SUBSCRIBER HANDBOOK

Golden Dental Plans, Inc.
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800-451-5918
www.goldendentalplans.com

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SECTION 1 - DEFINITIONS

Adverse Determination or Final Adverse Determination. A determination by Us that:
A. dental care;
B. availability of care;
C. continued care; or
D. other dental health care service that is a Covered Dental Benefit;
has been reviewed and, based on the information provided:
A. does not meet our requirement for: (1) medical necessity; (2) appropriateness; (3) health care setting; or (4) effectiveness; and
B. the requested service or payment for services is therefore: (1) denied; (2) reduced; or (3) terminated.
Failure to respond in a timely manner to a request for a determination constitutes: (A) an adverse determination; or (B) final adverse determination.

Application. The Application for the Policy. Application includes: (A) any subsequent Applications submitted to the Company to request a change in benefits or to reinstate the Policy; and (B) any amendments to the Application. The application consists of the completed form requested by, and submitted to us which lists the Subscriber and his/her dependents to be covered under the Policy.

Business Day. The normal work week, Monday through Friday, (9:00 am – 5:00 pm).
Coinsurance. The out-of-pocket cost based on a percentage amount that the Covered Person must pay for a Covered Dental Service. The percentage amount payable by the Company for a Covered Dental Benefit is shown in the Schedule of Benefits. The Covered Person pays the remaining percentage balance for the cost of the Covered Dental Benefit. The Coinsurance payment is required by the covered person after he or she pays any Co-Payment required for the Covered Dental Benefit.
Commissioner. The Commissioner of the Michigan Office of Financial and Insurance Regulation, Department of Energy, Labor and Economic Growth (OFIR).

Co-Payment. A fixed dollar amount the covered person is obligated to pay to the dental office or dentist for a specifically listed Covered Dental Service. The required co-payments are shown in the Schedule of Benefits

Course of Treatment. A planned program consisting of one or more services or supplies, whether rendered by one or more dentists, for the treatment of a dental condition diagnosed by the attending dentist as a result of an oral examination. A course of treatment commences on the date a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Services. The services or supplies described in the Schedule of Benefits and Schedule of Services which are: (A) necessary for the restoration and/or maintenance of the oral health of the covered person; or (B) at other times with the permission of GDP.

Covered Dependent. The Subscriber's dependents who are covered under the Policy.

Covered Person. An individual who is covered under the Policy. A covered person includes the Subscriber and any covered dependents.

Dental Office and **Dental Center.** A dental office which has agreed to provide Covered Dental Services as contracted under the GDP Dental Provider Agreement. The Subscriber selects the dental office or dental center as his or her designated dental office or dental center where dental services will be provided for him or her and his or her covered dependents. The charges for Covered Dental Services provided by the dental office or dental center are based on the contracted rate between GDP and the dental office or dental center.

Dentist. A dentist or group of dentists who are legally licensed to practice dentistry within scope of his/her license. As used in the Policy, the term "dentist" also includes a legally licensed physician authorized by his/her license to perform the particular dental services.

Dependent:

A. the spouse of the Subscriber. The Subscriber's spouse of a common law marriage is eligible for coverage only to the extent such a relationship is recognized under the laws of the applicable state in which the Subscriber is enrolled.
B. the unmarried child of the Subscriber up to age 19 and residing at home with the Subscriber.
C. the unmarried child of the Subscriber age 19 to age 25 who is a full-time student in an accredited institution of higher learning:
D. any child who is totally and permanently disabled by any medically determinable physical or mental condition which prevents the dependent from engaging in substantial gainful activity and which can be expected to result in death or to be of long continued or indefinite duration. The Subscriber must submit satisfactory proof of such child's incapacity to us once every two years.
E. an unmarried handicap child of the Subscriber age 19 or older who remains dependent on the Subscriber for support and maintenance because that child is incapable of working due to physical handicap or mental retardation. Written proof of the handicapped dependent child's incapacity must be furnished to us at our home office within 31 days prior to the dependent child reaching the limiting age while covered under the Policy. We may require, at reasonable intervals, evidence that the handicap is continuing. In any event, we will not require evidence more often than once a year after the 2 year period following attainment of the limiting age.

Each such child who has reached nineteen (19) years of age must legally reside with and is a member of the household of the Subscriber within the meaning of the Internal Revenue Code of the United States.

Child means an unmarried child under age 25 who is:

A. a child of the Subscriber by birth, legal adoption, or by legal guardianship while the child legally resides with and is dependent upon the Subscriber.
B. a child of the spouse of the Subscriber while: (1) such child is in the custody of and dependent upon the spouse; and (2) is residing in and is a member of the Subscriber's household.
C. a child, as defined above in A. and B. who does not reside with the Subscriber but such child is the legal responsibility of the Subscriber for the provision of medical, including dental care. Such child includes a child: (1) of divorced parents; (2) whose legal guardian is the Subscriber; and (3) who is confined in a training institution; or (4) who is in school.
D. a child: (1) who resides with and related to the Subscriber by blood or marriage; and (2) for whom the Subscriber provides principal support, as defined by the Internal Revenue Code of the United States; and (3) who was reported as a dependent on the Subscriber's most recent income tax return or who qualify in the current year for dependency tax status.

Diagnostic Services. Includes the necessary procedure which will aid the dentist in evaluating conditions and determine the dental care required, including: (A) dental examinations; (B) visits; (C) consultation; and (D) treatment planning services.

Effective Date of Coverage. The date coverage starts under the Policy for a Covered Person. Refer to Section 2, When Coverage Takes Effect and Terminates, in the Policy.

Emergency. The nonspecific, medically necessary dental treatment for the immediate and or temporary relief of acute pain, swelling, bleeding or discomforts which are required unexpectedly or immediately and would jeopardize the life or health of the Covered Person.

Emergency Treatment. The nonspecific, medically necessary dental treatment for the immediate and temporary relief of acute pain, swelling, bleeding or discomfort which is required unexpectedly or immediately and would jeopardize the life or health of a Covered Person.

Expedited Grievance. The immediate action taken by GDP when a grievance is submitted and a dentist or physician orally or in writing, substantiates that the time frame for the grievance would acutely jeopardize the life or health of the Covered Person.

GDP is the abbreviation for Golden Dental Plans, Inc.

GDP Providing Office. An office engaged in dental practice which has contractually agreed with GDP to furnish dental care to persons covered under the GDP dental plan policies.

Grievance/Complaint. An inquiry, complaint or grievance on behalf of a Covered Person submitted by:
A. the Subscriber; or

B. a person including, but not limited to a Dentist or a physician authorized in writing by the Subscriber to act on behalf of the Subscriber regarding:
   a. the availability, delivery, or quality of dental health care services, including: (i) a complaint regarding an adverse determination; or (ii) final adverse determination made pursuant to utilization review.
   b. benefits or claims payment handling or reimbursement for dental health care services.
   c. matters pertaining to the contractual relationship between the Subscriber and GDP.

HIPPA. The Federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Independent Review Organization. An entity appointed by the Commissioner of OFIR that conducts independent external review of adverse determinations or final adverse determinations.

Oral Surgery. Includes necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including pre-operative care and post-operative care.

Orthodontics. Includes treatment for: (1) malocclusion; and (2) the proper alignment of teeth (straightening of teeth).

Owner means the Subscriber. Owner is also referred to as “You” or “Your”.

Periodicity Schedule. An examination by a Dentist that is recommended by age one. An examination is required by age three. It is then recommended that dental visits be repeated every six months.

Periodontics. Includes all necessary procedures for treating diseases of the gums and bones which support the teeth not requiring hospitalization.

Policy. The Policy issued to the Owner as shown in the Schedule of Benefits.

Policy Anniversary. The same day and month as the Policy Effective Date for each succeeding year the Policy remains in force. The Policy Effective Date is shown in the Schedule of Benefits.

Policy Coverage Period. The one-year period for which the annual premium is paid for coverage under the Policy.

Premium. The money prepaid by the Subscriber to GDP. The premium required for the Policy is shown in the Schedule of Benefits.

Preventive Denistry. Those procedures which prevent oral disease from occurring, including:
A. prophylaxis - cleaning, polishing and scaling of teeth as necessary.

B. topical fluoride applications for covered dependent children under age 15 at 6 month intervals.
C. space maintainers - temporary space maintenance for covered dependent children until permanent teeth erupt to prevent unnecessary orthodontic expense.

Primary Care Dentist. The Dentist selected by You to provide dental care and treatment for You and Your Covered Dependents, if any.

PRIRA. The Patient's Right to Independent Review Act. This Act provides: (1) a review of certain health care coverage adverse determinations; or (2) final adverse determinations made by a health carrier.

Prosthodontics. The necessary procedures for providing standard artificial replacements for missing natural teeth:
A. construction, placement and insertion of bridges, partials, and complete denture.
B. repair or re-cementing of bridges, partials, and complete dentures.

Referral Provider:
A. a dentist;
B. an orthodontist;
C. an endodontist;
D. a medical doctor;
other than an affiliated provider who provides dental care to a Covered Person on the referral order of an affiliated provider.

Restorative Dentistry. All necessary procedures in a dental office not requiring hospitalization.

Schedule of Benefits. The document issued in the Policy which indicates the benefit plan elected by the Subscriber and indicates the benefit amounts payable. The Schedule of Benefits also includes: (A) the name of the Subscriber; (B) the initial premium payment; and (C) type of enrollment coverage elected by the Subscriber.

Schedule of Services. The document which:
A. lists for the covered person all covered services; and
B. shows those covered services that are subject to copayments and those that are not.
The Schedule of Services is available upon request from us. A summary Schedule of Services lists the most frequently performed covered services and their applicable co-payments.

Service Area. The geographic area where dentists, dental offices and dental centers in the GDP network are located. The listing of dentists, dental offices and dental centers in the GDP network, that will be given to each Subscriber, describes this geographic area. The service area for GDP is the service area that has been approved by the Office of Financial and Insurance Regulation. The service area is the area in which GDP may market its policies as approved by the Office of Financial and Insurance Regulation.

Subscriber. The person named as the Subscriber in the Schedule of Benefits. The Subscriber is the Owner of the Policy, which means he or she may exercise the rights set forth in the Policy. On the Policy Effective Date, the Subscriber and the Owner are as designated in the application for the Policy. The Subscriber is also referred to as "You" or "Your".

SECTION 2 - GENERAL SUBSCRIBER INFORMATION

2.1 WELCOME TO GOLDEN DENTAL PLANS, INC.

This Handbook is designed to help you, the Subscriber, learn how to use your GDP services and benefits. GDP differs from some traditional dental coverage in that GDP actually arranges for your dental care in a well coordinated network of dental professional facilities, rather than merely paying claims after dental services have been provided. The emphasis is on preventative dentistry to help you achieve and maintain good dental health rather than just treating you when you have a dental problem.

Please read this Handbook carefully, and keep it handy. It will answer most of your questions about Golden Dental Plans, Inc. procedures or services. Please refer to your Policy which provides the actual terms, conditions, and benefits (including covered dental services, coinsurance and co-payments, if any) for your dental coverage. Also, refer to the dental center listing which is provided with this Handbook. If you have any questions about Golden Dental Plans, Inc., please call one of our professional relations representatives at the following address or phone number:

Administrative Offices:

Golden Dental Plans, Inc.
29377 Hoover Road
Warren, MI 48093
Phone (586) 573-8118 or 1-(800) 451-5918
FAX (586) 573-8720
Website: wwwgoldendentalplans.com

2.1 EFFECTIVE DATE OF COVERAGE

Your dental coverage begins on the Policy Effective Date shown in the Schedule of Benefits. If you enrolled your eligible dependents on the date of application for the Policy, coverage for your eligible dependents also begins on the Policy Effective Date. Refer to Section 2, WHEN COVERAGE TAKES EFFECT AND TERMINATES, of the Policy for more details regarding eligibility and termination provisions applicable to you, your covered dependents, and the Policy.

2.2 SUBSCRIBER'S OBLIGATION

The GDP Plan is designed to deliver quality dental care to the satisfaction to persons covered under our dental policies. To help us accomplish this, we make the following suggestions:

A. You and your dependents must first select a dentist from our list of providers found in your enrollment package or visit the GDP website: www.goldendentalplans.com, and click on 'dentist search' to find a provider in your area.

B. Appointments should be made in advance. "Squeezing" in or failing to make an appointment will only result in unjustified and unnecessary delays for everyone.

C. If you or your covered dependents receive out-of-area emergency treatment, please notify your dental center so that follow-up care can be arranged for you or your covered dependent. (Please refer to Emergency Coverage and Out-of-Area Emergency Coverage provisions in Sections 3.1 and 3.2).

D. Consultations with Specialists to whom you have not been referred in writing by your primary dentist are not covered by GDP. Payment of expenses incurred for such consultations are your responsibility. (See section 3.3 for more details.)

E. GDP will make every effort to keep you and your family in good dental health. To assist us in this practice, it will be up to each covered person to have periodic dental checkups, practice good dental hygiene, and to contact your dentist at the first sign of a dental problem.

F. You MUST notify GDP and your primary provider if you or your covered dependents are eligible for dental benefits through another plan.

G. When a co-payment is required for a dental service, you are expected to pay the co-payment amount at the time of your dental visit unless special arrangements have been previously made with your dentist.

H. If we pay less than 100% for a covered dental service as shown in the Schedule of Benefits, you must pay that portion of the coinsurance percentage not paid by us.

2.3 SUBSCRIBER DENTAL POLICY

Upon approval of your application and payment of the required premium, GDP will provide you with this Handbook, an ID card, and the Policy. The Policy is your certificate of coverage. You are entitled to receive dental services for yourself and your covered dependents, if any, on the Policy Effective Date shown in the Schedule of Benefits.

Coverage under the Policy is provided for 12-month periods, beginning with the Policy Effective Date until the first Policy Anniversary Date, and from each subsequent Policy Anniversary Date thereafter; provided, the Subscriber remits all premiums due and the Policy remains in force. Coverage will continue until terminated in accordance with the terms of the Policy.

This Handbook is not the Policy and does not amend, extend or alter the coverage afforded by the Policy. This Handbook is subject to all terms, exclusions and conditions of the Policy. READ YOUR POLICY CAREFULLY.

2.4 USING YOUR DENTAL FACILITY

Subscribers can find a dental center located conveniently near their homes.

Our participating dental providers have been carefully selected through Our Quality Assurance Program to provide you with quality dental care. The dental facilities are private and group practices offices are staffed with trained licensed dental care professionals who will provide dental care and treatment to you and your covered dependents.

Your designated dental center will maintain your and your covered dependent's complete dental records and maintain confidentiality of you and your covered dependents' care.

2.5 CHOOSING YOUR PRIMARY CARE DENTIST

You have the right to choose or change a dentist as your designated dental center as your primary care dentist. Your primary care dentist will be responsible to ensure that your dental care needs are cared for properly. Your primary care dentist will refer you or your covered dependent to one of our approved participating Specialist for care or treatment as needed by a Specialist or for Specialty Care.

2.6 MAKING AN APPOINTMENT

We recommend that you or your covered dependent make an appointment in advance of a dental visit. Your primary care dentist can: (1) assess your or your

covered dependent's present dental health; (2) develop a dental care plan and begin to correct any current dental problems; and (3) work with you or your covered dependents towards maintaining dental health.

2.7 CONFIDENTIALITY AND INSPECTION OF MEDICAL RECORDS

All of your dental treatment and services claim records will be maintained on a confidential basis. Upon request, you or your covered dependent will have the right to inspect and review his or her dental claim record maintained by us.

2.8 RESPONSIBILITIES OF THE SUBSCRIBER

You are responsible for the following:

A. Making timely payment of the annual premium.
B. Nonassignment of Benefits. Benefit payments under the Policy cannot be assigned.
C. Truth in application and statements. The Subscriber will to best of his or her knowledge and beliefs provide truthful information in the application(s) and statements regarding coverage under the Policy.
D. Notify us in writing when you have a change in address as soon as possible.
E. Inform us if there has been a theft in your membership identification. If you lose your membership identification card, please contact us immediately to obtain a new card.

2.9 YOUR DENTAL CENTER

All GDP dentists offer a comprehensive range of services available for the dental care needs of our Subscribers. The staff at the dental center(s) is dedicated to providing continuous, quality dental care. For a current list of approved GDP providers please refer to your provider directory, or visit the GDP website: www.goldendentalplans.com.

SECTION 3 – DENTAL BENEFITS

GDP is your assurance that the dental health needs of you and your family will be cared for properly. Don't delay treatment when a problem arises. Remember, minor dental problems can become serious if left untreated. Your dental plan covers routine visits to the dentist, x-rays, and other diagnostic services which will assist your dentist in properly diagnosing your needs and planning a course of treatment. These services are provided for you as an integral part of your dental plan.

The dental policy is a prepaid dental Policy. Covered dental benefits and the amount we will pay for them are shown in the Schedule of Benefits. The covered person is responsible for paying any Co-payment and any Coinsurance payment at the time of the visit, unless other arrangements are made between the covered person and the dental

provider. Benefits will only be paid as shown in the Schedule of Benefits. (The amount charged by the dental provider will be the GDP contracted fee.)

In order for benefits to be payable under the Policy, the covered person must receive treatment or care from a participating GDP dentist or GDP dental office. No benefits will be payable for treatment or care received from a non-participating GDP dentist or GDP dental office, except for emergency treatment as provided in the Emergency Coverage and Out-of-Area Emergency Coverage provisions indicated in Sections 3.1 and 3.2. A current list of approved GDP providers are provided in your provider directory, or you may obtain the information from the GDP website www.goldendentalplans.com.

The principal benefits provided by the GDP Dental Plan you selected are summarized below. However refer to your Policy, which is your certificate of coverage, for complete details of your dental coverage.

3.1 EMERGENCY COVERAGE

Your Golden Dental Plan provides dental coverage for you and your family on a 24-hour basis, 365 days of the year. Your designated dental center will have someone on staff to receive your call should you need emergency care during regular office hours. If the emergency occurs after regular office hours, each center has a 24-hour answering service available. Our dental providers regularly check in with their services for emergencies. If you or your covered dependents need emergency care after regular office hours, you may contact:

A. Your designated dental center. The dental center has a 24-hour answering service available; or

B. GDP at our emergency 800-number (1-800-451-5918) which is available to assist you in locating a dentist after regular office hours of the designated dental center.

3.2 OUT-OF-AREA EMERGENCY COVERAGE

If you or your covered dependents are outside the geographic area of your primary care dentist, and an emergency arises, you should seek treatment from a dentist in the area. We will reimburse the reasonable expenses incurred by you or your covered dependent as appropriate in an individual case $50.00 for the emergency treatment. The "geographic area" is a 50-mile radius from your designated dental center.

Follow-up treatment for any emergency treatment or care must be obtained from your designated dental center.

3.3 CONSULTATIONS WITH SPECIALIST

Your primary care dentist will provide you or your covered dependent with a written referral to a Specialist for a consultation if he or she determines that you or your covered dependent requires care or treatment from a Specialist. Such referral will be to a Specialist approved by us. There will be no charge for the

referral consultation provided by the Specialist; however, the co-payment for the office visit will apply.

Consultations with Specialists will not be payable under the Policy if a written referral from your primary care dentist is not received on the date of the consultation. Payment of expenses incurred for such consultation service will be the responsibility of the covered person.

3.4 PERIODICITY SCHEDULE

Coverage for the Periodicity is provided under the Policy. An examination by a Dentist is recommended by age one. An examination by a Dentist is required by age three. It is then recommended that dental visits be repeated every six months.

3.5 QUALITY ASSURANCE PROGRAM

To ensure that you and your covered dependents receive the appropriate level of dental care, we have a Quality Assurance Committee to continuously monitor the care received by our policyholders and report to that information to Our Board of Directors.

Through the activity of the Quality Assurance Committee, you can be confident that every measure is taken to monitor and evaluate all facets of your dental care. Each dental office and dental center is subjected to regular peer reviews conducted by our dental director. The results are on file at our corporate office. Reviews are used to evaluate the quality of care delivered to persons covered under our policies.

SECTION 4 – BENEFIT LIMITATIONS

All benefits provided under the Policy are subject to the limitations indicated in this Section.

4.1 PROSTHODONTICS

A prosthodontic appliance, crown, inlay or bridge solely for the purpose of replacing an existing appliance will not be provided more often than once in a five year period. The five year period will be measured from the date on which the existing appliance was last supplied, whether provided under the Policy, or under any prior dental policy. The term "existing" as used in this provision is intended to include an appliance that was placed at the inception of the beginning or the five year period but which, for whatever reason, is no longer in the possession of the patient.

4.2 RESTORATIVE

Cast metal, inlays, crown and jackets; if a tooth can be restored with amalgam, composite or plastic, these will be the material used to restore the tooth. The judgment will be solely that of the dentist providing the service. If a patient and

the dentist select a course of dental treatment, our obligation will be to cover only those benefits appropriate to eliminate oral disease and replace missing teeth, with the least expensive professionally acceptable method of replacement. The balance of the cost of treatment to increase vertical dimension or restore the occlusion, will remain the responsibility of the patient.

Porcelain on crowns posterior to the 1st bicuspid are considered cosmetic and/or enhancements and therefore not a covered benefit. Upgrade metal alloys are not a covered benefit.

4.3 MOUTH REHABILITATION

If the covered person and the primary care dentist selects a course of mouth rehabilitation, the Policy will cover only those benefits appropriate to eliminate oral disease and replace missing teeth. The balance of the treatment, including costs to increase vertical dimension or restore the occlusion, will remain the responsibility of the patient. A bridge for bi-lateral missing teeth or congenially missing teeth is not a covered benefit.

4.4 TEMPORAL MANDIBULAR JOINT DISORDER OR DYSFUNCTION

Services provided under the Policy for treatment of Temporal Mandibular Joint Disorder or Dysfunction (TMJ) will be limited to Equilibration, partial or complete and/or placement of a Habit Appliance (occlusal guard). Such appliance will be provided once during lifetime.

4.5 ORTHODONTICS

Orthodontic care will only be provided when, in the opinion of the Orthodontic Consultant, a satisfactory result can be achieved in permanent dentition only. Cross-bite in permanent dentition (teeth) will only be treated when in the opinion of the Orthodontist; other conditions are present which would indicate that Orthodontic Treatment is necessary.

Class I - Preventative

Benefit limitations apply to the following Covered Preventative Dental Procedures as indicated. The associated dental code for each procedure is also indicated.

Code	Dental Procedure	Benefit Limitation
00150	Initial Oral Exam	1 exam every 24 months
00120	Periodic Oral Exam	1 exam every 6 months
01110	Prophylaxis (Adult)	1 every 6 months for Adults
01120	Prophylaxis (Children)	1 every 6 months for Children
01230	Fluoride Treatment	1 every 6 months unless specified age limit is 15
04355	Full Mouth Debridement	1 during lifetime
00210	Intraoral - Complete Series	1 every 36 months; Age limitation – Covered Person must be 10 years of age or older Oral Surgeon – not covered if limited to upper wisdom teeth only
00270	Bitewing - Single Film	1 every 6 months, combination of up to 4
00272	Bitewing - Two Films	1 every 6 months

Class I – Preventative (continued)

Code	Dental Procedure	Benefit Limitation
00274	Bitewing - Four Films	1 every 6 months
00330	Panoramic - Maxilla & Mandible (Single Film)	1 every 36 months
00460	Pulp Vitality Test	By report only
00470	Diagnostic Casts	By report only for occlusal guard pre-d

Class II - Restorative

Benefit limitations apply to the following Covered Restorative Dental Procedures as indicated. The associated dental code for each procedure is also indicated.

Code	Dental Procedure	Benefit Limitation
02140	Amalgam - One Surface – Permanent	Each surface 1 every 12 months
02150	Amalgam - Two Surfaces – Permanent	Each surface 1 every 12 months
02160	Amalgam - Three Surfaces – Permanent	Each surface 1 every 12 months
02161	Amalgam - Four Surfaces – Permanent	Each surface 1 every 12 months
02330	Resin - One Surface	Each surface 1 every 12 months Anterior & buccal surface on 1st and 2nd bicuspid
02331	Resin - Two Surfaces	Each surface 1 every 12 months Anterior & buccal surface on 1st and 2nd bicuspid
02332	Resin - Three Surfaces	Each surface 1 every 12 months Anterior & buccal surface on 1st and 2nd bicuspid
02333	Resin - Involving Incisal Angle or Four or more Surfaces	Each surface 1 every 12 months Anterior buccal surface on 1st and 2nd bicuspid
02910	Recement Inlay	After initial 6 months, 3 times during lifetime
02920	Recement Crowns	After initial 6 months, 3 times during lifetime
03110	Pulp Cap - Direct (Excluding Final Restoration)	1 every 12 months
03120	Pulp Cap - Indirect (Excluding Final Restoration)	Not a covered benefit

Class III – Prosthetics

Code	Dental Procedure	Benefit Limitation
03210	Therapeutic Apical Closure/Apexification	Not including Final Root Canal Therapy per Treatment
03220	Pulpotomy	Primary teeth only

Class II – Restorative: Root Canal Therapy

Code	Dental Procedure	Benefit Limitation
03310	Anterior (Excludes Final Restoration)	1 every 12 months
03320	Bicuspid (Excludes Final Restoration)	1 every 12 months
03330	Molar (Excludes Final Restoration)	1 every 12 months
03346	Retreatment of previous root canal therapy – anterior	12 months after initial root canal therapy
03347	Retreatment of previous root canal therapy – bicuspid	12 months after initial root canal therapy
03348	Retreatment of previous root canal therapy – molar	12 months after initial root canal therapy

Class II – Restorative: Non-Specialist

Code	Dental Procedure	Benefit Limitation
04210	Gingivectomy or Gingivoplasty (Per Sextant)	1 every 24 months
04211	Gingivectomy or Gingivoplasty (One to three teeth, per quadrant)	1 every 24 months
04220	Sub-Gingival Curettage (Full Mouth)	By report
04221	Sub-Gingival Curettage (Per Sextant)	By report
04231	Sub-Gingival Curettage (Per Quadrant)	By report
04260	Osseous Surgery - Per Quadrant (Including Flap Entry & Closure)	1 every 24 months
04341	Root Planing (Fewer than 12-Teeth)	1 every 24 months
04360	Occlusal Guard BR	1 during Lifetime Treatment must be pre-authorized including FMX and study models required
04910	Periodontal Maintenance Procedures Following Active Therapy (Periodontal Prophy)	Only one allowable cleaning in a six month period, i.e. Codes 01110 or 04910
05850	Tissue Conditioning, Upper	Maximum 2 within 3 months, no more than 2 in one year
05851	Tissue Conditioning, Lower	Maximum 2 within 3 months, no more than 2 in one year
07270	Tooth Replantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus	Not a covered benefit if trauma related
09220	General Anesthesia –	Non-covered benefit

Class III – Prosthetics

Benefit limitations apply to the following Covered Prosthetics Dental Procedures as indicated. The associated dental code for each procedure is also indicated.

Code	Dental Procedure	Benefit Limitation
01515	Space Maintainer - Fixed Bi-Lateral	Age restriction for individuals under 19 years old
01520	Space Maintainer - Removable Unilateral	Age restriction for individuals under 19 years old
01525	Space Maintainer - Removable Bi-Lateral	Age restriction for individuals under 19 years old

Class III – Prosthetics: Crowns

Code	Dental Procedure	Benefit Limitation
02710	Resin (Laboratory)**	As permanent restoration – non covered benefit, as temporary be part of cost for permanent restoration
02720	Resin (With Precious Metal)**	Non-covered benefit
02721	Resin (With Non-Precious Metal)**	Non-covered benefit
02722	Resin (With Semi-Precious Metal)**	Non-covered benefit

Class III – Prosthetics: Crowns and Three-Fourth Crowns

Code	Dental Procedure	Benefit Limitation
02740	Porcelain/ceramic Substrate Crown**	1 every 5 years; age limitation 12 years or older
02750	Porcelain with Precious Metal Crown**	1 every 5 years, age limitation 12 years or older
02751	Porcelain with Non-Precious Metal Crown**	1 every 5 years, age limitation 12 years or older
02752	Porcelain with Semi-Precious Metal Crown**	1 every 5 years, age limitation 12 years or older
02790	Precious Metal (Full Cast) Crown	1 every 5 years, age limitation 12 years or older
02791	Non-Precious Metal (Full Cast)**	1 every 5 years, age limitation 12 years or older
02792	Semi-Precious Metal (Full Cast)**	1 every 5 years, age limitation 12 years or older
02810	Precious Metal (3/4 Cast)**	1 every 5 years, age limitation 12 years or older
02811	Non-Precious Metal (3/4 Cast)**	1 every 5 years, age limitation 12 years or older

Class III – Prosthetics

Code	Dental Procedure	Benefit Limitation
02812	Semi-Precious Metal (3/4 Cast)**	1 x 5 years, age limitation 12 years or older
02820	Thimble	Non payable with a core/cast post as is considered duplication of purpose and function
02830	Stainless Steel	1 every 12 months per primary tooth only
02841	Core/Core Build-Up (Amalgam/Resin Pin or Post Retained)	1 every 12 months
02891	Cast Post and Core (Non-Precious)	1 every 5 years
02892	Post Performed (In Addition to Crown)	1 every 5 years, if in addition to core Non-covered benefit

Class III – Prosthetics: Dentures and Partials

Code	Dental Procedure	Benefit Limitation
05410	Adjustment to Upper Dentures	Payable benefit 6 months after initial placement
05411	Adjustment to Lower Dentures	Payable benefit 6 months after initial placement
05420	Adjustment to Upper Partial Denture	Payable benefit 6 months after initial placement
05421	Adjustment to Lower Partial Denture	Payable benefit 6 months after initial placement
05510	Repair Broken Complete Denture Base	6 months after initial placement 3 times during lifetime
05520	Repair Broken or Missing Teeth (Complete Denture - Each Tooth)	6 months after initial placement 3 times during lifetime
05610	Repair Acrylic Saddle or Base	6 months after initial placement 3 times during lifetime
05620	Repair Cast Framework	6 months after initial placement 3 times during lifetime
05630	Repair or Replace Broken Clasp	6 months after initial placement 3 times during lifetime
05640	Replace Broken Teeth - Per Tooth	1 every 12 months
05650	Add Tooth to Existing Partial Denture	6 months after initial placement 3 times during lifetime
05660	Add Clasp to Existing Partial Denture	1 every 12 months
05710	Upper Rebase, Complete Denture	1 every 12 months, no more than 3 times during lifetime
05711	Lower Rebase, Complete Denture	1 every 12 months, no more than 3 times during

Class III – Prosthetics: Dentures and Partials (continued)

Code	Dental Procedure	Benefit Limitation
05720	Upper Rebase, Partial Denture	1 every 12 months, no more than 3 times during lifetime
05721	Lower Rebase, Partial Denture	1 every 12 months, no more than 3 times during lifetime
05730	Relining Upper Complete Denture (Office Reline)	1 every 36 months
05731	Relining Lower Complete Denture (Office Reline)	1 every 36 months
05740	Relining Upper Partial Denture (Office Reline)	1 every 36 months
05741	Relining Lower Partial Denture (Office Reline)	1 every 36 months

Class III – Prosthetics

Code	Dental Procedure	Benefit Limitation
05750	Relining Upper Complete Denture (Laboratory)	1 every 36 months
05751	Relining Lower Complete Denture (Laboratory)	1 every 36 months
05760	Relining Upper Partial Denture	1 every 36 months
05761	Relining Lower Partial Denture (Laboratory)	1 every 36 months
05820	Upper Denture, Temporary (Partial Stayplate)	1 during lifetime; if permanent denture not placed within 12 months, stayplate cannot be replaced for 5 years
05821	Lower Denture, Temporary (Partial Stayplate)	1 during lifetime; if permanent denture not placed within 12 months, stayplate cannot be replaced for 5 years
05110	Complete Upper Denture	1 every 5 years
05120	Complete Lower Denture	1 every 5 years

Class III – Prosthetics: Partial Dentures

Code	Dental Procedure	Benefit Limitation
05210	Upper Without Clasps - Acrylic Base	1 every 5 years
05211	Lower Without Clasps - Acrylic Base	1 every 5 years
05224	Upper Without Clasps - Acrylic Base	1 every 5 years
05225	Lower With Two Chrome Clasps, Acrylic Base	1 every 5 years
05251	Upper With Chrome Cast Framework and Two Clasps, Acrylic Base	1 every 5 years
05281	Removable Unilateral Partial Denture, One Piece Casting, Chrome Cobalt Clasp Attachments	1 every 5 years

Class III – Prosthetics: Fixed Dental Pontics

Code	Dental Procedure	Benefit Limitation
06210	Precious Metal Crown (Full Cast)**	1 every 5 years, bi-laterally missing tooth clause applies
06211	Non-Precious Metal (Full Cast)**	1 every 5 years, bi-laterally missing tooth clause applies

Class III – Prosthetics: Fixed Dental Pontics (continued)

Code	Dental Procedure	Benefit Limitation
06212	Semi-Precious Metal (Full Cast)**	1 every 5 years, bi-laterally missing tooth clause applies
06240	Porcelain Fused to Precious Metal**	1 every 5 years, bi-laterally missing tooth clause applies
06241	Porcelain Fused to Non-Precious Metal**	1 every 5 years, bi-laterally missing tooth clause applies
06242	Porcelain Fused to Semi-Precious Metal**	1 every 5 years, bi-laterally missing tooth clause applies
06250	Resin Processed to Precious Metal**	1 every 5 years, bi-laterally missing tooth clause applies
06251	Resin Processed to Non-Precious Metal**	1 every 5 years, bi-laterally missing tooth clause applies

Note: Any treatment rendered for Class I, Class II and Class III procedure performed by a Specialist is covered under Class IV – Specialty Care as shown in the Schedule of Benefits.

**** If the Covered Person and the Dentist select a course of dental treatment, the obligation of Golden Dental Plans, Inc. will be to cover only those benefits appropriate to eliminate oral disease and replace missing teeth, with the least expensive professionally acceptable method of replacement. The balance of the cost of treatment to increase vertical dimension or restore the occlusion, will remain the responsibility of the Covered Person. Porcelain on crowns posterior to the 1st bicuspid are considered cosmetic and/or enhancements and, therefore, not a covered benefit. Upgrade metal alloys are not a covered benefit.**

SECTION 5 – EXCLUSIONS, LIMITATIONS AND EXCEPTIONS

5.1 GENERAL EXCLUSIONS, LIMITATIONS AND EXCEPTIONS

No benefits will be paid under the Policy for the following treatments, services and care, unless otherwise indicated:

A. Dental services not appearing on the Schedule of Benefits.
B. Dental treatment for cosmetic purposes.
C. Dental treatment performed in a hospital and/or any related hospital-fee.
D. Treatment of cleft palate, anodontia and mandibular prognathism.
E. Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
F. The cost of services secured from physicians, dentists or dental surgeons, other than authorized GDP providers, will not be paid for unless expressly authorized in writing by the primary care dentist as cited under Emergency Coverage and Out-of-Area Emergency Coverage provisions (see sections 3.1 and 3.2).
G. Treatment for any condition for which benefits of any nature are recovered or found to be recoverable whether by adjudication or settlement under any Workmen's Compensation or Occupational Disease Law, even though you or your covered dependent fails to claim the right of such benefits, provided that this exclusion will only apply to the extent that such benefits are payable through other plans.
H. Treatment for any disease, condition or injuries sustained, as a result of war, declared or undeclared, or any illness or injury occurring after the effective date of the Policy and caused by atomic explosion or exposure whether or not the result of war.
I. Care of treatment obtained from or for which payment is made by any Federal, State, and County, Municipal or other governmental agency including any foreign government.
J. Dental implants or transplants.
K. No covered person will be denied dental coverage due to trauma. However, dental care coverage under the Policy may not cover the covered person for certain traumatic events that may occur if those procedures are specifically excluded in the Policy. A covered person who requires dental care due to a serious trauma will not be covered for dental care in those areas that are specifically described as excluded.
L. A nominal administrative or sterilization fee charged by Select Dental Offices. Please refer to the GDP Provider Directory for further information.
M. Services or appliances started before a covered person became eligible under the Policy (for example, teeth prepared for crowns or root canals in progress).
N. Prescription drugs.
O. Nitrous oxide analgesia.
P. Preventive control programs (including home care items).
Q. Services started after termination of coverage,

R. Charges for failure to keep a scheduled visit with the dentist;
S. Lost, missing, or stolen appliances (for example retainers, occlusal guards, partial or full dentures, or flippers).
T. Duplicate full or partial dentures.

U. Inlays, unless listed as a Covered Service in the Schedule of Benefits.
V. Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
W. Cysts and malignancies.
X. Removal of impacted teeth that exhibit no symptoms or pathology.
Y. Consultations, or examinations/evaluations for noncovered services.
Z. Services or appliances performed by a dentist whose practice is limited to prosthodontics (prosthodontist).
AA. Behavior management fees for covered persons requiring additional or unusual efforts to complete a dental procedure.
BB. Soft tissue management (irrigation, infusion, or special toothbrush).
CC. Restorative work caused by orthodontic treatment.
DD. Extractions solely for the purpose of orthodontics.
EE. Composite resin restorations on occlusal surfaces of bicuspids and molars.

5.2 ORTHODONTIC EXCLUSIONS, LIMITATIONS AND EXCEPTIONS

A. Retreatment of prior Orthodontic problems unless provided under the Policy or any extension or renewal of the Policy.
B. Patients with severe disabilities which may prevent satisfactory Orthodontic results.
C. Surgical Orthodontics not normally performed in a dental office by a general dentist or orthodontist.
D. Any charge made by the Orthodontist for the cost of replacement and/or repair of an appliance furnished to the patient which is lost or broken through no fault of the Orthodontist.
E. Periodontal treatment as specified within the dental Policy.
F. Interceptive Orthodontic Treatment is not a covered benefit.
G. Surgical procedures incidental to orthodontic treatment.
H. Myofunctional therapy.
I. Supplemental appliances not routinely used in typical orthodontic cases.
J. Active treatment extending more than 24 months from the point of banding due to lack of patient cooperation. For cases extending past 24 months, the covered person will be charged a monthly fee that is prorated at the Orthodontist's Submitted Fees.
K. Treatment started before the covered person became covered under the Policy.
L. Transfer to another Dentist after banding has been initiated.
M. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and are subject to additional charges.

SECTION 6 – COORDINATION OF BENEFITS (COB)

If a covered person has medical or dental benefits under any other health care or insurance plan(s), including motor vehicle insurance, we will coordinate benefits with those other plans. As such, we may:

A. reduce our benefits; or
B. collect from the other plan(s) the cost of benefits paid by us that were also provided by the other plan(s);

so that no more than 100% of the eligible expenses incurred by a covered person in a calendar year will be paid under the Policy and all other plans combined. To determine the benefits available under this provision the following rules apply:

A. Benefits are not provided for services or treatments of automobile-related injury to the extent to which the covered person is covered under any automobile policy. Where such services are provided, Golden Dental Plans, Inc. is assigned the covered person's right to seek reimbursement from automobile policy or be re-compensated for the cost of such services by the covered person.

B. The benefits of a plan which does not have a coordination of benefits provision shall in all cases be determined before the benefits of the Policy, and our benefits and benefits payable under the other plan do not exceed total of the actual, reasonable expenses.

C. For those plans which have valid coordination of benefits clauses, the following rules will apply:
   1. The benefits of the plan which cover the covered person as a dependent.

   2. Except as otherwise provided in section (C), if two (2) policies or certificates cover a covered person as a dependent, the benefits of the policy or certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a policy or certificate which has covered the member as a dependent for the longer period of time shall be determined before the dependent for the shorter period of time. However, if either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedures regarding dependents based on birthday anniversaries shall determine the order of benefits.

3. Claims for children of separated or divorced spouses which involve covered expenses will be administered with the following rules:

4. Benefits for a dependent child of divorced or separated parents will be determined first by the plan covering the child as a dependent of the parent with custody prior to the plan of the parent without custody.

5. Benefits of the plan covering the dependent child of a remarried parent will be determined first by the plan covering the child as a dependent of the natural parent without custody.

6. If, however, a court decrees otherwise established financial responsibility for medical, dental or other health care expenses for dependent children, will not apply. Benefits of the plan covering the child as dependent of the parent with such responsibility will be determined prior to any other plan, which covers the child.

7. If paragraphs 1, 2, or 3 do not establish an order of benefit determination, the benefits of a policy or certificate which has covered the person on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate which has covered the person for the shorter period of time, subject to the following:

    a. The benefits of a policy or certificate covering the person on whose expenses the claim is based as a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the person other than as a laid-off or retired employee.

    b. Subparagraph (a) shall not apply if either policy or certificate is lawfully issued in another state and does not have a provision regarding laid-off or retired employees and, as a result, each policy or certificate determines its benefits after the other.

    c. Services for treatment of any automobile related injury to the extent to which the member is covered under any no-fault automobile policy.

We may release or obtain any information and make or recover any payments we consider necessary to administer this COB provision including obtaining a refund from the covered person if applicable.

SECTION 7 – GRIEVANCE PROCEDURES

A Grievance must be initiated by the covered person within 2 years from the date of discovery of the potential grievance. When we receive a Grievance from a covered person, we will make a full investigation of the complaint and provide timely written notifications of our progress of the investigation. Upon completion of our investigation of the Grievance, We will provide written notification of the results of our investigation. Upon receipt of the results of our investigation, the covered person can then appeal to have their complaint reviewed by OFIR. OFIR will the make the determination if an independent review organization will be utilized as a consultant in rendering its decision. The contact information for OFIR is as follows:

Office of Financial and Insurance Regulation (OFIR)
Department of Energy, Labor and Economic Growth
P.O. Box 30220, 611 West Ottawa Street, Third Floor
Lansing, MI 48909
1-877-999-6442
FAX (517) 335-4978

7.1 FILING A GRIEVANCE

If We give an Adverse Determination to a covered person, it will be provided in writing and contain the reasons for the adverse determination. We will also provide the covered person with any written notifications required under the Patient's Right to Independent Review Act. Upon receipt of the Adverse Determination, the covered person or a person, including but not limited to, a dentist or physician, authorized in writing to act on behalf of the covered person, may file a written Grievance requesting further review by contacting:

Golden Dental Plans, Inc.
Professional Relations Manager
29377 Hoover Road
Warren, MI 48093
(800) 451-5918 or (586) 573-8118
FAX (586) 573-8720

The request should include the following information:

A. Sufficient documentation for us to appropriately investigate the Grievance.
B. The providers' response.
C. The Subscriber's name, Social Security Number, address, and phone number; the Subscriber information is to be provided in all communications with us.

We may also request a second opinion at our own expense.

We will complete our review of the Grievance and make a final determination in writing to the covered person not later than 35 calendar days after the written Grievance is submitted to us. The 35-day period may be extended by 10 business days if we have not received requested information from a health care facility or health professional.

Grievances will be administered as outlined in the Grievance Administration Procedure Steps 1 through 4, and as provided under Expedited Grievances. Under no circumstance will the total time for a final determination be more than 35 (thirty-five) days from the date of the original grievance.

7.2 GRIEVANCE ADMINISTRATION PROCEDURES

Grievances received by us will be administered as outlined in Steps One to Three, and Expedited Grievance. Step Four will be administered by OFIR.

7.21 Step One

The first step in the Grievance process includes a conference with the providing dentist or his/her staff. If the covered person has been advised of an Adverse Determination, he or she or a person, including, but not limited to a dentist, authorized in writing to act on behalf of the covered person may appeal to our Professional Relations Manager.

When we receive the Grievance: (1) it will be logged into our records; (2) a letter of acknowledgment outlining the facts of the Grievance will be sent to the covered person; and (3) a copy of our Internal Grievance Procedure will be provided to the covered person within 5 (five) calendar days.

The Grievance will be investigated by the Professional Relations Manager, and a written initial determination, outlining the reasons for the determination will be provided to the covered person within 5 (five) calendar days after receipt of the Grievance.

Only the covered person or the covered person's authorized representative may request or agree to a delay in the resolution of a Grievance. In such event, the covered person or the covered person's authorized representative will be notified in writing of the requested or agreed upon delay and the reason(s) for such delay.

A covered person who receives an adverse determination may make an appeal in accordance with *Step Two* or he or she may appeal to us as outlined above.

7.22 Step Two

If the Grievance is not resolved in Step One, the covered person, or a person, including but not limited to, a dentist or physician, authorized in writing to act on behalf of the covered person may request further review

either orally or in writing to the GDP Professional Relations Manager as provided under the *Filing A Grievance* provision.

When communicating with the Manager, Professional Relations, the covered person must provide the Subscriber's: (1) name; (2) social security number; (3) address; and (4) phone number(s).

The Professional Relations Manager will record, investigate and attempt to resolve the problem. New findings, supporting documentation, and the proposed determination will be reviewed with the covered person verbally followed by a letter outlining the reasons for the determination.

Step Two grievances will be resolved within ten (10) calendar days of receipt of the Step Two appeal. If the determination of the Professional Relations Manager satisfies the covered person, the Grievance will be closed.

When the covered person receives an Adverse Determination at Step Two, he or she may appeal to us.

7.23 Step Three

If a Grievance is not resolved at Step Two, the covered person or a person authorized in writing to act on the covered person's behalf may request further review in writing to our Dental Director at our address indicated under *Filing A Grievance*.

The Grievance will be presented to and reviewed by the Quality Assurance (QA) Committee of the Board of Directors. This meeting will be scheduled within fifteen (15) days of the date of receipt of the appeal.

The covered person will be notified by telephone and in writing:

A. Regarding the time, date and location of the hearing; and
B. Advised that he or she may be: (1) present; (2) present with counsel; (3) represented by counsel or by a person, including, but not limited to, a dentist or physician, authorized in writing to act on the behalf of the covered person to present evidence on the covered person's behalf.

We will provide written confirmation of the determination to the covered person not later than two (2) business days after the oral determination.

The chairperson of the QA Committee will inform the covered person or the covered person's representative of the covered person's right to request a determination by the Commissioner.

7.24 Step Four

Step Four is the external review as conducted by the OFIR. The covered person may not file a request for an external review of an Adverse Determination with OFIR until the covered person has exhausted our Internal Grievance Procedures, unless the covered person has requested an Expedited Grievance.

Not later than sixty (60) days after the date of receipt of an Adverse Determination or final Adverse Determination from us, the covered person or his or her representative may file for an external review with the Commissioner. The Commissioner will render a binding order for all parties which constitute a final determination.

To obtain information regarding the external review or to file a Grievance with OFIR, contact the OFIR at the address provided above in this provision.

7.25 Expedited Grievance

A covered person may request an Expedited Grievance if a Grievance is submitted and a physician, orally or in writing, substantiates that the 35-day time frame for a Grievance review would:

A. seriously jeopardize the life or health of the covered person; or

B. jeopardize the covered person's ability to regain maximum function.

We will make our determination within 72 hours after we receive an Expedited Grievance. Within 10 days after the covered person receives our determination, the covered person may request a determination of the matter by the OFIR (contact information for OFIR is shown above under "Grievance Procedures".

If our determination is made orally, We will provide a written confirmation of the determination to the covered person not later than 2 business days after the oral determination.

7.3 SUBROGATION

We reserve the right of subrogation in the event of a loss. In this event, we may choose to take action to recover the amount of a claim paid to a covered person if the loss was caused by a third party. The covered person will be required to furnish any necessary information and complete documents needed by us in order to enforce the right to subrogation. Further, the covered person cannot take any action that would prevent us from pursuing this right of subrogation.

SECTION 8 - NOTICE OF MEDICAL INFORMATION PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Dear [Subscriber]:

Golden Dental Plans, Inc. and its subsidiaries ("Golden Dental") acknowledge how important it is to maintain confidential and secure financial and personal information that we receive about the covered persons we serve. Golden Dental requires all of its employees to keep your personal and financial information secure and confidential. This Notice describes Golden Dental's privacy policy and is intended to meet all legal requirements.

A. Introduction

The Health Insurance Portability and Accountability Act ("HIPAA") is a federal law that regulates the use of personal health information and requires certain covered

entities such as health insurance issuers or other entities providing health coverage to secure the personal information of persons insured or covered under their policies. HIPAA requires providers that provide dental coverage policies such as Golden Dental to provide this Notice to you to describe:

1. The uses and disclosures of protected health information that Golden Dental may make;

2. Your rights with regard to your protected health information;

3. Golden Dental's responsibilities;

4. Your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Service; and

5. The person or office to contact for further information regarding Golden Dental's privacy practices.

B. Effective Date of Notice

This Notice is effective April 14, 2003.

C. Important Definitions

1. Covered Entities - Covered entities are those groups that are required to meet the privacy requirements of HIPAA. Examples include health providers (i.e. doctors, dentists), health plans (i.e. Golden Dental or Blue Cross/Blue Shield), and health care clearing houses. HIPAA also applies to employers and vendors and administrators who work with a covered entity and have access to protected health information.

2. Designated Record Set - Designated record set includes the following records: medical, billing, enrollment, payment, claims adjudication, and case management which are maintained by a covered entity and used to make decisions about individuals. Information for quality control or not used to make decisions is not included

3. HIPAA - HIPAA is the acronym which stands for the Health Insurance Portability and Accountability Act, a federal law passed in 1996 that, among other things, has provisions designed to ensure the privacy of personal health information.

4. Payment - Payment includes, but is not limited to, actions to make determinations and payment. Examples include: billing, claims management, subrogation, policy reimbursement, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

5. Protected Health Information ("PHI") - Protected health information includes all individually identifiable health information that is transmitted or maintained by Golden Dental, regardless of the form of that information (for example transmitted orally, in writing or via electronic means).

6. Treatment - Treatment is the providing, coordination or management of health care and related services. Examples include, but are not limited to, the providing of a health service, consultations and referrals.

D. Company Policies and Procedures

Protected Health Information Collected

In providing health coverage to you, Golden Dental collects the following types of information provided to us or our affiliates.

1. Information that you provided to us on the application or other form used to obtain dental coverage with us. Examples of this information includes your: address, telephone number, date of birth, and Social Security Number;

2. Premium payments and account balance information;

3. The fact that you are or have been covered under a policy issued by Golden Dental;

4. Health related information received from any of your physicians, dentists or other health care providers;

5. Health status information, including diagnosis and claims payment information;

6. Other information about you from a consumer reporting agency; and

7. Any other information that is necessary for Golden Dental to have in order to provide you with dental coverage.

E. Golden Dental Uses of Protected Health Information

1. Golden Dental will not disclose any personal information about persons covered under our dental policies to anyone, other than as permitted by law and applicable federal regulations. However, Golden Dental needs to use Protected Health Information (PHI) in many aspects of its business. In using that PHI, it will be necessary for Golden Dental to disclose some PHI. Golden Dental will use PHI as follows:

   a. Upon your request and as required by law, to provide you with access to certain of your PHI so that you may inspect and copy it;

b. To comply with any requirement by the Secretary of Health and Human Services to investigate or determine Golden Dental's compliance with the privacy regulations.

c. To carry out treatment, payment and health care operations. Disclosure may occur to business associates of Golden Dental. Examples include: (1) Golden Dental may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may request copies of your x-rays; (2) Golden Dental may tell a dentist whether you are eligible for coverage or what percentage of the bill will be paid by Golden Dental.

d. To operate health care operations. Examples include: (1) quality assessment; (2) reviewing competence of health care professionals; (3) benefit coverage activities such as underwriting and creating and renewing policies; (4) disease management; (5) medical reviews; (6) legal services; (7) fraud compliance programs; (8) business planning and development; (9) business management and other general administrative duties.

2. Some uses will require your prior written consent. They are as follows:

   a. Treatment, payment and health care operations. However, if you decline to provide consent for the use of your PHI for these purposes you will not be eligible to be issued a dental policy by GDP; and

   b. Release of PHI to family members and other close personal friends.

3. Your consent, authorization or request is not necessary for disclosure under the following circumstances.

   a. When required by law;

   b. When permitted for purposes of public health activities, if authorized by law;

   c. When authorized by law to report information about abuse, neglect or

   d. domestic violence to public authorities if there exists a reasonable belief that you may be a victim of that abuse, neglect or domestic violence;

   e. When authorized by law for disclosure to a public health oversight agency, including civil, administrative, or criminal investigations; inspections, licensure, and other activities for appropriate oversight;

   f. When required for judicial or administrative proceedings in response to a subpoena or discovery request. Such disclosure will be made only upon evidence that the requesting party has made a good faith effort to provide written notice to you allowing you ample opportunity to object and such objection was either not raised or resolved in favor of disclosure by the court

or tribunal;

g. For law enforcement purposes, including identifying or locating a missing person, material witness, suspect or fugitive; and

h. When required by a coroner or medical examiner for purposes of identifying a deceased person, determining cause of death or other lawful purpose.

4. Except as otherwise provided in this Notice, uses and disclosures will only be made with your written authorization subject, to any revocation.

5. We will restrict access to personal information about you only to those GDP employees who need to know that information to provide services and products to you. We maintain physical, procedural and electronic safeguards that comply with federal regulations to guard your personal information. Company employees are required:

   a. To safeguard and secure your confidential PHI and financial information;

   b. To limit the collection and use of information to the minimum necessary to deliver our services;

   c. To permit only trained, authorized employees to have access to confidential information; and

   d. To sign a confidentiality agreement as a condition of employment; violations are subject to Golden Dental's disciplinary process.

F. Privacy Rights

Under federal law you have the right to:

1. Request that restrictions be placed on the release of your personal health information. Such requests should be made to Golden Dental on the form as provided by Golden Dental upon request;

2. Receive confidential communications regarding your personal health information;

3. Inspect and copy your own medical records in a Designated Record Set. The information will be provided within 30 days if that information is maintained onsite and 60 days if it is maintained off-site. Golden Dental may elect a single 30-day extension if it deems it necessary;

4. Request an amendment to your medical records. Golden Dental has 60 days upon receipt of your written request to act, subject to a single 30-day extension, if necessary. If Golden Dental denies your request, we will

provide the reason for the denial in writing. You may submit a written statement disagreeing with the denial which will be included with any future disclosures of your PHI;

5. Obtain an accounting for any disclosures of your PHI. Such accounting will include the six years prior to the date of your request, not including time prior to April 14, 2003 or disclosures to carry out treatment, payment or health care operations. Golden Dental will provide this accounting within 60 days of your request. If you request more than one (1) accounting in a rolling 12-month period, Golden Dental will charge you a reasonable, cost-based fee for each subsequent accounting;

6. Receive, on request, a paper copy of any notice regarding the uses and disclosures of your PHI that you receive electronically. You may contact Golden Dental Plans to receive that copy;

7. If you believe your privacy rights have been violated, complain to Golden Dental in care of the following officer: Mr. Anthony Lentine, Senior Vice President, 29377 Hoover Road, Warren, Michigan, 48093. You may also file a complaint with the Office of Civil Rights (OCR), U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601, (312) 886-2359, (312) 353-5693 (TODD), (312) 886-1807 (fax). You also may visit OCR's website at http://www.hhs.gov/ocr/privacyhowtofile.htm for more information.

G. Reservation of Right

Golden Dental reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained prior to the date of the change. If Golden Dental changes its privacy policy, a revised notice will be provided to all present and former persons covered under a GDP dental policy and for whom Golden Dental maintains PHI in either electronic or written form.

H. Questions

If you have any questions regarding this Notice, you may contact the following officer at this address and phone number:

Anthony Lentine
Senior Vice President
29377 Hoover Road
Warren, Michigan 48093
1-800-451-5918
www.goldendentalplans.com

HIPAA and other applicable regulations will supersede any discrepancy between the information in this Notice and that law.

Golden Dental Plans

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Warren, MI 48093
800-451-5918
www.goldendentalplans.com