



Thank you for considering HDS for your employees and their families. Please complete and return the required documents listed below to HDS. The documents must be received by the 15th of the month for the plan to be effective the first of the following month. This will also expedite the processing of your employer group information into our system and the enrollment of your employees into the dental plan. Please note the minimum enrollment requirement as stated on the benefit and rate sheet.

The completed documents are:

1. The employer application form,
2. The Contract for Dental Services signed by an authorized party and returned in its entirety,
3. A completed enrollment form for each eligible employee, and
4. The initial payment form along with a check for the first month's premium payment.

Please mail the completed documents to:

Hawaii Dental Service  
Attn: Marketing and Sales Department  
700 Bishop Street, Suite 700  
Honolulu, HI 96813

Once we receive all the required documents, an HDS Account Executive will contact you to confirm the effective date of your dental plan. They will work with you on your group's dental plan implementation.

If you have any questions regarding this plan or the required forms, please call our Marketing and Sales Department at (808) 529-9206 or toll-free at 1-800-232-2533 extension 206.

We look forward to working with you.

## Employer Application

Hawaii Dental Service  
700 Bishop Street Suite 700  
Honolulu, Hawaii 96813

www.deltadentalhi.org

Phone: (808) 529-9206  
1 (800) 232-2533 ext. 206

Fax: (808) 529-9212  
1 (866) 376-7600

---

---

### Group Information

---

---

1. Number of employees\*: \_\_\_\_\_ 2. Number of employees enrolling: \_\_\_\_\_

\*"Employee" is defined as a person who works for the group in return for wages or salary

3. Enrolling full-time employees:  Yes  No 4. Enrolling part-time employees:  Yes  No

5. Current dental carrier: \_\_\_\_\_ 6. Current medical carrier: \_\_\_\_\_

7. Employer contribution (% or \$) for employees: \_\_\_\_\_ 8. for dependents: \_\_\_\_\_

9. Desired start date (Upon acceptance, HDS will confirm and advise of start date): \_\_\_\_\_

10. Full legal name of group as it should appear on the contract (The business must be registered with the Hawaii State Department of Commerce and Consumer Affairs – DCCA):  
\_\_\_\_\_

11. Federal Identification Number (FIN): \_\_\_\_\_ - \_\_\_\_\_

12. Department of Labor (DOL) Number: \_\_\_\_\_

13. Nature of business: \_\_\_\_\_

14. Name of union (if applicable): \_\_\_\_\_

---

---

### Broker/Consultant

---

---

We do not use a broker/consultant.

The broker/consultant indicated below is hereby designated as Broker of Record by the employer.

Company: \_\_\_\_\_

Name:  Mr.  Ms.  Dr. \_\_\_\_\_

Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_

---

---

COBRA

---

---

Employer groups who offer COBRA dental benefits are responsible for compliance with the COBRA regulations. Detailed COBRA regulations and procedures should be obtained from the Department of Labor or through consultation with your legal counsel. Every employer group plan that provides COBRA should have a Plan Administrator. The Plan Administrator is responsible for ensuring that COBRA regulations are adhered to, proper COBRA documentation is maintained and required notifications are provided on a timely basis. **HDS does not serve as the COBRA Plan Administrator.** HDS may provide assistance to the Plan Administrator with the collection of monthly premiums and payment/eligibility notifications to COBRA subscribers.

1. COBRA will be offered  Yes  No
2. HDS should collect COBRA premiums directly from the group's subscribers  Yes  No

---

---

Divisions

---

---

Separate divisions are required  Yes  No

If you require separate divisions, please fill out the table below.

Division Name	Separate Bill
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

---

---

Certification

---

---

The employer/applicant hereby represents and warrants that the individuals designated herein as representatives are duly authorized to act on behalf of the employer/applicant with respect to all matters pertaining to this group dental plan. The employer/applicant acknowledges that HDS is relying upon the statements and information provided or incorporated by reference in this application for the plan. The employer/applicant hereby represents and warrants that all such statements and information were true, correct and complete as of the date of the Employer Application, and hereby agrees that it shall promptly notify HDS in writing of any changes in such statements and information.

---

Approval (Employer) Signature

---

Title

---

Date

---

---

### Group Administrator

---

---

The person responsible for the overall administration of the plan

Name:  Mr.  Ms.  Dr. \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_

---

---

### Billing Contact

---

---

The person who should receive the bill

Check here if same as Group Administrator

Name:  Mr.  Ms.  Dr. \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_

---

---

### Eligibility Contact

---

---

The person HDS should call for eligibility questions

Check here if same as Group Administrator

Name:  Mr.  Ms.  Dr. \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_

This is a third party administrator (TPA):  Yes  No TPA's company name: \_\_\_\_\_

---

---

### Schedule A Contact

---

---

The group requires a 5500 Report  Yes  No Fiscal Year: From \_\_\_\_\_ through \_\_\_\_\_

The person who should received the 5500 report

Check here if same as Group Administrator

Name:  Mr.  Ms.  Dr. \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ ext. \_\_\_\_\_ Fax: \_\_\_\_\_



## Contract for Dental Services

This Contract for Dental Services, herein called this "Agreement", has been entered into by Hawaii Dental Service, a Hawaii nonprofit dental service corporation, herein called "HDS", and the following organization, herein called "Contracting Party":

Contracting Party Name: \_\_\_\_\_  
Contracting Party Address: \_\_\_\_\_  
\_\_\_\_\_

This Agreement is subject to the terms set forth on the subsequent pages, exhibits and amendments, which are a part of this Agreement. Contracting Party acknowledges acceptance of this Agreement by the signature of its authorized representative(s) at the bottom of this page.

Hawaii Dental Service

Contracting Party Name

By \_\_\_\_\_  
Its: Vice President  
Date: \_\_\_\_\_

By \_\_\_\_\_  
Its: \_\_\_\_\_  
Date: \_\_\_\_\_

By \_\_\_\_\_  
Its: Vice President  
Date: \_\_\_\_\_

By \_\_\_\_\_  
Its: \_\_\_\_\_  
Date: \_\_\_\_\_

"HDS"

"Contracting Party"

*To be completed by HDS upon acceptance:*  
HDS Group Number Assigned: \_\_\_\_\_  
Effective Date of Agreement: \_\_\_\_\_

## Exhibit A

### Schedule of Dental Benefits

BENEFIT	COPAYMENT	DEDUCTIBLE	WAIT PERIOD
<b>DIAGNOSTIC</b>			
Examinations 2x/calendar year	100%	None	None
Bitewing X-Rays < 15 years 2x/ calendar year	100%	None	None
Bitewing X-Rays >=15 years 1x/ calendar year	100%	None	None
X-Rays (other)	70%	None	None
Full mouth X-Rays 1x/5-years	70%	None	None
<b>PREVENTIVE</b>			
Cleanings 2x/calendar year	100%	None	None
Cleanings/Perio Maint*-pregnant 3x/calendar year	100%	None	None
Cleanings/Perio Maint*-diabetic 4x/calendar year	100%	None	None
*Perio Maint benefit level	70%	None	None
Stannous Fluoride 1x/calendar year (through age 19)	70%	None	None
Fluoride Varnish-High Risk 1x/calendar year	70%	None	None
Space Maintainers (through age 17)	70%	None	None
Sealants (through age 18)	70%	None	None
<b>RESTORATIVE</b>			
Routine Restorative	70%	None	None
Crowns and Gold Restorations 1x/7-years per tooth	50%	None	12 MONTHS
<b>ENDODONTICS</b>	70%	None	None
<b>PERIODONTICS</b>	70%	None	None
<b>PROSTHODONTICS 1x/7-years per tooth</b>	50%	None	12 MONTHS
<b>ENDOSTEAL IMPLANT 1x/7-years per tooth</b>	50%	None	12 MONTHS
<b>ORAL SURGERY</b>	70%	None	None
<b>ADJUNCTIVE GEN. SERVICES</b>			
Adjunctive Services	70%	None	None
Palliative Treatment (for relief of pain but not to cure)	70%	None	None

**PLAN MAXIMUM:**

Per Person = \$1200 per calendar year

**ELIGIBLE PERSON INCLUDES:**

- |  |   |
|--|---|
| <input checked="" type="checkbox"/> Employee<br><input checked="" type="checkbox"/> Dependent (through age 18)<br><input checked="" type="checkbox"/> Domestic Partner | <input checked="" type="checkbox"/> Spouse<br><input checked="" type="checkbox"/> Full Time Student (through age 24)*<br><input checked="" type="checkbox"/> Reciprocal Beneficiary |
|--|---|

\*Please refer to Full-Time Student Rider for description.

## **GUIDELINE FOR ENDOSTEAL IMPLANT**

### General Guidelines

An implant body is not a benefit of all HDS benefit plans. The following guidelines apply only to those group plans with the implant benefit:

1. Implants are limited to endosteal implants submitted as ADA procedure code D6010.
2. An implant is allowed as an alternative benefit only if replacing a missing permanent tooth between two natural teeth.
3. The implant will not be benefited for use as an abutment for a bridge or removable prosthesis.
4. Implant procedures will be paid as an alternate procedure equivalent to the payment for the two abutments of a standard three-unit bridge. Providers can charge up to their submitted amount.
5. An implant is not a benefit for patients under age 16.
6. Since the implant placement is in lieu of the abutments of a three-unit bridge, it is subject to treatment limitations for existing inlays, onlays, crowns, veneers and fixed and removable prosthodontics. Appropriate processing policies will be applied. (For example, a crown placed on a tooth adjacent to an implant is not a benefit for five years following implant placement.)

## I. DEFINITIONS

For purposes of this Agreement, the following definitions shall apply:

- A. "Administrative Fee"  
shall mean the amount HDS is entitled to receive for administering this Plan.
- B. "Allowed Amount"  
shall mean the amount to which the benefit percentage is applied to calculate the HDS payment.
- C. "Alternate Benefit"  
shall mean an alternate service that is the 'least expensive, professionally accepted treatment'. The HDS Plan Benefit will be based on the alternate benefit's Allowed Amount, and the patient is responsible for the difference in cost up to the Submitted Amount.
- D. "Annual Plan Maximum"  
shall mean the total HDS Payments for each Eligible Person for all covered dental services processed by HDS during any Plan Year, if such maximum is set forth in this Contract Agreement.
- E. "Approved Amount"  
shall mean the maximum amount that the patient is responsible for.
- F. "Benefits"  
shall mean services that are covered by this Agreement, as set forth in the Schedule of Benefits attached as Exhibit A.
- G. "COBRA"  
shall mean the Consolidated Omnibus Budget Reconciliation Act as amended from time to time.
- H. "Contract Agreement"  
shall mean this Contract for Dental Services, including exhibits, riders and amendments from time to time.
- I. "Contract Term"  
shall mean the 12 month period commencing on the effective date indicated on the first page of this Agreement and each subsequent 12 month renewal period, subject to renewal or early termination as set forth herein.
- J. "Contracting Party"  
shall mean the employer group or business organization entering into this Agreement with HDS as indicated on the first page of this Agreement.
- K. "Copayment Percentage"  
shall mean the applicable percentage of the Allowed Amount which HDS shall pay with respect to services under the Plan as set forth in Exhibit A.
- L. "Deductible Amount"  
shall mean the amount applied once a year to certain covered benefits. Each member is responsible for the deductible payment portion until it is satisfied.
- M. "Delta Dental Participating Dentist"  
shall mean a dentist, other than an HDS Participating Dentist, who participates in the Delta Dental network of dentists.
- N. "Description of Benefits"  
shall mean the description attached to this Agreement as Exhibit B which is comprised of those services that HDS benefits and excludes. These procedures are processed to the most current HDS Procedure Code Guidelines and may be amended from time to time.

- O. "Eligible Dependent"  
shall mean any dependent of an Eligible Employee who meets the conditions of eligibility set forth in the Eligibility, Enrollment & Coverage section of this Contract Agreement.
- P. "Eligible Employee"  
shall mean any employee who meets the conditions of eligibility set forth in the Eligibility, Enrollment & Coverage section of this Contract Agreement.
- Q. "Eligible Person"  
shall mean an Eligible Employee or an Eligible Dependent.
- R. "Explanation of Benefits"  
shall mean a statement of services utilized by an Eligible Person and the applicable payment amounts for such services.
- S. "Group Administration Handbook"  
shall mean a handbook used as a guide to the policies, practices and procedures of administering the HDS Plan.
- T. "HDS Non-Participating Reimbursement Schedule"  
shall mean the non-participating provider fee schedule which is not necessarily representative of the dentist's fees.
- U. "HDS Participating Dentist"  
shall mean any dentist who participates in the HDS network of participating dentists.
- V. "HDS Plan Benefit"  
shall mean the HDS benefit calculated for each service.
- W. "HDS Procedure Code Guidelines"  
shall mean the HDS policies used to process claims for dental services as amended from time to time.
- X. "HDS"  
shall mean Hawaii Dental Service, a Hawaii nonprofit dental service corporation.
- Y. "LEPAT"  
shall mean Least Expensive Professionally Acceptable Treatment.
- Z. "Member Identification Card"  
shall mean the card issued by HDS to each Subscriber, which includes his or her name and member identification number. The Subscriber's member identification number is used for the Subscriber and his/her covered spouse and dependents.
- AA. "National Provider File" or "NPF"  
shall mean the Delta Dental national dentist database of dentists' fees.
- BB. "Non-Participating Dentist"  
shall mean any dentist who is not an HDS Participating Dentist or a Delta Dental Participating Dentist.
- CC. "Patient Share"  
shall mean the out-of-pocket amount for which the patient is responsible.
- DD. "Patient"  
shall mean an individual who has established a professional relationship with a dentist for the delivery of dental health care.
- EE. "Plan"  
shall mean the dental benefit plan provided for the Contracting Party under this Agreement.

FF. "Submitted Amount"

shall mean the full amount charged on claims submitted by dentists performing any work under this Agreement.

GG. "Wait Period"

shall mean the applicable period an Eligible Person must wait until he or she is eligible for Plan Benefits set forth in Exhibit A.

**II. TERM**

This Agreement shall be for successive one year terms and shall be automatically renewed unless the Agreement is terminated earlier in accord with Sections III.C. or XII.B.

**III. CONTRACTING PARTY'S PAYMENTS**

- A. Contracting Party shall remit the Monthly Payment to HDS, in advance, on or before the first day of each month during the Contract Term. The Monthly Payment shall be calculated by multiplying the rates listed in Exhibit C by the actual number of Eligible Employees in each category as of the first day of each month for which the Monthly Payment is being prepaid.
- B. If there shall be imposed upon HDS any tax or assessment by any governmental authority, whether such tax or assessment is now in effect or shall hereafter come into effect, which is measured directly by payments made by Contracting Party under this Agreement, the amount payable by Contracting Party hereunder shall be increased by the amount of such tax which is directly applicable to such payments. HDS will provide notice to Contracting Party of the imposition of any such tax or assessment.
- C. In the event Contracting Party fails to pay the Monthly Payment by the due date, HDS may terminate this Agreement for failure to pay the Monthly Payment, unless the Monthly Payment is brought current and any additional amounts charged under Section III. D are paid within ten days of HDS providing written notice of default to Contracting Party.
- D. In the event Contracting Party fails to pay the Monthly Payment by the due date, HDS may charge, and Contracting Party agrees to pay (i) a late fee of \$25.00, and (ii) interest in the amount of 1% per month on any unpaid balance. Contracting Party also agrees to pay to HDS all costs of collection or attempting to collect all such amounts owed by Contracting Party.

**IV. ELIGIBILITY, ENROLLMENT & COVERAGE**

Contracting Party shall be responsible for determining the eligibility of all plan participants meeting the HDS eligibility requirements set forth in Section A below. Contracting Party may apply its own eligibility requirements in limiting enrollment, but under no circumstance provide eligibility to a person who does not meet the HDS eligibility requirements. Contracting Party is also responsible for providing HDS with timely information relating to eligibility changes. HDS may examine Contracting Party's eligibility determinations from time to time in its discretion, but any failure to examine or object to such determinations shall not constitute a waiver by HDS of its eligibility requirements or its right to require compliance with the same.

A. Eligibility

1. Employee Eligibility

An Eligible Employee is an employee of Contracting Party for whom Contracting Party has submitted Monthly Payment to HDS.

2. Dependent Eligibility

An Eligible Dependent is a dependent for whom eligibility to enroll in the Plan has been verified by Contracting Party and for whom Contracting Party has submitted Monthly Payment to HDS.

Dependents eligible to enroll in the Plan are:

- a. Eligible Employee's lawful spouse or domestic partner.
- b. Unmarried dependent child of the Eligible Employee or Eligible Employee's spouse or domestic partner under age 19.
- c. Unmarried dependent child of the Eligible Employee or Eligible Employee's spouse or domestic partner under age 25 if attending an accredited school, college or university on a fulltime basis.

- d. Unmarried dependent child of the Eligible Employee or Eligible Employee's spouse or domestic partner regardless of age if such child is mentally or physically incapable of self-sustaining employment, provided that the incapacity was incurred prior to such child's nineteenth birthday.

Unmarried children of the Eligible Employee or Eligible Employee's spouse or domestic partner include: (1) Biological children, (2) Stepchildren, (3) Foster children, (4) Adopted children and (5) Children placed under legal guardianship of the Eligible Employee or Eligible Employee's spouse or domestic partner.

## B. Enrollment & Coverage

Eligible Persons must be enrolled within two (2) months of the date of eligibility, or must wait until the Contracting Party's subsequent open enrollment period. Dependents eligible to enroll in the Plan must be enrolled at the same time as the Eligible Employee upon initial enrollment or enroll according to the dates of eligibility after open enrollment listed in IV.B.1.

### 1. Persons Newly Eligible for Enrollment

A person who becomes eligible to enroll in the Plan after open enrollment may enroll by submitting an enrollment form to Contracting Party and Contracting Party submitting the information to HDS within two (2) months of the date of becoming eligible to enroll in the Plan.

The dates of eligibility after open enrollment are:

- a. The Eligible Employee's date of marriage, to add a spouse,
- b. The child's date of birth, to add a newborn,
- c. The date the Eligible Employee or Eligible Employee's spouse or domestic partner legally becomes a parent, to add a stepchild or adopted child,
- d. The date the child is legally placed under guardianship of Eligible Employee or Eligible Employee's spouse or domestic partner,
- e. The date the child is placed with the Eligible Employee or Eligible Employee's spouse or domestic partner for adoption and such Eligible Employee or Eligible Employee's spouse or domestic partner has assumed legal obligation for total or partial support of such minor child, or
- f. The date the employee or dependent becomes ineligible to receive dental benefits under any other dental plan.
- g. The date the Eligible Employee's domestic partner is recognized by Contracting Party for enrollment in the Plan.

### 2. Open Enrollment Period

Persons eligible to enroll in the Plan who choose not to enroll when eligible, may not be enrolled until the month prior to Contracting Party's subsequent contract renewal month, for coverage beginning on the first month of the new Contract Term.

### 3. HDS Identification Cards

HDS provides identification cards to Eligible Persons which contain information for HDS Participating Dentists to use when filing claims to HDS for services provided. The identification card indicates the Eligible Employee's ID number and is used for all Eligible Dependents. The HDS identification card does not guarantee eligibility unless requirements for eligibility as described in Section IV and V are met.

### 4. When Eligibility for Coverage Ends

Eligibility for coverage will terminate at the end of the month in which any of the following events takes place:

- a. An employee shall cease to be eligible at the end of the calendar month in which employee ceases to be an Eligible Employee.
- b. A dependent shall cease to be eligible at the end of the calendar month during which the Eligible Employee's eligibility terminates or the dependent no longer meets the definition of an Eligible Dependent, whichever occurs first.
- c. If this Agreement is terminated, eligibility for all Eligible Persons will cease on the effective date of such termination.

In the event an Eligible Person ceases to be eligible (including if this Agreement is terminated), HDS shall not be required to pay for services performed after the date on which such Eligible Person ceases to be eligible, except for completion of services which are benefits under this Agreement that are commenced prior to such date and are completed within thirty days after commencement.

HDS shall not be held responsible for any delays in processing of claims and/or denial of payment of claims if eligibility changes are not received by HDS by the required date.

Upon receipt of reasonable advance written notice from HDS, the Contracting Party shall allow HDS, its auditors or other authorized representatives to inspect records of Contracting Party pertaining to eligibility under the Plan.

HDS will consider requests for retroactive terminations within two (2) months after the requested termination date, provided that dental services have not been rendered to the Eligible Person during the period for which retroactive termination is being requested.

## **V. COBRA**

Contracting Party shall remain solely responsible for meeting all COBRA requirements. The Contracting Party shall also be responsible for promptly notifying HDS of persons who elect to continue coverage under the Plan under COBRA provisions.

Any Eligible Person whose eligibility for benefits under this Agreement terminates, may elect continued coverage under this Agreement pursuant to COBRA.

## **VI. PLAN BENEFITS**

- A. If an HDS Participating Dentist or Delta Dental Participating Dentist performs services for a person shown as eligible on HDS records as of the date of service, HDS shall determine the Plan Benefit and make payment directly to the dentist. The Plan Benefit is based on the applicable Copayment Percentage applied against the Allowed Amount for HDS Participating Dentists or Delta Dental Participating Dentists, as applicable.
- B. If the dentist performing services for a person shown as eligible on HDS records as of the date of service is a Non-Participating Dentist, HDS shall determine the Plan Benefit and make payment directly to the Eligible Employee or patient over 18, unless otherwise directed by a Court order. The Plan Benefit for Non-Participating Dentists shall be based on the applicable Copayment Percentage applied against the Allowed Amount for Non-Participating Dentists. Eligible Person shall be responsible for any difference between the Plan Benefit and the Non-Participating Dentist's fees. Non-Participating Dentist fees may be higher than the fees of HDS Participating Dentists or Delta Dental Participating Dentists. The Non-Participating Dentist may submit a claim to HDS for processing or may ask the patient to submit the claim form to HDS.
- C. All determinations of Plan Benefits will be subject to applicable Wait Periods and other applicable limitations under this Agreement.
- D. No Plan Benefit will be determined for dental procedures designed to correct or cure injuries or conditions paid for under workers' compensation or employers' liability laws, or for services which are provided without cost to any Eligible Person by any government or government agency.
- E. HDS shall pay no more than the Annual Plan Maximum toward the cost of dental services rendered to any Eligible Person during any calendar year.
- F. HDS will provide an Explanation of Benefits to the Eligible Person over 18, detailing the Plan Benefits. If the Eligible Person is not satisfied with the Plan Benefit determination, a request for reconsideration may be sent to the Director of Dental Claims at HDS within one year of the date of service.
- G. Once HDS has paid the Plan Benefit, HDS shall not be responsible for any further payments under this Agreement for the services performed.
- H. No claim adjustments will be made for retroactive terminations.

## **VII. COORDINATION OF BENEFITS**

If an Eligible Person has dental benefits covered by a dental insurer other than HDS, the total of the HDS payment and the other plan payment will not exceed the HDS Plan Benefit for the service performed. HDS utilizes the NAIC (National Association of Insurance Commissioners) Rules as amended from time to time to determine order of benefit. Eligible Persons are responsible for advising their dentists of all dental plans in which they are enrolled.

## **VIII. TREATMENT LIMITATIONS**

Applicable limitations on Plan Benefits are set forth in Exhibits A and B and in the HDS Procedure Code Guidelines. If the Plan limits the number of times a particular benefit (e.g., cleaning treatments) is available annually, even if an Eligible Person is covered by two or more dental plans, such Eligible Person is not entitled to that Benefit more frequently than permitted by the Plan. Previous restorative, endodontic, periodontic, prosthodontic and oral surgery services performed within the applicable time limitations will be considered when determining the Plan Benefit, including prior services performed under a different contract. HDS will not pay for two or more dentists for concurrently performing duplicative dental services to any Eligible Person under a single treatment plan.

## **IX. PREAUTHORIZATION AND PROCESSING OF CLAIMS**

A preauthorization may be submitted to HDS by the treating dentist. HDS will advise the dentist and the Eligible Person whether the services are authorized under the Plan. The treating dentist has one year from the processing of the pre-authorization, to complete the authorized services. During this time, the funds for these preauthorized services will be reserved against the Eligible Person's Annual Plan Maximum unless released upon request by the Eligible Person or preauthorizing dentist to HDS. If preauthorized services are not performed within the one year allowed, the funds will be automatically released from the Eligible Person's Annual Plan Maximum.

Dentists submitting claims for services performed must do so within one year of the service date. Payment of claims not submitted within one year of the service date is neither the Eligible Person's nor HDS's responsibility, provided the Eligible Person has notified the dentist of dental coverage. If the Eligible Person has not notified the dentist of dental coverage, the Eligible Person is solely responsible for payments owed to the dentist.

## **X. NO CHANGE IN DENTIST/PATIENT RELATIONSHIP**

Nothing in this Agreement is intended to change the basic relationship between dentists and patients. Each dentist retains the privilege of refusing to treat any patient, and each patient has the right to select any dentist. HDS does not guarantee the performance of any dentist, and shall not be responsible for remedying any alleged dental work deficiency or other dispute with the dentist.

## **XI. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)**

Contracting Party shall be responsible for complying with any Medical Child Support Order (MCSO) it receives, including all notification responsibilities with respect to MCSOs, the establishment of written procedures to determine if an MCSO is a Qualified Medical Child Support Order (QMCSO), and the administration of benefits under such QMCSOs.

Contracting Party shall promptly notify HDS of the receipt of an MCSO relating to the Plan, Contracting Party's determination as to whether such MCSO is a QMCSO, the name and address of alternate recipients (as defined in any such MCSO) determined to be eligible to receive benefits under the Plan, and the name and address of any custodial parent or legal guardian designated to receive benefits on behalf of such alternate recipient.

HDS's sole responsibility shall be to mail benefit checks to the alternate recipient or the designated custodial parent or guardian when required under the terms of the Plan and the QMCSO, and to answer routine inquiries from alternate recipients or designated guardians.

## **XII. RENEWAL OR TERMINATION OF CONTRACT AGREEMENT; CERTAIN MODIFICATIONS**

### **A. Renewal**

1. Not fewer than 30 days prior to the end of the Contract Term, HDS shall notify Contracting Party in writing if a renewal of this Agreement will be offered by HDS. If a renewal is offered, such notice shall specify the renewal period, and such changes to the Monthly Payment, Benefits and/or other provisions of this Agreement as will be applicable to the renewal period.
2. This Agreement shall be renewed upon the terms specified in the renewal notice unless HDS is notified in writing by Contracting Party of termination at least seven (7) days prior to the end of the Contract Term.

### **B. Termination**

1. This Agreement will terminate upon the expiration of the Contract Term: (a) if HDS notifies Contracting Party that no renewal is being offered by HDS pursuant to Subsection A.1 above; or (b) if Contracting Party gives written notice of termination to HDS at least seven (7) days prior to the end of the Contract Term.
2. It shall be the responsibility of the Contracting Party to notify all Eligible Persons of the termination of this Agreement.

### **C. Certain Modifications**

HDS reserves the right to change the Benefits, terms and conditions hereof as made appropriate by changes in any law or regulation, industry standards, or changes to Delta Dental Plans Association (DDPA) requirements or HDS Procedure Code Guidelines.

## **XIII. NO WAIVER OF DEFAULTS**

No delay or omission of HDS to exercise any right or power accruing upon any default shall impair any such right or power or be construed to be a waiver of any such default or an acquiescence therein; and every power and remedy given to HDS hereunder may be exercised from time to time and as often as may be deemed expedient.

#### **XIV. CONFIDENTIALITY**

HDS agrees that it will comply with the requirements of 45 C.F.R. Part 160-164 (HIPAA) with respect to individually identifiable health information in its possession regarding any Eligible Persons.

#### **XV. GENERAL PROVISIONS**

A. Severability

If any provision of this Agreement shall be held to be illegal or invalid, such illegality or invalidity shall not affect any other provision of this Agreement, and this Agreement shall be construed and enforced as if the illegal or invalid provision had not been contained herein.

B. Governing Law

The construction and enforcement of this Agreement shall be governed by the laws of the State of Hawaii.

C. Notices

Except as otherwise provided herein, any notice which is required to be sent by either party to the other shall be deemed delivered if deposited in the United States mail, first class postage prepaid, and any such notice shall be addressed to the address of the party shown on the first page of this Agreement, or at such other address as either party shall designate upon written notice to the other. The date of delivery of any notice is the date of the postmark on the letter sent.

D. Hawaii General Excise Taxes

Hawaii general excise taxes imposed or incurred in connection with any fees charged by a dentist, whether or not passed on to an Eligible Person by the dentist, are not eligible charges and HDS shall not make any payment with respect to such taxes.

E. Plan Liability

HDS shall have no liability for any wrongful conduct of any third party, including but not limited to tortious conduct, negligence, wrongful acts or omissions, or any other act of any person including but not limited to employees, dentists, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services, and shall also have no liability for any services or facilities which, for any reason, are unavailable to any Eligible Person.

F. Publication Of This Agreement

No material shall be published or distributed by Contracting Party or otherwise, interpreting, relating to or concerning this Agreement unless such material has been approved by HDS in advance of such publication or distribution.

G. Assignment

Contracting Party may not assign its interest in this Agreement without the prior written consent of HDS.

H. Default

In the event of breach or default of this Agreement, the non-breaching party may recover any damages, attorney's fees and costs, and costs of collection caused by such breach.

## Exhibit B

### Description of Benefits

Benefits are limited to the group's dental benefits coverage indicated in Exhibit A

#### DIAGNOSTIC

##### BENEFITS

Accession of tissue; Bitewing films (x-rays); Cephalometric film (x-rays); Consultation on slides prepared elsewhere; Extraoral films Intraoral periapical films (x-rays); intraoral complete series (full-mouth); Oral evaluations (exams); Oral/facial photographic images; Panoramic film (x-rays); Posterior-anterior or lateral skull and facial bone survey film (x-rays); Processing and interpretation of exfoliative cytologic smears; Pulp vitality tests

##### EXCLUSIONS

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions; Assession of brush biopsy sample, microscopic examination, preparation and transmission of written report; Caries susceptibility tests; Cone beam – craniofacial data capture; Cone beam – two-dimensional image reconstruction; Cone beam – three-dimensional image reconstruction; Collection of microorganisms for culture and sensitivity; Decalcification procedure; Diagnostic casts; Electron microscopy – diagnostic; Genetic test for susceptibility to oral diseases; Immunofluorescence; Immunohistochemical stains; Sialography; Special stains; Temporomandibular joint arthrogram, including injection; Tissue in-situ hybridization, including interpretation; Tomographic survey; Viral culture

#### PREVENTIVE

##### BENEFITS

Prophylaxis (cleanings); Re-cementation of space maintainer; Removal of fixed space maintainer (not by dentist who placed appliance); Sealants (if indicated as a contracted benefit); Space maintainers; Topical application of fluoride – up to contracted age.

##### EXCLUSIONS

Nutritional counseling for control of dental disease; Oral hygiene instructions; Tobacco counseling for the control and prevention of oral disease; Topical fluoride varnish (unless indicated as a contracted benefit)

#### RESTORATIVE

Services to rebuild, repair or reform natural tooth structure when necessary due to disease or injury

##### BENEFITS

Additional procedures to construct new crown under existing partial denture framework; Amalgams; Cast post and core; Core buildup, including any pins; Crowns: Gold; Resin-based composite, porcelain/ceramic and porcelain-fused-to-metal (on anterior teeth); Fillings: amalgam; Resin-based composite (on anterior teeth); Gold foils; Inlays; Labial veneer; Onlays; Pin retention; Post removal (not in conjunction with endodontic therapy); Prefabricated stainless steel or resin crown; Prefabricated post and core; Provisional crown; Recement inlays, crowns, post and core; Sedative filling; Temporary Crown (fractured tooth)

##### EXCLUSIONS

Coping restoration; Restorations performed for Aesthetic/Cosmetic reasons

## **ENDODONTICS**

Procedures for the treatment of teeth with diseased or damaged nerves such as root canals

### **BENEFITS**

Apexification/recalcification; Apicoectomy/periradicular surgery; Hemisection (including any root removal), not including root canal therapy; Incomplete endodontic therapy; Internal root repair of perforation defects; Pulp caps; Pulpal debridement; Pulpal therapy; Pulpotomy; Retreatment of previous root canal therapy; Retrograde filling - per root; Root amputation - per root; Root canal; Therapeutic pulpotomy (excluding final restoration); Treatment of root canal obstruction; non-surgical access

### **EXCLUSIONS**

Canal preparation and fitting of preformed dowel or post; Endodontic endosseous implant; Intentional reimplantation (including necessary splinting); Surgical procedure for isolation of tooth with rubber dam

## **PERIODONTICS**

Procedures for the treatment of diseases of the gums and supporting structures of the teeth

### **BENEFITS**

Biologic materials to aid in soft and osseous tissue regeneration; Bone replacement graft; Clinical crown lengthening - hard tissue; Free soft tissue graft procedure (including donor site surgery); Full mouth debridement; Gingival flap procedure; Gingivectomy or gingivoplasty; Guided tissue regeneration; Osseous surgery; Periodontal maintenance; Periodontal scaling and root planing; Soft tissue allograft; Subepithelial connective tissue graft procedures

### **EXCLUSIONS**

Anatomical crown exposure; Apically positioned flap; Combined connective tissue and double pedicle graft; Distal or proximal wedge procedure; Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue; Pedicle soft tissue graft procedure; Provisional splinting; Surgical revision procedure

## **PROSTHODONTICS (REMOVABLE)**

Services and appliances that replace missing natural teeth, such as bridges, partial dentures and complete dentures

### **BENEFITS**

Add clasp to existing partial denture; Add tooth to existing partial denture; Complete, partial and immediate dentures; Denture adjustments; Denture repair; Interim partial denture; Overdenture; Rebase; Reline; Replace all teeth and acrylic on cast metal framework; Replace missing or broken teeth on dentures; Tissue conditioning

### **EXCLUSIONS**

Commissure splint; Facial moulage; Feeding aid; Fluoride gel carrier; Interim complete denture; Modification of removable prosthesis following implant surgery; Prosthesis; Prosthesis Replacement; Radiation carrier; Radiation cone locator; Radiation shield; Replacement of replaceable part of semi-precision or precision attachment (male or female component); Surgical splint; Surgical stent; Trismus appliance (not for TMD treatment)

## **PROSTHODONTICS (FIXED)**

### **BENEFITS**

Cast post and core in addition to fixed partial denture retainer; Core build up for retainer, including any pins; Crowns; Fixed bridges; Fixed partial denture sectioning; Inlays; Onlays; Pontics; Prefabricated post and core in addition to fixed partial denture retainer; Provisional retainer crown; Recement fixed partial denture; Retainers; Stress breaker; Provisional pontic

### **EXCLUSIONS**

Cast post as part of fixed partial denture retainer; Connector bar; Coping – metal; Each additional cast post - same tooth; Each additional prefabricated post - same tooth; Precision attachment; Pediatric partial denture, fixed

## **IMPLANT SERVICES**

An alternate benefit only if replacing a missing permanent tooth between two natural teeth

### **BENEFITS**

Recent implant/abutment supported crown or fixed partial denture; Abutment or implant supported crown in cast metal, porcelain/ceramic, or porcelain fused to metal; Implant/abutment supported removable denture, partial and complete; Repair implant supported prosthesis and abutment; Abutment or implant supported retainer in cast metal, porcelain/ceramic, or porcelain fused to metal

### **EXCLUSIONS**

Custom abutment - includes placement; Dental implant supporting connecting bar; Implant maintenance procedures; Implant supported retainer; Implant/abutment supported fixed denture; Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment; Prefabricated abutment - includes placement; Surgical placement of interim implant body for transitional prosthesis; Surgical placement of implant body and endosteal implant and procedures (unless implant guideline is attached)

## **ORAL AND MAXILLOFACIAL SURGERY**

Extractions and other surgical dental procedures, including pre-operative and post-operative care

### **BENEFITS**

Alveoloplasty; Alveolus; Arthroplasty; Biopsy of oral tissue; Complicated suture; Excision of hyperplastic tissue - per arch; Excision of lesions; Excision of pericoronal gingival; Excision of tumors; Exfoliative cytological sample collection; Extraction, coronal remnants - deciduous tooth; Extraction, erupted tooth or exposed root (elevation and/or forceps removal); Frenulectomy (frenectomy or frenotomy) - separate procedure; Frenuloplasty; Incision and drainage of abscess; Malar and/or zygomatic arch; Mandible - closed reduction; Maxilla - open reduction; Maxillary sinusotomy for removal of tooth fragment or foreign body; Mobilization of erupted or malpositioned tooth to aid eruption; Oroantral fistula closure; Partial ostectomy/sequestrectomy for removal of non-vital bone; Placement of device to facilitate eruption of impacted tooth; Primary closure of a sinus perforation; Radical resection of maxilla or mandible; Removal of benign cysts or tumors; Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue; Removal of impacted tooth; Removal of lateral exostosis (maxilla or mandible); Removal of reaction producing foreign bodies, musculoskeletal system; Removal of torus mandibularis; Removal of torus palatinus; Sialolithotomy; Surgical access of an unerupted tooth; Surgical reduction of fibrous tuberosity; Surgical reduction of osseous tuberosity; Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth; Surgical removal of residual tooth roots (cutting procedure); Surgical repositioning of teeth; Suture of recent small wounds up to 5 cm; Synovectomy; Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth; Vestibuloplasty - ridge extension

### **EXCLUSIONS**

Appliance removal; Arthrocentesis; Arthroscopy; Arthrotomy; Bone replacement graft for ridge preservation - per site; Brush biopsy - transepithelial sample collection; Closed reduction of dislocation; Closure of salivary fistula; Condylectomy; Coronoidectomy; Disc repair; Emergency tracheotomy; Facial bones - complicated reduction with fixation and multiple surgical approaches; Joint reconstruction; Lefort; Manipulation under anesthesia; Myotomy; Non-arthroscopic lysis and lavage; Open reduction of dislocation; Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous; Osteoplasty - for orthognathic deformities; Osteotomy; Placement of intermaxillary fixation device not in conjunction with a fracture; Repair of maxillofacial soft and/or hard tissue defect; Sialodochoplasty; Skin graft (identify defect covered, location and type of graft); Sinus augmentation with bone or bone substitutes; Surgical discectomy, with/without implant; Surgical placement: temporary anchorage device; Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)

## **ADJUNCTIVE GENERAL SERVICES**

Procedures that support or augment definitive treatment

### **BENEFITS**

Consultation, deep sedation/general anesthesia; Internal bleaching - per tooth; Intravenous conscious sedation/analgesia; Office Visits for injuries (during & after hours); Palliative (emergency) treatment of dental pain – minor procedure

### **EXCLUSIONS**

Analgesia, anxiolysis, inhalation of nitrous oxide; Application of desensitizing resin for cervical and/or root surface, per tooth; Case presentation, detailed and extensive treatment planning; Enamel microabrasion; External bleaching; Fabrication of athletic mouthguard; Hospital call; House/extended care facility call; Local anesthesia; Local anesthesia not in conjunction with operative or surgical procedures; Non-intravenous conscious sedation; Occlusal adjustment – limited and complete; Occlusion analysis - mounted case; Odontoplasty 1 - 2 teeth; includes removal of enamel projections; Regional block anesthesia; Therapeutic parenteral drug administration; Trigeminal division block anesthesia; Repair and/or relines of occlusal guard; Application of desensitizing medicament

## **OTHER EXCLUSIONS**

### **Reconstruction and occlusion treatments:**

Procedures, appliances or restorations other than those for replacement of structure loss from caries, that are necessary to alter, restore or maintain occlusion are considered non-covered services. Such procedures include, but are not limited to increasing vertical dimension, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, restorations for tooth malalignment, gnathological recordings, and treatment of disturbances of the temporomandibular joint

### **Services or procedures to correct or alleviate congenital malformations, cosmetic surgery or medically related problems:**

Services with respect to medically related problems, congenital malformations, cosmetic surgery or dentistry for purely cosmetic reasons including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis and anodontia are not covered services

### **Hospitalization, including emergency room visits:**

Charges for hospitalization, including any emergency room visits, even if in conjunction with an authorized oral surgery procedure for treatment of fractures or dislocations are not considered Basic services, and all costs are the patient's responsibility

## Exhibit C

### Monthly Rates for Contracts Beginning 2010

RATE TYPE	FORMULA	MONTHLY RATE
Eligible Employee	SINGLE	\$26.98
Eligible Employee w/ one dependent	TWO PARTY	\$53.96
Eligible Employee w/ two or more dependents	FAMILY	\$86.34

# Hawaii Dental Service ENROLLMENT/CHANGE FORM

HDS Use Only	
Date Processed	Processed By

**A. Group / Contact Information** To be completed by the Group Administrator PLEASE PRINT LEGIBLY

Group/Division #  /  Group Name  Email Address

Contact Person  Contact Phone #  -   ext

**B. Eligible Employee** This section must be completed PLEASE PRINT LEGIBLY (leave a blank box between each word)

Enroll  Terminate  Change / Correct Information

Effective Date of Change  /  / 2 0  Social Security Number  -  -  Date of Birth  /  /  Sex  M  F

Group Transfer

Fr:  /  Group #  Division #

To:  /

Last Name

First Name  MI

Address  Check here if this is a new address  Apt #

City  State  Zip Code  Phone Number (  )  -

**C. Eligible Dependents** Please attach a separate sheet for additional dependent(s). Be sure to include the Eligible Employee's Social Security Number and Name when attaching additional sheets.

Enroll  Terminate  Correct Information

Reason For Change:  Open Enrollment  Loss of Coverage  Probation  Newborn  Full-time Student  Disabled  Marriage (Date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Legal Guardianship / Adoption

Effective Date of Change  /  / 2 0  Social Security Number  -  -  Date of Birth  /  /  Relationship  Spouse  Domestic Partner  Child

Last Name

First Name  Sex  M  F

Enroll  Terminate  Correct Information

Reason For Change:  Open Enrollment  Loss of Coverage  Probation  Newborn  Full-time Student  Disabled  Marriage (Date): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Legal Guardianship / Adoption

Effective Date of Change  /  / 2 0  Social Security Number  -  -  Date of Birth  /  /  Relationship  Spouse  Domestic Partner  Child

Last Name

First Name  Sex  M  F

**D. Authorization** I certify that the information provided is true, correct and meets the terms and conditions of the HDS Agreement.

Group Administrator Signature \_\_\_\_\_

Date \_\_\_\_\_



Initial Payment

Hawaii Dental Service
700 Bishop Street Suite 700
Honolulu, Hawaii 96813

Phone: (808) 529-9206
1 (800) 232-2533 ext. 206

www.deltadentalhi.org

Fax: (808) 529-9212
1 (866) 376-7600

Group Information

Desired Start Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_

Group Name: \_\_\_\_\_

Calculation of First Month's Premium

Table with 4 columns: Rate Type, Employees Enrolling by Rate Type, Rate, Total. Rows include 1 Party, 2 Party, 3 Party+, and Total Employees Enrolling.

Please attach all completed HDS Enrollment Forms along with a check for the first month's premium (as calculated above). Be sure to review the completed HDS Enrollment Forms for completeness and accuracy to avoid delays in processing.

(For HDS Use Only)

HDS Group Number \_\_\_ - \_\_\_

Date Received: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ Received By: \_\_\_\_\_

Check Received: [ ] Yes [ ] No Check Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_ Check Number: \_\_\_\_\_

First Month's Premium Due: \_\_\_\_\_

Amount Received: \_\_\_\_\_

Balanced Due: \_\_\_\_\_

Number of Enrollment Forms Received (Should Equal Total Employees Enrolling): \_\_\_\_\_

Date Forwarded to Accounting: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ / \_\_\_ \_\_\_