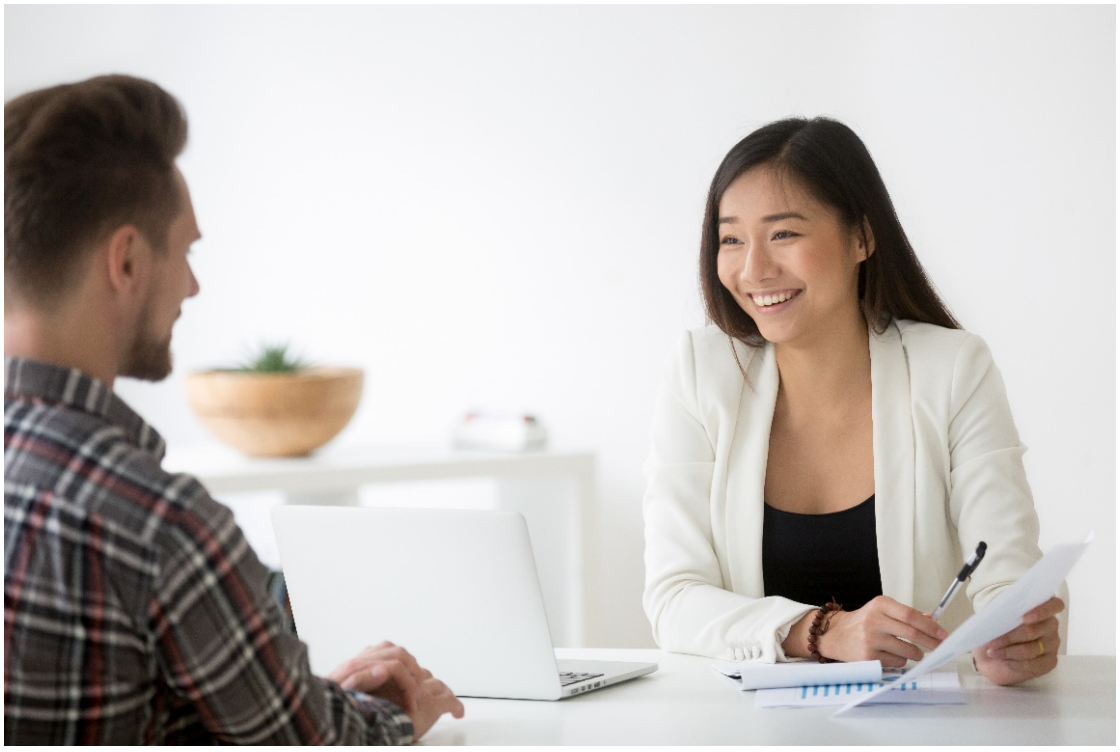
DELTA DENTAL®

HDS
Hawaii Dental Service

Group Administrator Reference Guide



Live Well, Smile More.

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WELCOME TO HAWAII DENTAL SERVICE

Thank you for choosing Hawaii Dental Service (HDS). As Hawaii's first and leading dental benefits provider, we are excited to be your partner in providing quality dental benefits to your employees and their families.

At HDS, our mission is to improve oral health and create a lifetime of healthy smiles for Hawaii families. HDS was established in 1962 to design and offer dental benefit plans at reasonable costs to increase access to oral health care. Today, our services impact nearly 1,000,000 Hawaii residents. Our network of coverage spans across Hawaii, Guam and Saipan. Our network of dentists includes 95% of all licensed, practicing dentists in Hawaii and 70% of all licensed, practicing dentists in Guam and Saipan.

HDS is committed to providing your employees and their families opportunities to access oral health care through our services. As HDS members, your employees and their families can:

- **Find a dentist they trust –** More than 95% of all licensed, practicing dentists in Hawaii participate with HDS. All HDS participating dentists are committed to making costs as reasonable as possible. Your employees' and their families' out-of-pocket expenses are minimized when they choose to see an HDS participating dentist.
- **Access dental care across the U.S. Mainland** – HDS is a member of Delta Dental Plans Association (DDPA), the nation's largest and most experienced dental benefits company. DDPA provides a large network of dentists, which your employees and their families may choose from when receiving dental services on the Mainland.

We invite you to use the following reference guide as a resource to understand your dental benefits, how to enroll or disenroll employees, manage billing and payments, and reach the appropriate support teams we have here at HDS.

This reference guide is not a legally binding document nor a comprehensive summary of the contractual obligations between HDS and employer groups. Please refer to your Group Dental Contract for specific details of your HDS dental benefits program and appropriate legal documents or publications for advice on legal requirements you may be required to adhere to.

CONTACTING HDS

We are here for you! Feel free to contact HDS regarding any questions you may have. HDS has a staff of experienced local professionals ready to assist you, your employees, and their families.

Our Mailing Address:

HDS
700 Bishop Street, Suite 700
Honolulu, HI 96813-4196

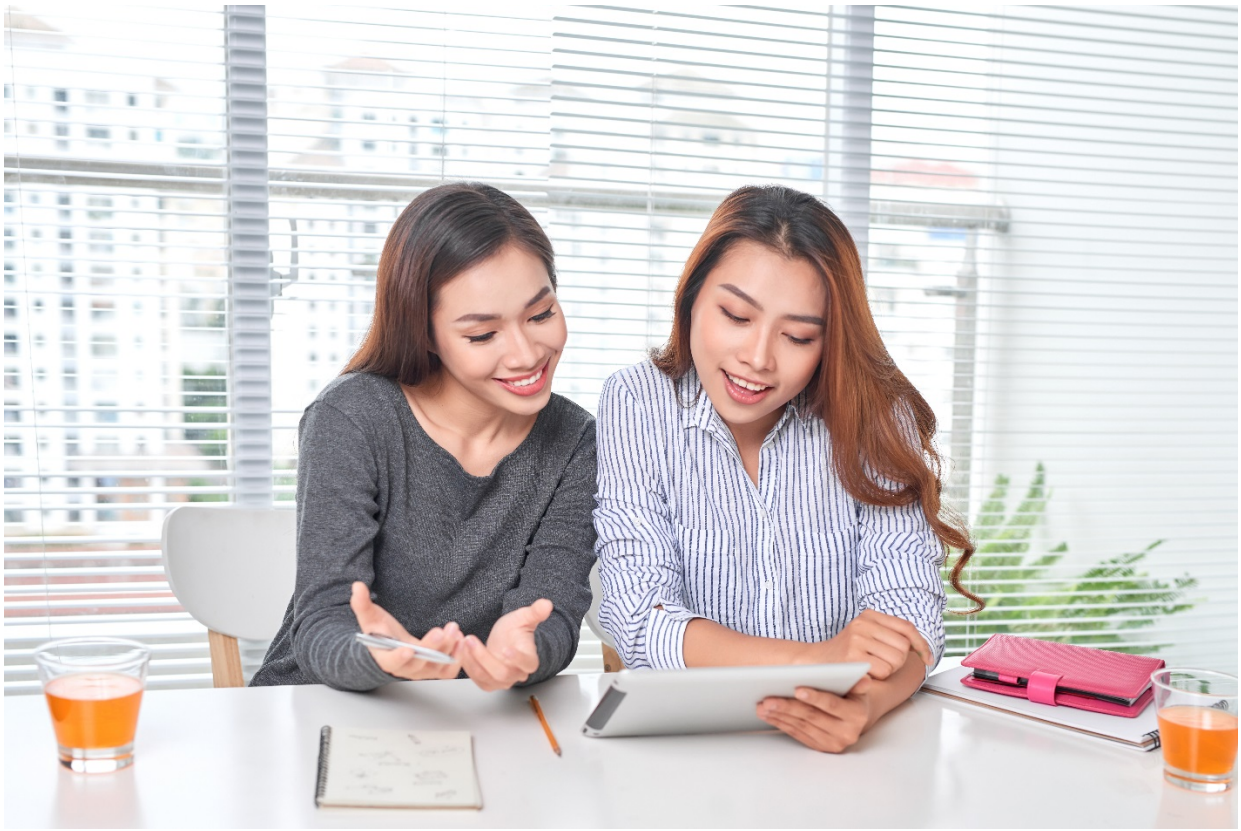
Telephone and Fax

CUSTOMER SERVICE	For questions/concerns about dental claims or plan benefits. Hours: Monday – Friday from 7:30 AM – 4:30 PM (HST)
Phone	(808)529-9248
Toll-Free Phone	1-844-379-4352
Fax	(808)529-9366
Toll-Free Fax	1-866-590-7988
Email	CS@HawaiiDentalService.com

MEMBERSHIP SERVICES	For enrolling new members, making changes to existing enrollment information, and ID Card Information. Hours: Monday – Friday from 8:00 AM – 4:30 PM (HST)
Phone	(808)529-9230
Toll-Free Phone	1-844-829-3256
Fax	(808)529-9207
Toll-Free Fax	1-866-590-7989
Email	MS@HawaiiDentalService.com

BILLING/COBRA	For questions on your invoice or COBRA. Hours: Monday – Friday from 8:00 AM – 4:30 PM (HST)
Phone	(808)529-9285
Toll-Free Phone	1-844-379-4326
Fax	(808)529-9343
Toll-Free Fax	1-866-721-1951
Email	HDSBilling@HawaiiDentalService.com

SALES AND ACCOUNT MANAGEMENT	For general questions on account information or plan options. Contact your Account Executive or the main sales line. Hours: Monday – Friday from 8:00 AM – 4:30 PM (HST)
Phone	(808)529-9206
Toll-Free Phone	1-844-502-1989
Fax	(808)529-9212
Toll-Free Fax	1-866-376-7600
Email	Sales@HawaiiDentalService.com



Fraud and Abuse Program

Fraud and abuse are taken seriously at HDS. HDS periodically conducts reviews at HDS participating dentists' offices to ensure that your employees and their families are being charged in accordance with HDS's contract agreements.

If your employees or their families see services listed on their EOBs that were not performed, or are aware of any false information submitted to HDS, they may file a confidential report online at hawaiidentalservice.ethicspoint.com, call the HDS Ethics and Compliance Hotline toll-free at 1-866-505-9227 or email HDSCompliance@HawaiiDentalService.com.

GLOSSARY

(These terms and others are defined in your Group Dental Contract)

A. **Allowed Amount**: the dollar amount to which the HDS Copayment Percentage is multiplied when calculating the HDS Share for a service.

B. **Approved Amount**: the total dollar amount a dentist will receive for a service provided to an enrollee under the HDS Plan.

C. **Civil Union Partner**: a person who is party to a civil union, as defined in Haw. Rev. Stat. Chapter 572B (2012), with the Subscriber.

D. **Coordination of Benefits**: the process of determining the order in which each plan will pay when an Enrollee is covered by more than one plan.

E. **Delta Dental Participating Dentist**: a dentist, other than an HDS Participating Dentist, who is a member of the Delta Dental network of dentist.

F. **Dependent Child**: a person who is

   a. a biological child, a stepchild, a foster child, an adopted child, or a child placed under legal guardianship of the Subscriber, Spouse, Reciprocal Beneficiary, Civil Union Partner, or Domestic Partner who is age 0 through 25; or

   b. a biological child, a stepchild, a foster child, an adopted child, or a child placed under legal guardianship of the Subscriber, Spouse, Reciprocal Beneficiary, Civil Union Partner, or Domestic Partner who is age 0 or older who is mentally or physically incapable of self-sustaining employment.

G. **Domestic Partner**: a person who cohabitates with the Subscriber and who is in a committed relationship with the Subscriber. Domestic Partners and Subscribers must not be married to each other nor anyone else. Domestic Partners and Subscribers must not be in a civil union nor reciprocal beneficiary relationship with each other or anyone else. Domestic partners and Subscribers may be of the same sex or opposite sex.

H. **Explanation of Benefits**: a statement that reports the dental claims processed by HDS including the HDS Share and the Patient Share for dental services received by the Enrollee.

I. **HDS Copayment Percentage**: the percentage to which the Allowed Amount is multiplied when calculating the HDS Share.

J. **HDS Participating Dentist**: a dentist who is a member of the HDS network of dentists.

K. **HDS Procedure Code Guidelines**: the policies HDS uses to process claims for dental services, as amended from time to time in HDS's sole discretion.

L. **Member:** any person who is covered under an HDS Plan.

M. **Non-Participating Dentist**: a dentist who is neither an HDS Participating Dentist nor a Delta Dental Participating Dentist, and who is participating within the scope of a valid, current, and unrestricted license to practice as a dentist in the jurisdiction in which services are rendered.

N. **Open Enrollment Period**: a time specified by Group when all Eligible Persons can enroll or make changes to their enrollment in the HDS Plan.

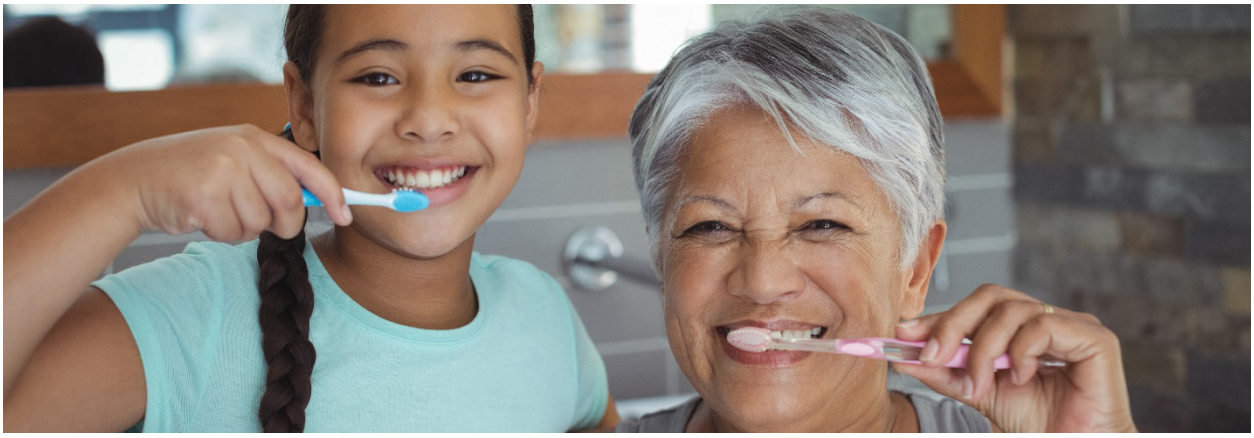
O. **Patient Share**: the amount an Enrollee must pay for a dental service.

P. **Plan Maximum**: the maximum amount payable for the specified time by the HDS Plan for Covered Benefits for an Enrollee.

Q. **Reciprocal Beneficiary**: a person who is party to a valid reciprocal beneficiary relationship, as defined in Haw. Rev. Stat. Chapter 572C (1997), with the Subscriber.

R. **Spouse**: a lawful wife or husband of the Subscriber or an ex-wife or ex-husband of the Subscriber who has a court-ordered right to dental benefits from Subscriber.

S. **Subscriber**:
    a. an enrolled employee



ELIGIBILITY

Eligibility is generally effective as of the first day of the month.

General Eligibility

Eligible members include:

- Eligible employees and:
  - Their spouse, partner (civil union or domestic), or reciprocal beneficiary as defined by the Group Dental Contract.
  - Their or their spouse's, partner's (civil union or domestic), or reciprocal beneficiary's dependent children up to the group's indicated age limit.
    - Disabled dependent children at or over the group's indicated age limit who are mentally or physically incapable of self-sustaining employment, provided that the child was enrolled with HDS continuously since before the child reached the group's indicated age limit.
    - Dependent children under the group's indicated full-time student age limit (if applicable) that are full-time students at an accredited school, college or university.

HDS mails two Member Identification Cards (HDS ID Cards) to all eligible employees upon enrollment under the plan. HDS ID Cards display the Subscriber's name and the Subscriber's HDS ID number, but the cards are also valid for all enrolled family members.

Qualifying Events

Generally, eligibility will begin on the first day of the month following any of these qualifying events:

Qualifying Event	Description
Open Enrollment	The period in which the Group Dental Contract renews. New enrollments and changes to current enrollments can be made.
Probation	Period in which Subscribers must fulfill their obligation to add a spouse, partner (civil union or domestic), or reciprocal beneficiary and/or dependent children to the dental plan.
Loss of Coverage	Subscriber, spouse, partner (civil union or domestic), or reciprocal beneficiary and/or dependent children become ineligible to receive dental benefits under another dental plan.
Newborn	Birth of a newborn child.
Adoption/Legal Guardianship	Subscriber or spouse, partner (civil union or domestic), reciprocal beneficiary legally becomes a parent or guardian of a child.
Newlywed	Date of marriage, civil union, domestic partnership or acquiring a reciprocal beneficiary.

Employee Enrollment Form and Employee Change Form

For general eligibility or qualifying event transactions, the completed Employee Enrollment Form and Employee Change Form (Forms) should be submitted to HDS **two months before** the dental benefits effective date.

The Employee Enrollment Form should be submitted for:

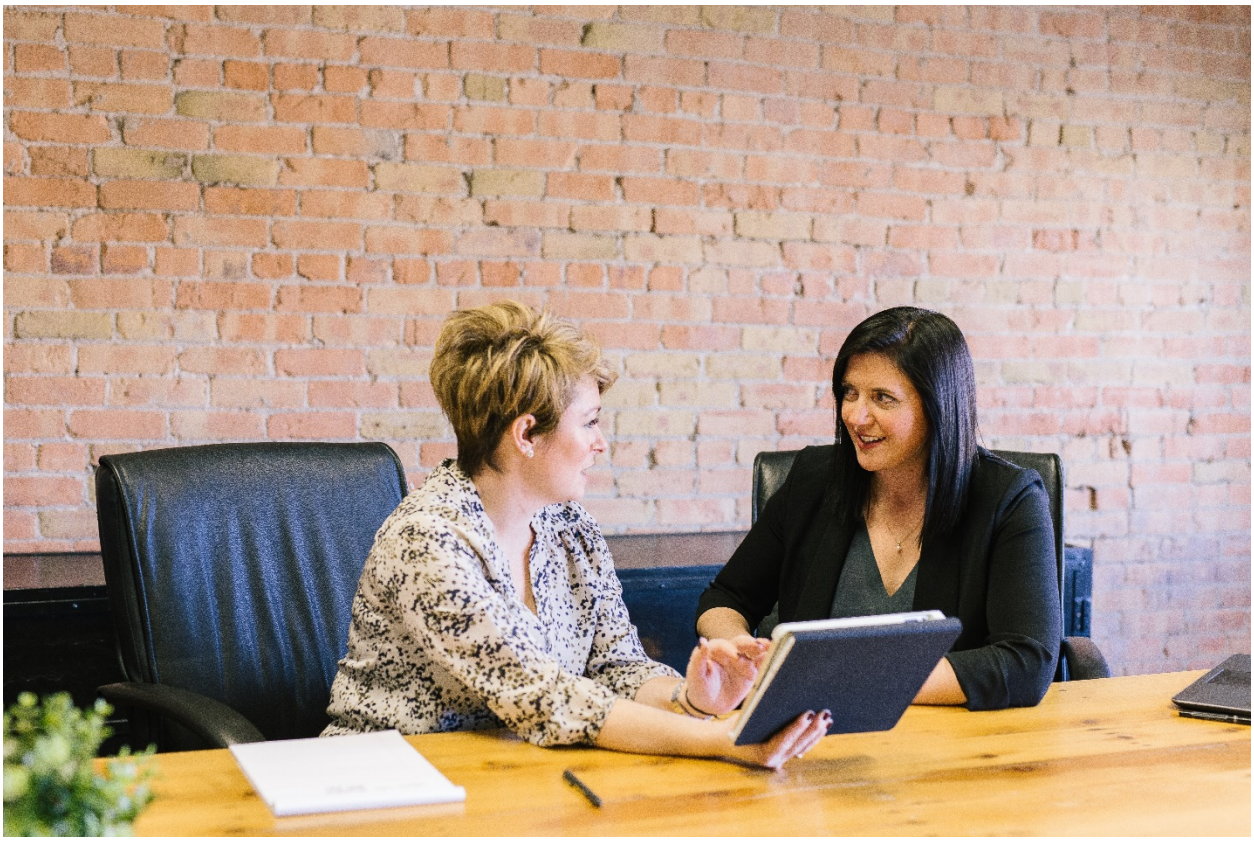
- Enrollment of all new eligible employees and family members.
- Reinstatement of an eligible employee with a break in coverage.

The Employee Change Form should be submitted to update information for Subscribers and/or their family members already enrolled in the plan. The Employee Change Form should also be submitted for the following requests:

- Add/terminate dependent children, including disabled child or full-time student
- Update subscriber's or family member's name, birthdate, gender, address (mail/email) and phone number
- Add/terminate spouse, partner (civil or union), or reciprocal beneficiary
- Transfer subscriber(s) from one division to another

Age Notification Report

The Age Notification Report is mailed monthly and will identify dependent children under the plan that will reach your group's indicated age limit within two months.



TERMINATION

Termination Dates are defined in your Group Dental Contract. In general, coverage for enrolled employees and their family members terminates on the last day of the month in which the employee is no longer employed by the group. In addition, coverage for enrolled family members terminates when they no longer meet the definition of a Spouse, Reciprocal Beneficiary, Partner (Civil Union or Domestic) or Dependent Child, as stated in your Group Dental Contract.

Employee Termination Form

For termination of enrolled employees, complete and submit an Employee Termination Form within the same month of the requested termination date. HDS may consider retroactive termination requests within two months after the termination date, provided no dental claims have been paid during the retroactive period.

Should eligible employees and/or their family members elect to continue coverage through COBRA, the active dental coverage should be terminated. Submit the completed Employee Termination Form to terminate the coverage for employees or the Employee Change Form to terminate the coverage for the family member(s).

BILLING

HDS generates and mails a monthly invoice by the 20th of the month for the next month. The invoice reflects the current billing information by division, including any changes in your group's eligibility that has been reported to HDS since the previous statement.

Reading your Invoice

The monthly invoice consists of four sections:

1. Group Summary and Remittance Advice
   The Group Summary page displays a count of active Subscribers and their dependents by division. It shows a breakdown of the current premium amount with any retroactive premium changes and the final adjusted billing for the month by division. It also reflects any payment received and the total amount due for the month. The bottom portion is a detachable Remittance Advice that is to be mailed with your group's monthly premium payment.

2. Division Summary *(This page may not apply to some groups.)*
   The Division Summary breaks the detail down further from the Group Level to the Division Level. It shows the tier structure, its rates, total enrollment counts, current premiums, retroactive premium adjustments, and the total premiums due for the division. There is a Division Summary for each division within a group.

3. Current Month Premium
   The Current Month Premium page lists all active Subscribers and the respective current month premiums. The current enrollment count reflects coverage for any spouse or dependent children.

4. Adds, Terms, & Dependent Changes Since Last Group Invoice
   This section lists all changes submitted to HDS since the last monthly invoice, including billing adjustments for retroactive changes.

Auditing your Invoice

1. Compare the names and current enrollment count of employees listed in the invoice to your records.
2. Verify the adjustments listed on the *Adds, Terms & Dependent Changes* page. This page reflects invoice adjustments for eligibility changes received after the last monthly invoice.
3. If any discrepancies in *eligibility* are found on the invoice, contact the HDS Membership Services Department from Oahu at (808)529-9230, or toll-free at 1-844-829-3256.
4. If any discrepancies in *premium amounts* are found on the invoice, contact the HDS Billing Department from Oahu at (808)529-9285, or toll-free at 1-844-379-4326.

Paying your Invoice

Premiums are due by the date indicated on each invoice. Below is the payment process for invoices.

Step 1
- Audit invoice as outlined

Step 2
- Detach the Remittance Advice, indicate your payment amount and group number.
- Include your group number on the check or check stub.

Step 3
- Pay the "Total Amount Due" indicated on the *Group Summary* page

Step 4
- Mail Remittance Advice and payment to:
  Hawaii Dental Service
  PO Box 30500
  Honolulu, HI 96820-0500

Please do not include correspondence with the payment. Correspondence relating to the group's payment, premium calculations, or payment adjustments should be mailed to:

Hawaii Dental Service
Attn: Billing Department
700 Bishop St Ste 700
Honolulu, HI 96813

Other Payment Options Available

- **Automatic Payments**: authorize HDS to automatically deduct the monthly premiums due each month from your company checking account.
- **Online**: log on to our Employer website to make a one-time payment from a bank account.

WHAT HDS OFFERS

HDS Member Portal

By creating an online account on the HDS Member Portal, eligible employees and their families will be able to review their dental plan benefits, search for a participating dentist, view their Explanation of Benefits reports, print their HDS ID Cards, and more. Eligible employees and their families may register for an online account via the HDS Member Portal at https://www.hawaiidentalservice.com/hds/member/login.

Help Manage Dental Costs

HDS participating dentists agree to accept an HDS schedule of fees for services that are covered and charge HDS Members the agreed upon fee, even after they reach their annual Plan Maximum. The participating dentist may submit a preauthorization request to HDS **before** providing services. The preauthorization will reserve funds for the specified services against the Plan Maximum. It will also help HDS Members to plan their dental services accordingly should they reach their Plan Maximum.

Explanation of Benefits (EOB) Statement

HDS provides its members with EOB statements which summarize the services received from their dentist and lists payment information. An EOB will be provided if a service is not covered (in whole or in part). HDS Members will not receive an EOB for services with no patient share or when only tax is due.

EOBs are made available electronically and can be viewed after creating an online account on the HDS Member Portal.

It is important to note that the EOB statement is not a bill. Depending on the dentist's practice, the dentist may bill the HDS Member directly or collect any portion not covered by the plan at the time of service.

Calculating the Benefit Payment

Determining the amount that should be paid to the HDS participating dentist is based on a simple formula (see box below). HDS will pay the "% plan covers" amount.

HDS Members are responsible for the balance owed to their dentist, which includes the Approved Amount (the maximum amount that the member is responsible for), any applicable deductible amounts, and taxes, less the HDS payment. Participating dentists are paid based upon their Allowed Amount. (The amount to which the benefit percentage is applied to calculate the HDS payment.)

Dentist's Allowed Amount
X % plan covers

HDS Payment

Dentist's Approved Amount
<minus HDS Payment>

Patient Share

Dual Coverage/Coordination of Benefits

HDS Members should let their dentist know if they are covered by any other dental benefits plan(s).

When HDS Members are covered by more than one dental benefits plan, the amount paid will be coordinated with the insurance carrier(s) in accordance with guidelines and rules of the National Association of Insurance Commissioners. Total payments or reimbursements will not exceed the dentist's Allowed Amount when HDS serves as the second plan.

There is a limit on the number of times certain covered procedures will be paid and payment will not be made beyond these plan limits.

Coverage of identical procedures will not be combined in cases where there are multiple plans. For example, if an HDS Member has two plans and each includes two cleanings during each calendar year, HDS will cover two cleanings (not four) in each calendar year.

In Hawaii, Guam, and Saipan

Choose an HDS Participating Dentist

HDS Members may select any licensed dentist, but they save on their out-of-pocket costs when visiting an HDS participating dentist for services received in Hawaii, Guam and Saipan. HDS participating dentists agree to accept an HDS schedule of fees for services that are covered.

On the Mainland

Choose a Delta Dental Participating Dentist

- If an eligible employee's job takes him/her out of state or his/her child attends school on the Mainland, we recommend that the HDS Members visit a Delta Dental participating dentist to receive the maximum benefit from their plan.
- For a list of Delta Dental participating dentists, visit the HDS website at HawaiiDentalService.com and click on "Find a Dentist". Click on the "U.S. Mainland & Puerto Rico" search button to search for a dentist.
- When visiting a dentist on the Mainland, HDS Members should let the dentist know they have an HDS plan and present their HDS ID Card.
- If the dentist is a Delta Dental participating dentist, the claim will be submitted directly to HDS.
- The Patient Share will usually be the difference between the Delta Dental dentist's agreed upon fee and HDS's payment amount.

Visiting a Non-Participating Dentist

If the HDS Member decides to have services performed by a dentist who is not an HDS or Delta Dental participating dentist, the HDS Member is responsible for the difference between the amount that the non-participating dentist actually charges and the amount paid by HDS in accordance with the plan.

BENEFIT PLAN LAWS

Below are brief summaries of some laws applicable to employee benefit plans. This information is only an overview of certain legal requirements and is not a comprehensive list nor legal advice.

ERISA

The **Employment Retirement Income Security Act of 1974 (ERISA) sets minimum standards for most retirement and health plans** established by employers in the private sector. ERISA is intended to protect the rights of participants in employee benefit plans. Under ERISA, various legal requirements apply to benefit plans. For example, all ERISA plans, regardless of size, must prepare and distribute certain information and notices to participants. Employers and group plans subject to ERISA are responsible for compliance with the ERISA rules.

More information about ERISA can be found on the U.S. Department of Labor website at https://www.dol.gov/general/topic/health-plans/erisa.

COBRA

The **Consolidated Omnibus Budget Reconciliation Act (COBRA)** was signed into law on April 7, 1986. Employers and group plans subject to COBRA are responsible for compliance with the COBRA rules.

The law generally applies to group health plans sponsored by employers with 20 or more employees on more than 50 percent of its typical business days in the previous calendar year. Under the law, such group health plans must offer covered employees and their families the opportunity for temporary continuation of coverage at the employee's expense (up to 102 percent of the premium) when a qualifying event occurs.

A qualifying event is defined as an event that results in a loss of coverage, which entitles qualified beneficiaries (employees, covered spouses, and dependents) to COBRA benefits. Qualified beneficiaries are eligible for 18 months of continuation coverage and, depending on their circumstances, may be eligible for additional continuation coverage for a total of up to 36 months. The following is an overview of qualifying events and circumstances and the corresponding maximum total length of COBRA coverage:

Qualifying Event	Maximum Length of Coverage
Termination of employment (for reasons other than "gross misconduct")	18 months
Reduction in hours of employment	
Retirement	
Divorce or legal separation	36 months
Death of covered employee	
Loss of dependent child status under the plan rules	
Employee enrollment in Medicare	
Qualifying disability under the Social Security Act	29 months

COBRA-covered group plans are generally considered welfare plans under ERISA and therefore subject to ERISA's other requirements. Under ERISA, group health plans must be administered by a Plan Administrator, who is usually named in the plan documents. A Plan Administrator is responsible for carrying out the requirements of COBRA for the group plan. ***HDS does not serve as a Plan Administrator.***

Group Plan Administrators are responsible for the following:

- Ensuring applicable regulations are followed.
- Maintaining proper documentation.
- Providing required notifications on a timely basis.
- Providing the general (or initial) notice to covered employees and their families.
- Providing notice of non-entitlement of COBRA to employee and family members.
- Notifying HDS of all qualified beneficiaries electing to continue coverage under COBRA by providing the signed and completed HDS COBRA Continuation Coverage Election Form to HDS within 10 calendar days of receipt.
- Notify qualified beneficiaries of a group's open enrollment period and if there are any changes to the plan benefits or rates.

HDS provides the following COBRA assistance:

- Enrollment and tracking of eligibility
- Collection of premiums
- Only certain notifications to Subscribers, including:
  - Enrollment confirmation and payment coupons
  - Late payment reminders
  - COBRA Termination – due to non-payment, end of COBRA, plan termination, etc.
- COBRA enrollee listing upon request from group

More information about COBRA can be found on the U.S. Department of Labor's Employee Benefits Security Administration website: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations govern various aspects of the health care system. The HIPAA Privacy Rule set national standards for protecting certain health information. The HIPAA Security Rule set national standards for protecting personal health information in electronic form. Individuals, organizations, and agencies that meet the definition of a "covered entity" under HIPAA must comply with the HIPAA rules' requirements to protect the privacy and security of health information and must provide individuals with certain rights with respect to their health information. Health plans, to include employer health plans and health insurance companies, are covered entities. HIPAA prohibits covered entities from using or disclosing protected health information unless specifically permitted under the HIPAA rules.

The HIPAA rules prohibit HDS from disclosing protected heath information to an employer or a group plan if the HIPAA regulations or HDS's privacy policies do not expressly allow the disclosure.

APPEAL PROCESS

Claims Appeal

If your Subscriber and/or their dependents disagree with the benefit determination, you have the right to appeal the decision. Below are the instructions to process a Claims Appeal:

Step 1	Submit an appeal request in wiring to: HDS Attn: Appeals Manager 700 Bishop Street, Suite 700 Honolulu, HI 96813-4196 Include the following information in the appeal request: • HDS Subscriber ID • Patient's Name • Mailing address and Phone number • Claim number • Treating Dentist's Name • Date of service being appealed • Reason for the appeal • Any supporting documents HDS will review the request and provide a response within 30 days.
Step 2	If you do not agree with the response and are a member of an employer-sponsored group, you have the right to bring a civil action under Section 502(a) of ERISA.