS	Surgical incision and drainage of abscess of intraoral soft tissue.	Copayment 20%
OCCLUSAL ADJUSTMENT	Revising or altering the functional relationships between upper and lower teeth.	You pay 100% of charges.
OCCLUSAL ORTHOTIC DEVICE	Occlusal orthotic device (also known as occlusal splint therapy) is not covered.	You pay 100% of charges.
REMOVAL OF CYST OR TUMOR	Removal of benign odontogenic cyst or tumor.	Copayment 20%
REPAIR	Excision of hyperplastic tissue or pericoronal gingival. Frenectomy, frenotomy, or frenuloplasty.	Copayment 20%

ORTHODONTIC SERVICES (TOOTH ALIGNMENT)

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
TREATMENT	Orthodontic treatment (including any repair or replacement of orthodontic appliances) is not covered.	You pay 100% of charges.

ANESTHESIA, EMERGENCY, & AFTER HOURS CARE

Service List	Descriptions and Service Limits	Copayment (also see pgs. 5-7)
ANESTHESIA	Deep sedation/general anesthesia and intravenous conscious sedation/analgesia (but not nitrous oxide).	Copayment 20%
PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	<p>Palliative (emergency) treatment of dental pain.</p> <p>Service Limit: The emergency treatment is for symptoms of sufficient severity that a layperson could reasonably expect, in the absence of dental treatment, to result in placing the member's health or condition in jeopardy.</p> <p>Payment for emergency dental services may be denied if a Dentist's report does not support the need for immediate attention. Please also see Chapter 1: Critical Concepts under Choosing A Dentist</p>	Copayment 20%
OFFICE CARE (AFTER HOURS)	Office visits that take place after regularly scheduled hours.	Copayment 20%

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.
INCIDENTAL PROCEDURES	Incidental services or procedures that are incurred during the normal course of providing care such as, but not limited to, infection control, etc., are not covered however, if such services are billed separately, the Member is not responsible for those charges.	You pay Zero (0)% of charges.
NITROUS OXIDE	Nitrous oxide is not covered.	You pay 100% of charges.
MAXILLOFACIAL PROSTHESIS	Maxillofacial prosthetics (artificial replacement of maxillofacial anatomical parts such as ears, eyes, orbits, nose, or cranium) are not covered.	You pay 100% of charges.
TEMPOROMANDIBULAR JOINT DYSFUNCTION	Any service associated with the diagnosis or treatment of temporomandibular joint problems or malocclusion (misalignment of teeth or jaws), including dental splints are not covered.	You pay 100% of charges.
WHITENING	External or internal bleaching of teeth is not covered	You pay 100% of charges.

GENERAL EXCLUSIONS

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

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

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

Chapter 4:

Eligibility & Enrollment

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

WHO IS ELIGIBLE

When You are Eligible for Coverage

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

- You currently are enrolled in an HMSA Medical Plan;
- You complete, sign and submit an enrollment form that is accepted by Us;
- You are a Legal Resident in the state of Hawaii; and
- You pay Your premium in advance.

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

Categories of Coverage

- Single coverage; You are the only one covered.
- Two-party coverage; You and one Dependent are covered. Your Dependent must be listed on Your enrollment form or added later as a new Dependent.
- Family coverage; You, Your spouse, and each of Your eligible 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: 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.

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; a child who is placed with You for legal 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 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 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 health care 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.

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 the requirements described below and enroll the child in accord with Our usual enrollment process:

- The birth date of a newborn, providing You comply with Our usual enrollment process within 31 days of the child's birth.
- The birth date of a newborn adopted child, providing We receive notice of Your intent to adopt the newborn within 31 days of the child's birth.
- The date the child is placed with You for adoption, providing We receive notice of the placement within 31 days of the placement. Placement occurs when You assume a legal obligation for total or partial support of the child in anticipation of adoption.

COVERAGE ACTIVATION

Your coverage will activate on Your Effective Date providing that:

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

COVERAGE TERMINATION

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

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

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

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

End Of Month Termination

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

- We end Our Agreement with You by providing You written notice 30 days prior to termination.
- 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's Eligible*. You must inform Us, in writing, if a child no longer meets the eligibility requirements. You must notify Us on or before the first day of the month following the month the child no longer meets the requirements. For example, let's say that Your child turns 26 on June 1, You 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 in Your enrollment form or in any claim for benefits.

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

If Your coverage is terminated for fraud, intentional misrepresentation, or the concealment of material facts:

- We will not pay for any services or supplies provided after the date the coverage is terminated.
- You agree to reimburse Us for any payments We made under this coverage.
- We will retain Our full legal rights. This includes the right to initiate a civil action based on fraud, concealment or misrepresentation.
- Conduct which, in Our opinion, seriously jeopardizes Our ability to provide coverage to You, for example, Your refusal to follow prescribed Participating Provider's operational procedures.
- Engagement in repeated disruptive or threatening behavior or the infliction of bodily harm to others in the provider's office.

Continued Coverage if Member Dies

Upon the death of a Member, his or her spouse, if not eligible for group coverage, may become a Member under an individual payment Plan. In this case, all dependent children of the deceased Member are eligible to be enrolled as dependents on the surviving spouses new plan.

Rejoining PPP Individual Dental Plus Plan

If You cancel Your coverage, You cannot re-enroll in the PPP Individual Dental Plus 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 PPP Individual Dental Plus Plan waiting periods based on a new Effective Date.

Filing Claims

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

CLAIM SUBMISSION

Notice of Claim

1. 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); and
 - Information about other coverage You may have (if applicable). For information about other coverage, see *Chapter 7: Other Party Responsibility*.
3. Enclose an itemized statement from Your Dentist (often called a provider statement). It is helpful to Us if the provider statement is in English, or accompanied by an English translation on the service provider's stationary. The provider statement must include all of the following information:
 - Provider's full name and address.
 - Patient's name.

- Date(s) You received service(s).
- Date of the Injury or beginning of Illness or Injury.
- The charge for each service in U.S. currency.
- Description of each service.
- Diagnosis or type of Illness or Injury.
- Where You received the service (office, outpatient, hospital, etc.).
- A claim without a provider statement cannot be paid. Statements You prepare, cash register receipts, receipt of payment notices or balance due notices cannot be accepted.

4. Send Your claim to the address listed on the back cover of this Guide.

Explanation of Benefits (EOB)

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

Timeframe for Claim Determination

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

Payment

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

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

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

Denials

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

Chapter 6:

Resolving Disputes

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

IMPORTANT CONTACT INFORMATION RELATED TO DISPUTES

Phone Numbers

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

Fax Number

(808) 538-8996

Mail Address

Appeals

HMSA Dental Services
P.O. Box 1320
Honolulu, Hawaii 96807-1320

Arbitration

HMSA Dental Services
P.O. Box 1320
Honolulu, Hawaii 96807-1320

EXPEDITED APPEALS REQUIREMENTS

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

Expedited appeals are appropriate when a nonexpedited appeal would result in any of the following:

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

NONEXPEDITED APPEALS REQUIREMENTS

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

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

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

PERSONS AUTHORIZED TO APPEAL

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

- Any person You authorize to act on Your behalf provided You follow Our procedures which include filing a form with Us. Call Us to obtain a form to authorize a person to act on Your behalf;
- A court appointed guardian or an agent under a health care proxy;
- A person authorized by law to provide substituted consent for you or to make health care decisions on Your behalf; or
- A family member or your treating health care professional if you are unable to provide consent.

Request for appeal from an Authorized Representative who is a Dentist must be in writing unless requesting expedited appeal.

OPTIONS WHEN YOU DISAGREE

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

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

- Request review by an Independent Review Organization selected by the Insurance Commissioner if You are appealing an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or a determination by HMSA that the service or treatment is experimental or investigational;
- For all other issues:
 - Request arbitration before a mutually selected arbitrator, or;
 - File a lawsuit under section 502(a) of ERISA.

Review By Independent Review Organization (Iro)

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

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

- Your request must be in writing and include:
- A copy of HMSA's final internal appeal decision.
- A completed and signed authorization form releasing Your medical records relevant to the subject of the IRO review. Copies of the authorization form are available from HMSA by calling (808) 948-5090, or toll free at (800) 462-2085 or on HMSA.com
- A complete and signed conflict of interest form. Copies of the conflict of interest form are available from HMSA by calling (808) 948-5090, or toll free at (800) 462-2085 or on HMSA.com.
- A check for \$15.00 made out to the Insurance Commissioner. It will be refunded to You if the IRO overturns HMSA's decision. You are not required to pay more than \$60.00 in any calendar year.

You must send the request to the Insurance Commissioner at:

Hawaii Insurance Division
 ATTN: Health Insurance Branch – External Appeals
 335 Merchant Street, Room 213
 Honolulu, HI 96813
 Telephone: (808) 586-2804

- You will be informed by the Insurance Commissioner within 14 business days if Your request is eligible for external review by an IRO.
- You may submit additional information to the IRO. It must be received by the IRO within 5 business days of the Your receipt of notice that Your request is eligible. Information received after that date will be considered at the discretion of the IRO.
- The IRO will issue a decision within 45 calendar days of the IRO's receipt of Your request for review.
- The IRO decision is final and binding except to the extent HMSA or You have other remedies available under applicable federal or state law.

Expedited Iro Review

You may request expedited IRO review if:

- The timeframe for completion of an expedited internal appeal would seriously jeopardize the enrollee's life, health, or ability to gain maximum functioning or would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse determination and You have requested expedited internal appeal at the same time;

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

Expedited IRO review is not available if the treatment or supply has been provided.

The IRO will issue a decision as expeditiously as Your condition requires but in no event more than 72 hours after the IRO's receipt of Your request for review.

External Review Of Decisions Regarding Experimental Or Investigational Services

You may request IRO review of an HMSA determination that the supply or service is experimental or investigational.

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

- Written requests for review must include, and oral requests must be promptly followed up with, the same documents described above for standard IRO review plus a certification from Your physician that:
- Standard health care services or treatments have not been effective in improving Your condition;
- Standard health care services or treatments are not medically appropriate for You; or
- There is no available standard health care service or treatment covered by Your plan that is more beneficial than the health care service or treatment that is the subject of the adverse action.

Your treating dentist must certify in writing that the service recommended is likely to be more beneficial to you, in the dentist's opinion, than any available standard health care service or treatment, or your licensed, board certified or board eligible physician must certify in writing that scientifically valid studies using accepted protocols demonstrate the service that is the subject of the external review is likely to be more beneficial to you than any available standard health care services or treatment.

The IRO will issue a decision as expeditiously as Your condition requires but in no event more than 7 calendar days of the IRO's receipt of Your request for review.

Arbitration

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

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

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

material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b).

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

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

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

If You Are Enrolled In A Self Funded Group Plan And You Wish To Contest Our Appeal Decision

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

If you choose review by an IRO you must submit your request in writing to HMSA at

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

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

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

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

Other Party Responsibility

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

WHEN YOU HAVE MORE THAN ONE DENTAL PLAN

You may have other dental insurance coverage that provides coverage that is the same or similar to this Plan. If You have such coverage, We will coordinate with the other coverage(s) to determine payment under this Plan. Other coverage includes Group insurance: non-Group insurance: other Group benefit plans: Medicare or other governmental benefits, and the dental benefits coverage in Your automobile insurance (whether issued on a fault or no fault basis).

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

Notice to Us

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

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

Notice to Your Provider

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

How Much We Pay

You may have other insurance coverage that provides benefits which are the same or similar to this Plan.

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

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

General Coordination Rules

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

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

Dependent Child Coordination Rules

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

- For a child who is covered by both parents who are not separated or divorced and have joint custody, the coverage of the parent whose birthday occurs first in a Calendar Year pays first.
- For a child who is covered by separated or divorced parents and a court decree says which parent has health insurance responsibility, that parent's coverage pays first.
- For a child who is covered by separated or divorced parents and a court decree does not stipulate which parent has health insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this Dependent child is as follows:
 1. Custodial parent.
 2. 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.

General Provisions

This chapter provides general provisions applicable to Your Plan.

PREMIUMS

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

In the event You fail to pay monthly premiums on or before the due date, We may terminate coverage, unless all premiums are brought current within ten (10) days of Our providing written notice of default to You. We are not liable for benefits for services received after the termination date.

COVERAGE TERMS

By submitting the enrollment form, You accept and agree to the provisions of Our constitution and bylaws now in force and as amended in the future.

AUTHORITY TO TERMINATE, AMEND, OR MODIFY

We have the authority to amend, modify, or terminate the Agreement provided that We give 30 days prior written notice to Your Group regarding the change.

RIGHT TO INTERPRET

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

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

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

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

CONFIDENTIAL INFORMATION

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

GOVERNING LAW

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

RELATIONSHIP BETWEEN PARTIES

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

CIRCUMSTANCES BEYOND OUR CONTROL

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

NOTICE ADDRESS

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

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

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

MEDICAID ENROLLMENT

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

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

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.

Defined Terms

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

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

- This *Guide To Benefits (Guide)*.
- Any riders and/or amendments.
- The enrollment form submitted to Us by You.

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

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

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

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

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

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

Eligible Charge – The lower of either the provider's actual charge or the amount We establish as the maximum allowable fee. HMSA's payment, and Your copayment, are based on the eligible charge.

The Eligible Charge for nonparticipating Dentists is less than the Eligible Charge for the same service provided by a Participating Dentist. We determine Eligible Charge according to the provisions of the Agreement between Us and the Participating Dentist and based on the following:

- The lower of the amount billed by the Dentist on a submitted claim; or

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

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

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

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

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

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

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

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

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

- (a) For the purpose of treating a dental condition.
- (b) The most appropriate delivery or level of service considering potential benefits and harms to the patient.
- (c) Known to be effective in improving dental health outcomes; provided that:
 1. Effectiveness is determined first by scientific evidence;
 2. If no scientific evidence exists, then by professional standards of care; and
 3. If no professional standards of care exists or if they exist but are outdated or contradictory, then by expert opinion, and

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

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

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

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

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

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

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

Plan - The specific dental coverage described in this Guide and which You pay premium toward.

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

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

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association

HAWAI'I MEDICAL SERVICE ASSOCIATION

hmsa.com

HONOLULU • P.O. Box 1320 • 96807-1320
Phone: 948-6440 or 1 (800) 792-4672 toll-free

HMSA is a Hawaii-based health care services organization dedicated, for over 70 years, to improving the health and wellness of individuals and our community. We will provide our customers real value and security by creating a broad range of products that gives them choices of health care plans, provider networks, prices, and other health care services, with a commitment to superior customer service.