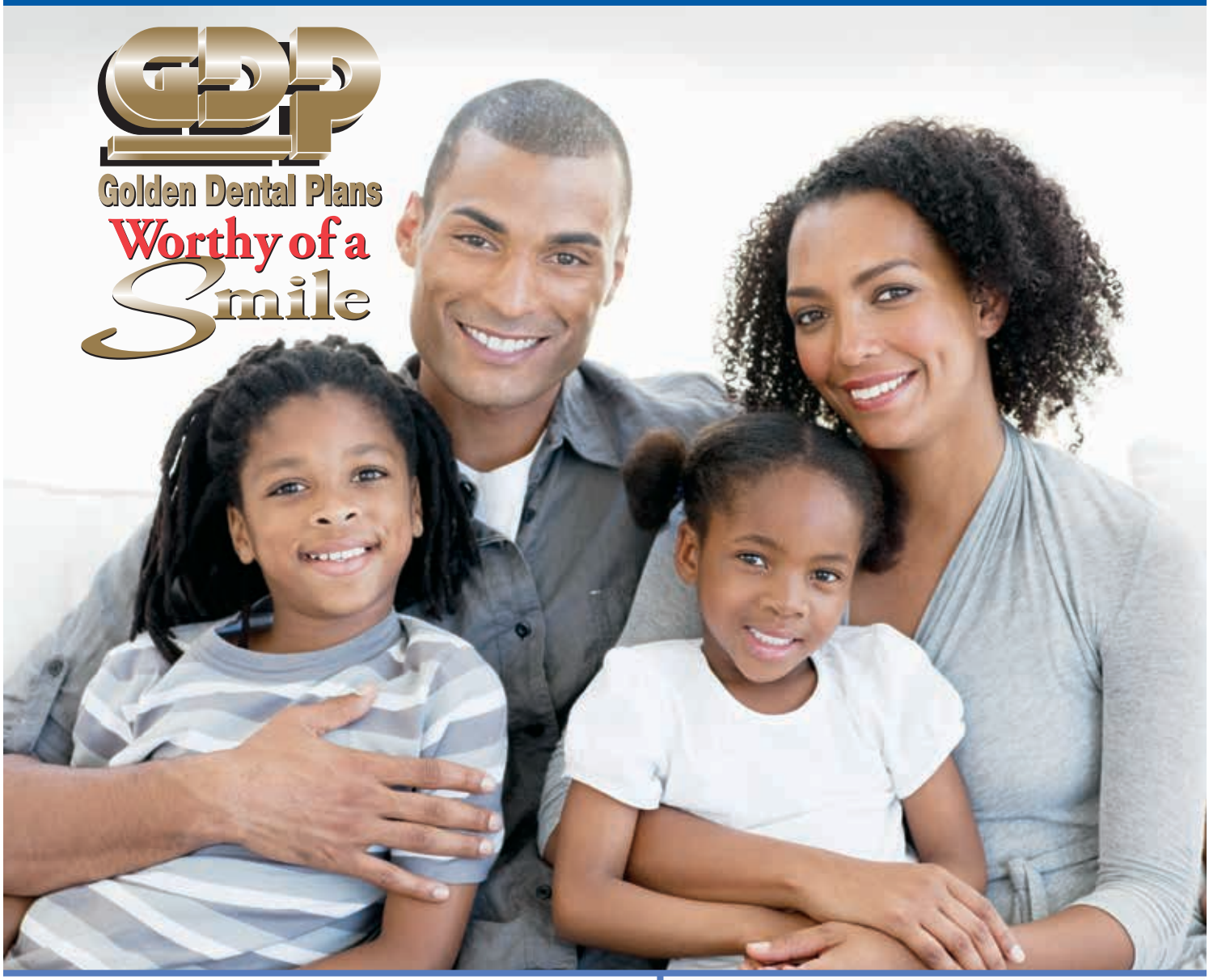
Golden Dental Plans

Worthy of a Smile



Member Handbook

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I DEFINITIONS

The Golden Dental Plans, Inc. (GDP) Board of Directors and the Department of Insurance and Financial Services (DIFS) have approved the following definitions. These definitions are intended to give the Enrollees a clear understanding of the terms used in the Enrollee Handbook and Certificate of Coverage.

1.1 **ADVERSE DETERMINATION OR FINAL ADVERSE DETERMINATION** - is a determination that has been made by GDP that dental care, availability of care, continued care or other dental health care services that is a covered benefit has been reviewed and based on the information provided, does not meet GDP's requirement for medical necessity, appropriateness, health care setting or effectiveness, and the requested service or payment for services is therefore denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination or final adverse determination.

1.2 **APPLICATION** - is the completed form requested by and submitted to GDP, which lists the subscriber and his/her dependents that are enrolling in GDP, and the subscriber's preferred Dental Office selection.

1.3 **BUSINESS DAY** – refers to the days during the week as to when business is normally conducted, Monday through Friday (9:00 am – 5:00 pm).

1.4 **CERTIFICATE OF COVERAGE** – is a document issued by GDP that indicates coverage amounts and/or percentages as agreed to by the employer group.

1.5 **COMMISSIONER** – refers to the Commissioner of the Department of Insurance and Financial Services (DIFS).

1.6 **CONTRACT** – member ID Card & Certificate of Coverage, along with any supplements, now or here after issued, and the subscriber's enrollment application.

1.7 **CO-PAYMENT** - the amount that the subscriber is obligated to pay to the dental office for a specified covered service. Co-payment percentages are set forth in the Certificate of Coverage.

1.8 **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.

1.9 **ENROLLEE, MEMBER or SUBSCRIBER** - an individual participating in GDP's dental plan.

1.10 **COVERED DENTAL SERVICES** - the services listed on the certificate of coverage, which are necessary for the restoration and/or maintenance of the oral health of a patient, or at other times with the permission of GDP.

1.11 **DENTAL OFFICE** – is an office that has agreed to provide dental care under the GDP Dental Provider Agreement.

1.12 **DENTIST** - is a dentist or group of dentist who are legally licensed to practice dentistry within scope of his/her license. As used herein, the term "dentist" also includes a legally licensed physician authorized by his/her license to perform the particular dental services he/she has rendered.

1.13 **DEPENDENT** – refers to one of following in relation to the subscriber: A. The spouse of an employee or retiree (but not the person a surviving spouse marries). A 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 employee or retiree is enrolled.

A. The spouse of an employee or retiree (but not the person a surviving spouse marries). A 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 employee or retiree is enrolled.

B. The unmarried children of an eligible employee or retiree, or unmarried children of a surviving spouse who were enrolled for coverage when the employee or retiree died, until they attain twenty-five (25) years of age, or to any age if they are 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.

(1) Each such child who has reached nineteen (19) years of age must legally reside with and is a member of the household of the employee, retiree or surviving spouse and must be dependent upon the employee, retiree or surviving spouse within the meaning of the Internal Revenue Code of the United States.

(2) Eligible children include:

(a) Children of the employee or retiree by birth, legal adoption, or by legal guardianship while they legally reside with and are dependent upon the employee, retiree or surviving spouse.

(b) Children of the spouse of the employee or retiree while they are in the custody of and dependent upon the spouse of the employee or retiree and are residing in and are members of the employee's or retiree's household.

(c) Children, as defined in (a) or (b), who do not reside with the employee, retiree or surviving spouse, but are his/her legal responsibility for the provision of medical, including dental care (i.e., children of divorced parents, legal guardianship, children confined in training institutions, children away at school).

(d) Children residing with and related to the employee or retiree by blood or marriage and for whom the employee or retiree provides principal support, as defined by the Internal Revenue Code of the United States, and who were reported as dependents on the employee's or retiree' most recent income tax return or who qualify in the current year for dependency tax status.

1.14 **DIAGNOSTIC SERVICES** - the necessary procedure that will aid the dentist in evaluating conditions and determine the dental care required, including dental examintions, visits, consultation and treatment planning services.

1.15 **EFFECTIVE DATE OF COVERAGE** - the first day of the calendar month that initial coverage begins, as indicated by the employer. For dependents of the subscriber who become eligible for coverage under this Certificate on or after the subscriber's effective date of coverage.

1.16 **EMERGENCY TREATMENT** - the nonspecific, medically necessary dental treatment for the immediate and /or temporary relief of acute pain, swelling, bleeding or discomfort, which is required, unexpectedly or immediately, and would jeopardize the life or health of the Enrollee.

1.17 **EMPLOYER** - the company providing the GDP dental care plan to its employees.

1.18 **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 period for the grievance would acutely jeopardize the life or health of the Enrollee.

1.19 **GROUP** - all of the subscribers enrolled in this Employer Dental Capitation Program at the place of employment where the subscriber is enrolled for benefits under this Certificate, according to the group designation made by the employer.

1.20 **GDP** – Golden Dental Plans, Inc.

1.21 **GDP PROVIDING OFFICE** - an office engaged in dental practice that is contracted by GDP to furnish dental care to members enrolled in GDP.

1.22 **GRIEVANCE/COMPLAINT** - an inquiry, complaint or grievance on behalf of an Enrollee submitted by an Enrollee or a person including, but not limited to a dentist or physician authorized in writing by the Enrollee to act on behalf of the Enrollee regarding:

A. The availability, delivery, or quality of dental health care services, including a complaint regarding an adverse determination or 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 an Enrollee and GDP.

1.23 **HIPAA** – is the [Federal] Health Insurance Portability and Accountability Act of 1996.

1.24 **INDEPENDENT REVIEW ORGANIZATION** - an entity appointed by the Commissioner of DIFS that conducts independent external review of adverse determinations or final adverse determinations.

1.25 **OPEN ENROLLMENT PERIOD** – the period, as agreed upon by GDP and the employer, when eligible persons can enroll into or transfer out of GDP.

1.26 **ORAL SURGERY** : - is necessary procedure for simple extractions and other routine dental surgery not requiring hospitalization.

A. Pre-operative care

B. Post-operative care

1.27 **ORTHODONTICS** – is the treatment for malocclusion and the proper alignment of teeth (straightening of teeth) for dependents and adult members if purchased by your employer or union.

1.28 **PREMIUM** - the money prepaid by the enrollee or employer to GDP.

1.29 **PERIODONTICS** - is all necessary procedures for treating diseases of the gums and bones, which support the teeth not requiring hospitalization.

1.30 **PREVENTIVE DENISTRY** - procedures that prevent oral disease from occurring, including:

A. Prophylaxis - cleaning, polishing and scaling of teeth as necessary.

B. Topical fluoride applications for dependent children at 6 month intervals.

C. Space maintainers - temporary space maintenance for children until permanent teeth erupt to prevent unnecessary orthodontic expense.

1.31 **PRIRA** - the Patient's Right to Independent Review Act, an Act to provide a review of certain health care coverage adverse determinations or final adverse determinations mad by a health carrier.

1.32 **PROSTHODONTICS** means 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.

1.33 **REFERRAL FORM** – this form is required whenever the general dentist is referring patient for specialty care, to an Orthodontist, Endodontist, Oral Surgeon, for treatment. All referrals must be written for In-Network Specialty Providers only.

1.34 **REMITTING AGENT** - any person or entity who assumes/undertakes the employer's responsibility to pay GDP for any amount due from the employer to GDP as set forth herein.

1.35 **RESTORATIVE DENTISTRY** – refers to all necessary procedures performed in a dental office and not requiring hospitalization.

1.36 **SERVICE AGREEMENT** - the executed agreement between GDP and the employer regarding the provision of dental services, as described in this Schedule of Benefits, to the employer's members or employees.

1.37 **SERVICE AREA** - the geographic area in which GDP is authorized by DIFS to provide dental care services to its members.

1.38 **SPOUSE** - the legally married husband or wife of a subscriber.

1.39 **SUBSCRIPTION CHARGE** - is the amount of money paid monthly to GDP by the employer, including subscriber contributions, if any, on behalf of each subscriber and his eligible dependents enrolled.

1.40 **UNDUE DELAY** - the lack of information needed to sufficiently investigate and respond to the grievance within the period for a specific step in the process.

II. GENERAL SUBSCRIBER INFORMATION

2.1 WELCOME TO GOLDEN DENTAL PLANS, INC.

This Handbook and Schedule of Benefits is designed to help our members learn how to use their GDP services and benefits. GDP differs from 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 thoroughly and keep it handy. It will answer most of your questions about Golden Dental Plans' procedures or services. Please refer to your Schedule of Benefits, which is included with your enrollment materials and identifies your specific benefit coverage (by percentage or co-payment amounts). A General Provider Directory is also included with your enrollment materials. If you ever have any questions about the Golden Dental Plans, please call one of our customer service representatives.

Administrative Office:

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

2.2 MEMBERS OBLIGATION

The GDP Plan is designed to deliver quality dental care to the satisfaction of its members. 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 brochure or visit the GDP website: **www.goldendentalplans.com**

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 do receive out-of-area emergency treatment, please notify your dental provider so that follow-up care can be arranged. (Please refer to emergency and out of area coverage section 2.9).

D. Consultations with Specialists to whom you have not been referred in writing by your primary dentist are not covered by GDP. Those fees are your responsibility (See 5.1 Limitations and Exclusions).

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 member 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 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 that amount at the time of your visit unless special arrangements have been previously made with your dentist.

2.3 MEMBER DENTAL PLAN CERTIFICATE

Each person receiving this Handbook, ID card and schedule of benefits having completed an application for dental coverage and qualifying as a Subscriber for such coverage, is entitled to receive dental services as set forth in this schedule of benefits from the Golden Dental Plans authorized provider selected by the Subscriber, subject to all the terms and conditions as set forth in this document.

Dental Services become available to the Subscriber (and Subscriber Dependents, if covered) upon acceptance of Subscriber's completed application and issuance of this ID card and schedule of benefits. Coverage continues from the initial coverage date throughout the term period specified by the Group, provided the Group remits all Subscriber dues and the Subscriber remains an eligible participant of the Group. Thereafter, coverage will continue until terminated in accordance with the terms of the Dental Plan Agreement.

This enrollee handbook is not the schedule of benefits and does not amend, extend or alter the coverage afforded by said schedule of benefits but is subject to all terms, exclusions and conditions of the schedule of benefits.

2.4 USING YOUR DENTAL FACILITY

GDP facilities have been carefully selected through our Quality Assurance Program to provide quality dental care. The facilities are private and group practice offices staffed with trained licensed dental care professionals who will provide dental care for our members. Each dental center is located conveniently near to member's homes.

Your facility will maintain your complete dental records and maintain confidentiality of your care.

2.5 CHOOSING YOUR DENTIST

As a member of GDP, you must choose one of the general providers as your "primary care dentist." Your "primary care dentist" will be responsible to ensure that your dental care needs are cared for properly.

If the dentist feels that you need a Specialist or Specialty Care, they will refer member to an approved GDP Specialist. This service is provided without charge if the service is part of your GDP Program. (Exclusive of any required co-payments.)

2.6 MAKING AN APPOINTMENT

Before enrollment in the GDP Program, financial considerations may have prevented you from visiting your dentist. As part of GDP's Program, this has been eliminated. We recommend that you make an appointment as soon as possible. This insures that your primary care dentist can assess your present dental health, develop a dental care plan and begin to correct any current dental problems you may have and work with you toward maintaining your dental health.

2.7 YOUR DENTAL CENTER

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

2.8 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.

2.9 EMERGENCY AND OUT-OF-AREA COVERAGE

Your dental plan provides coverage for you and your family on a 24-hour basis, 365 days of the year. Your designated provider 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. GDP also has an emergency 800 number **(1-800-451-5918)** available to assist you in locating a dentist after hours.

When you or a family member, are outside the geographic area of your primary dentist, and an emergency arises, you should seek treatment from a dentist in the area. GDP will reimburse you or your dependent (if eligible) for reasonable expenses as appropriate in an individual case $100.00 for emergency treatment. The "geographic area" is a 50-mile radius from your chosen dental provider.

"Emergency Treatment" means 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 member or their family.

FOLLOW-UP TREATMENT FOR ANY EMERGENCY MUST BE OBTAINED FROM YOUR ASSIGNED DENTAL CENTER.

2.10 DEPENDENT COVERAGE

Dependents are considered to be:

a) Spouse
b) Unmarried children to age 19 and residing at home,
c) Unmarried children age 19-25, who are full-time students 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.

Dependents are automatically covered when the Subscriber elects the "Family Coverage" and lists the Dependents in the enrollment application. A change in Dependent status resulting from a marriage, birth, adoption or attainment of eligibility must be submitted to GDP within 30 days of the occurrence. Coverage will become effective on the date Dependent is acquired. After the 30 day period, the Dependent will not be eligible for coverage until the next enrollment period as determined by the Group and as set forth in the Group Dental Plan Agreement. Should a dependent, leave school due to an illness or injury, coverage will be extended for up to 12 (twelve) months or up to the age of 25 (twenty-five) which ever come first under the subscriber's coverage.

2.11 QUALITY ASSURANCE PROGRAM

To insure that all GDP members receive the appropriate level of care, GDP has created a Quality Assurance Committee to continuously monitor the care received by our members and report to the GDP Board of Directors.

Through the activity of the QA Committee, GDP's Members can be confident that every measure is taken to monitor and evaluate all facets of their dental care. Each center is subjected to regular peer reviews conducted by the GDP dental director. The results are on file at the GDP cooperate office. Reviews are used to evaluate the quality of care delivered to the member.

III. SUBSCRIBER COVERAGE

Golden Dental has entered into a Group Dental Agreement with the Group wishing to provide dental services for its Members. Refer to Definitions, Group.

New hires for Groups shall become eligible for coverage on the first day of the month following the date of Group coverage notification to Golden Dental, and shall receive dental service coverage as provided under the Prepaid Dental Plan Agreement subject to the following:

A. Only to the extent that services are rendered by a dental office signatory to a GDP Dental Capitation Agreement, or by any other dentist to whom the member has been referred by such dental office for specified covered dental services, with the exception of emergency services required by a member while temporarily more than fifty (50) miles (computed by the most direct public highway route) from the dental office selected by the member, for which a reasonable amount will be payable for such services for each emergency;

B. Only if rendered in accordance with accepted standards of dental practice.

C. Only if received by a member while the member's coverage is in force.

Covered dental services provided under this program shall only be available from the dental office selected by the subscriber and from any dentist to whom a subscriber is referred by it for services, except as provided for in Section 1.16 which makes provisions for emergency services. Dental offices shall be selected by subscribers during an enrollment period prescribed by the employer.

3.1. TERMINATION OF SUBSCRIBER COVERAGE

Subject to certain extensions of coverage provided below, coverage of a Member shall cease if at any time: a) Member's participation in the Group shall terminate, b) the Group shall fail to remit Member Dues, or c) if, after the designated term period of coverage for Members of Group, the Dental Service Agreement is terminated whether by Golden Dental or Group.

3.2. PAYMENT OF SUBSCRIBER DUES

Under an Agreement between Golden Dental and the Group, the Group shall pay the Member's dues on behalf of the Member; the dues are payable monthly in advance. (Any arrangements between the Group and the Member under which the Member is to reimburse the Group for any portion of the dues are entirely between the Group and the Member; Golden Dental looks solely to the Group for payment of Member dues during which the Agreement will remain in effect. Should the Group fail to pay any installment, the Agreement shall terminate at the end of the "grace period" without the necessity of notice to either the Group or the Member; provided, however, that if Golden Dental shall accept payment of Member dues from the Group after the expiration of said grace period, coverage hereunder shall be reinstated as of the date of such acceptance of payment.

Upon termination for any reason, the Group shall be liable for all Member dues then due, including charges for any time the Agreement remains in force during said grace period.

3.3. DEPENDENT COVERAGE

Dependent coverage shall be provided subject to the following provisions: Applications for Dependent Coverage by a Member must be for all eligible Dependents which the Member has on the date of such application. In this event, coverage for Dependent(s) begins as of the effective date. Failure to make such application will result in Dependents(s) not being eligible until next enrollment period as established by the Group.

Dependent Coverage with respect to a child born of a Member while the Member is enrolled for Dependent Coverage shall be effective upon the date dependent is acquired.

If a Member acquires a Dependent (other than through the birth of a child to Member and spouse) while the Member is enrolled for Dependent Coverage, the Dependent Coverage with respect to such Dependent will become effective upon receipt of Member's written notification to Golden Dental and upon completion of Golden Dental records change.

This change will become effective the first day of the following month. Failure to make application within 30 days will result in the Dependent NOT being eligible until the next enrollment period.

3.4 TERMINATION, DIS-ENROLLMENT AND FAILURE TO QUALIFY AS DEPENDENT

A. This Agreement shall terminate upon failure of the policyholder to pay Subscription Dues on behalf of Subscribers and their dependents within 31 days after the expiration of the period for which the last Subscription Dues were paid. Acceptance of payment thereafter by GDP or any of its authorized agents shall reinstate this Agreement.

B. A Subscriber and any dependents of the Subscriber may be made ineligible, effective on the last day of the month in which ineligibility notice is given, with no refund to be paid to or in behalf of the Subscriber or any dependents for any of the following reasons:

1. Failure to pay Subscription Dues for the Subscriber and any dependents within 31 days after the expiration of the period for which the last Subscription Dues were paid. Acceptance of payment thereafter by the GDP or any of its authorized agents shall constitute re-enrollment of the Subscriber and any co-payments paid by or on behalf of the individual.

2. Committing acts of physical or verbal abuse that pose a threat to participating dentist or to the GDP staff.

3. Knowingly providing fraudulent information in applying for enrollment orin receiving services.

4. Moving outside of the geographical service area.

5. Inability to establish or maintain a satisfactory dentist-patient relationship with a primary dentist. GDP agrees to make a reasonable effort to assist a Subscriber and any dependents in establishing and maintaining such relationship. GDP agrees to permit a Subscriber to select an alternate primary dentist if the Subscriber and any dependent are unable to establish a satisfactory dentist-patient relationship with their first primary dentist.

   Only if the Subscriber and any dependents are unable to establish such relationship with the alternate primary dentist may GDP terminate facility assignment of the Subscriber and any dependents.

   Prior to ending facility assignment, Subscriber and any dependents may file a grievance regarding any aspect of the dentist-patient relationship, and GDP's actions with respect thereto.

C. An individual enrolled as a dependent is not eligible for benefits effective as of the date the individual no longer falls within the definition of "Dependents".

3.5 DEPENDENT COVERAGE EXTENSION FOR HANDICAPPED DEPENDANTS

1. The unmarried children of an eligible employee or retiree, or unmarried children of a surviving spouse who were enrolled for coverage when the employee or retiree died, until they attain twenty-five (25) years of age, or to any age if they are 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.

IV. COORDINATION OF BENEFITS

If a Member under this Benefit Code is eligible for medical or dental benefits under any other health care or insurance plan(s), including motor vehicle insurance, either the benefits provided by GDP, hereunder shall be reduced or GDP, shall collect from such plan or the Member the costof the benefits which have been provided or paid for by GDP, which are provided or paid bysuch other plan or insurance so that during the calendar year up to, but not more than 100% ofthe person's medical or dental expenses (at least a portion of which is covered under one or moreof such plans) will be paid by all such plans. To determine the benefits available under this provision the following rules apply:

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

4.2. The benefits of a plan which does not have a coordination of benefits provision shall in all cases be determined before the benefits of this contract, and Golden Dental Plans benefits and benefits payable under the other plan do not exceed total of the actual, reasonable expenses.

4.3. For those plans which have applicable coordination of benefits clauses, the following rules will apply:

1. The benefits of the plan which cover the member as a dependent.

2. Except as otherwise provided in section (c), if two (2) certificates cover a member as a dependent, the benefits of the certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a 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 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 involves' covered expenses will be administered with the following rules:

   a. 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.

   b. 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.

   c. 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.

4. 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.

GDP, may release or obtain any information and make or recover any payments it considers necessary to administer the C.O.B. provision, including obtaining a refund from the Member if applicable.

V. LIMITATIONS AND EXCLUSIONS

5.1 LIMITATIONS

All benefits provided under the GDP Program are subject to the following limitations:

A. 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. Said five year period will be measured from the date on which the existing appliance was last supplied, whether under the GDP Agreement, or under any prior dental agreement between, or involving as signatories, any of the parties of this Agreement. The term "existing" as used in this paragraph is intended to include an appliance that was placed at the inception of the aforesaid five year period but which, for whatever reason, is no longer in the possession of the patient.

B. 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, the obligation of Golden Dental Plans 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 second bicuspid are considered cosmetic and/or enhancements and therefore not a covered benefit. Upgrade metal alloys are not a covered benefit.

C. MOUTH REHABILITATION

If a patient and the dentist select a course of mouth rehabilitation, the obligation of the Golden Dental Program will be to 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.

D. TEMPORAL MANDIBULAR JOINT DISORDER OR DISFUNCTION

Services provided under this program 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). Said appliance will be provided once a lifetime.

E. ORTHODONTICS

Orthodontic care will be provided after ninety (90) days continuous enrollment by the eligible Member. 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.

5.2 EXCLUSIONS

The following treatments are not covered benefits under the GDP Program:

A. **General Exclusions, Limitations and Exceptions**
No benefits will be paid under this Policy for the following treatments, services and care, unless otherwise indicated:

1. Dental services not appearing on the Schedule of Benefits.
2. Dental treatment for cosmetic purposes.
3. Dental treatment performed in a hospital and/or any related hospital-fee.
4. Treatment of cleft palate, anodontia and mandibular prognathism.
5. Cases in which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained.
6. 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 provision, in Section 5.
7. 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.
8. 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.
9. 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.
10. Dental implants or transplants.

11. No Covered Person will be denied dental coverage due to trauma. However, dental care coverage under this Policy may not cover the Covered Person for certain traumatic events that may occur if those procedures are specifically excluded in this 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.
12. A nominal administrative or sterilization fee charged by Select Dental Offices. Please refer to the GDP Provider Directory for further information.
13. Services or appliances started before a Covered Person became eligible under this Policy (for example, teeth prepared for crowns or root canals in progress).
14. Prescription drugs.
15. Nitrous oxide analgesia.
16. Preventive control programs (including home care items).
17. Services started after termination of coverage,
18. Charges for failure to keep a scheduled visit with the Dentist.
19 Lost, missing, or stolen appliances (for example: retainers, occlusal guards, partial or full dentures or flippers).
20. Duplicate full or partial dentures.
21. Inlays, unless listed as a Covered Service in the Schedule of Benefits.
22. Porcelain, porcelain substrate, and cast restorations on primary (baby) teeth.
23. Cysts and malignancies.
24. Removal of impacted teeth that exhibit no symptoms or pathology.
25. Consultations, or examinations/evaluations for noncovered services.
26. Services or appliances performed by a Dentist whose practice is limited to Prosthodontics (prosthodontist).
27. Behavior management fees for Covered Persons requiring additional or unusual efforts to complete a dental procedure.
28. Soft tissue management (irrigation, infusion, or special toothbrush).
29. Restorative work caused by orthodontic treatment.
30. Composite resin restorations on occlusal surfaces of bicuspids and molars.
31. Biopsy or Brush Biopsy to detect cancer.

B. Orthodontic Exclusions, Limitations and Exceptions

1. Retreatment of prior Orthodontic problems unless provided under this policy or any extension or renewal of this Policy.
2. Patients with severe disabilities that may prevent satisfactory Orthodontic results.
3. Surgical Orthodontics not normally performed in a dental office by a general dentist or orthodontist.
4. 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.
5. Interceptive Orthodontic Treatment is not a covered benefit.
6. Myofunctional therapy.

7. Supplemental appliances not routinely used in typical orthodontic cases.
8. 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.
9. Treatment started before the Covered Person became covered under this policy.
10. Transfer to another dentist after banding has been initiated.
11. Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and are subject to additional charges.

VI. GENERAL PROVISIONS

A. This Enrollee Handbook, including the "Complete Schedule of Benefits" and any endorsements attached hereto, constitutes the entire Agreement between the Member and GDP, and the detailed terms and conditions of the Dental Care Plan Agreement shall govern with respect to all dental services referred to herein. No statement by the Member in the application for coverage shall void this Enrollee Handbook or be used in any legal proceeding hereunder unless such application, or an exact copy thereof, is attached to the Dental Plan Contract.

B. No agent of GDP has authority to change this document or to waive any of its provisions. No change shall be valid unless such approval be endorsed or attached to the Dental Plan Agreement.

C. The GDP authorized provider shall be solely responsible for all dental advice and service performed or prescribed by them. Neither GDP, any of its agents, nor any employer shall be liable for injuries, damages or expenses resulting from negligence, malfeasance, nonfeasance or malpractice on the part of any officer or employee or agent of GDP or on the part of any person, organization or entity rendering services to a Member or Dependent.

D. An individual who is or has been a patient is entitled to inspect, or receive for a reasonable fee, a copy of his or her dental record upon request. A third party, other than authorized State and Federal Agency representatives or authorized GDP designees, shall not be given a copy of the patient's dental record without prior authorization of the patient.

E. Services hereunder are personal to the Member and any covered Dependents and are not assignable.

F. All supplemental and additional fees or charges provided hereunder, with the exception of Orthodontic care, are due to the GDP authorized provider immediately upon commencement of extended treatments or upon performance of services for which such fees or charges are specified under the Complete Schedule of Benefits. Neither GDP nor the Group shall have any liability for collection of these charges.

G. All dental services to be rendered to the Members and Dependents hereunder shall be performed by the GDP authorized Provider designated in the member's application unless specifically authorized by GDP or its authorized providers.

The Member shall be entitled to select a general provider from those in the GDP network to perform the services to be rendered hereunder. Further, the Member shall have the right to transfer to another GDP authorized provider by giving at least 30 days prior written notice to GDP and upon completion of records changed by GDP.

H. Indemnity in the form of cash will not be paid to any Member or Member's dependent, except for emergency treatment pursuant to page 6 of this Enrollee Handbook or in reimbursement for payment made by the Member or Member's Dependent, to a dentist or dental surgeon for which the Member or Member's Dependent, has received expressed written authorization by GDP, or its authorized Provider and for which the authorized Provider was liable at the time of such payment.

I. No action or suit at law or in equity shall be commenced upon thirty (30) days after written notice of the claim has been given to GDP by the Member. All remedies are available to the Member through the Informal Grievance Procedures and The Patient's Right to Independent Review Act.

J. Any notice required or permitted to be given by GDP hereunder shall be deemed to have been given if in writing and personally delivered, or if in writing and deposited in the United States Mail with postage prepaid, addressed to the Member at the last address of record at the principal office of GDP such notice shall be deemed to have been given when so personally delivered or mailed.

K. The catch line and captions in no way shall be considered to be a part of this Schedule of Benefits, but are inserted only for the purposes of convenience.

L. This Enrollee Handbook may not be amended nor the subscription rate applicable hereto be changed by GDP without providing the Group or Members affected thereby with a clear written statement setting forth the extent and nature of the proposed changes sixty (60) days before the effective date of said proposed changes which must have the prior approval of the appropriate state, and where applicable, Federal regulatory agencies. Amendments may be communicated to the membership through periodic GDP releases or newsletters.

M. Conditions of eligibility are specified in the employer contract.

N. The effective date is specified in the employer group contract.

O. This Enrollee Handbook is made and shall be interpreted under the laws of the State of Michigan.

P. GDP may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration.

VII. SELF-CONTRIBUTIONS

A self-contribution is a payment that you make to the Plan in order to continue coverage for yourself and your dependents. Normally, you would make self- contributions when your employer no longer has to make contributions for you.

A. You make Self-Contributions:
   1. For a period not to exceed 36 months if you are continuously and totally disabled but not beyond the date you become eligible for coverage under Medicare.

   2. For a period not to exceed 18 months if you were granted a leave of absence, were laid off, or were absent on account of temporary work stoppage. This period may be extended if your collective bargaining agreement provides seniority rights beyond 18 months.

   3. If you quit, retire or were discharged from your job.

   4. In the event a covered employee dies, the spouse of such an employee shall have the right to choose continuation coverage for himself or herself, along with any eligible dependents, pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986.

B. If you decide to continue your coverage through the Plan by making self contributions, you may do so by any of the following methods:

   1. Send your check or money order directly to GDP or payment by credit card; please call GDP customer service at **800-451-5918.**

   2. Deliver your payment in person at the GDP Administrative offices.

3. If you belong to a union local outside the Detroit area, you may send your payment to your union local.

C. The following information should be included with your self-contribution payment:

* Your social security number
* Member ID# (located on your membership card)
* The name of your employer
* The reason for self-contribution (strike, lay-off, illness, etc.).
* The last day worked

D. Self-contributions must be received at the GDP Administrative Office by the 25th of the month following the month for which payments are being made. If you are not familiar with the contribution rate that your employer is making, you may call your employer or GDP at:

1-(800)-451-5918

FAX (586) 573-8720

VIII. INFORMAL ENROLLEE INQUIRY/GRIEVANCE PROCEDURE

8.1 FILING A GRIEVANCE

a. Enrollee may file an inquiry/complaint/grievance at any time by calling or writing the GDP Professional Relations Manager at the address listed below.

b. When an adverse determination is made at any level, the Enrollee or a person, including but not limited to, a dentist or physician, authorized in writing to act on behalf of the Enrollee may request further review by contacting:

Golden Dental Plans, Inc
Professional Relations Manager
29377 Hoover Road
Warren, MI 48093
(800) 451-5918 or (586) 573-8118
Website: www.goldendentalplans.com

A member cannot file an appeal with the Office of Financial and Insurance Regulation (OFIR) until they have completed all of the reviews available within the Informal Enrollee Inquiry/Complaint/Grievance Procedures. The only exception is if GDP fails to complete the internal grievance process within the statutory time frame.

c. Under no circumstance will the total time for a final determination be more than thirty five (35) calendar days from the date of the original grievance except as outlined below:

The timing for the 35-calendar-day period may be tolled, however, for any period of time the enrollee is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 business days if GDP has not received requested information from a health care facility or health professional.

An undue delay in resolving a grievance may occur because of but not limited to the following. However, in no case shall it exceed Ten (10) business days unless a longer delay is agreed to and authorized by the enrollee or a person authorized to act as a representative for the enrollee:

1. The lack of sufficient documentation to appropriately investigate the grievance.
2. The providers' response.
3. The need for a second opinion.
4. The member's availability and cooperation.

d. When communicating with GDP, the Enrollee must provide the following information: subscribers name, social security number, address and phone number(s).

e. If the Enrollee believes standard or normal grievance process may acutely jeopardize his or her health/life, and it is substantiated orally or in writing by a dentist or physician they may request an expedited grievance procedure as under the EXPEDITED GRIEVANCE SECTION, Page 6 of this program.

f. Not later than sixty (60) days after the receipt of notice of an adverse determination or final adverse determination, the Enrollee or the Enrollee's authorized representative may file a request for an external review with the Commissioner. Upon receipt of the request, the Commissioner immediately shall notify and send a copy of the request to the health carrier that made the adverse determination or final adverse determination.

g. Each written determination will include the Health Care Request for External Review Form. All written determinations will be timely and be written in plain English.

h. Inquires/ complaints and grievances received by GDP will be administered as outlined below:

STEP ONE

When the grievance is received, it will be logged and the office manager will contact the member, by telephone, within five (5) calendar days.

The next step should include a conference with the Professional Relations Manager and the providing dentist or his/her staff. The enrollee is contacted by telephone by the Professional Relations Manger as to the determination. If an Enrollee has been advised of an adverse determination, they or a person, including, but not limited to a dentist, authorized in writing toact on behalf of the Enrollee may appeal to the GDP Professional Relations Manager at the address shown above.

The grievance will be fully investigated by the Professional Relations Manager and the Dental Director and a written initial determination, outlining the reasons for the determination, will be provided to the Enrollee within 5 (five) calendar days after receipt of the grievance. The notification will be made timely and will be written in plain English.

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

Enrollees receiving an adverse determination may appeal to Step Two.

STEP TWO

For grievances not resolved in Step One, the Enrollee, or a person, including but not limited to, a dentist or physician, authorized in writing to act on behalf of the Enrollee may request further review either orally or in writing to the GDP Professional Relations Manager at the addresses listed above.

When communicating with the Manager, Professional Relations, the Enrollee must provide the following information; subscribers name, social security number, address, phone number(s) and the group name if applicable.

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

Step Two grievances will be determined within ten (10) calendar days of receipt of the Step Two appeal. The notification will be timely and will be written in plain English.
If the determination of the Professional Relations Manager satisfies the Enrollee, the grievance will be closed.

When an Enrollee receives an adverse determination at Step Two, they may appeal to GDP.

STEP THREE

If a grievance is not resolved at Step One or Two, the Enrollee or a person authorized in writing to act on their behalf may request further review either orally or in writing to the GDP Dental Director, c/o GDP at the address indicated in above.

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

The Enrollee will be notified by telephone and in writing the time, date and location of hearing and advised they may be present, present telephonically, present with counsel, represented by counsel or a person, including, but not limited to, a dentist or physician, authorized in writing to act on the behalf of the Enrollee to present evidence on their behalf. GDP shall provide written confirmation of the determination to the Enrollee not later than two (2) business days after the oral determination. The notification will be timely and will be written in plain English.

The chairperson, of the QA Committee shall inform the Enrollee or their representative, in writing, of their right to a determination of the matter by the commissioner or his or her designee or by an independent review by an independent review organization under the Patient's Right to Independent Review Act (PRIRA).

The Enrollee or the Enrollees authorized representative will be provided the Health Request for External Review Form for application to the Commissioner by the Professional Relations Manager.

The chairperson of the QA Committee will report the results of the hearing to the Board of Directors at the next scheduled meeting.

STEP FOUR

Step four is the external review as allowed by the Patient's Right to Independent Review Act. A request for external review of an adverse determination shall not be made until the Enrollee has exhausted the GDP Informal Grievance Procedures unless the enrollee has requested an expedited grievance.

The Commissioner shall render a determination for all parties. No later than sixty (60) days after the date of receipt of the Commissioner's determination or final adverse determination from GDP, the Enrollee or their representative may seek judicial review in the circuit court for the county where the enrollee resides. GDP will seek other remedies available under the Michigan law if GDP does not agree with the Commissioner's determination.

EXPEDITED GRIEVANCE

The enrollee has ten (10) calendar days to request an expedited external review with the

Department of Insurance and Financial Services (DIFS)

To obtain information regarding the external review or to file a grievance with DIFS, the enrollee or the person authorized to represent the enrollee should contact the GDP Professional Relations Manager who will assist them with the filing of the appropriate form to file a Health Request for External Review.

If an Enrollee or a person, including, but not limited to a Dentist or physician, authorized in writing to act on behalf of an Enrollee requests an Expedited Grievance, GDP will assist the enrollee in completing the Health Care Request for External Review Form within seventy-two (72) hours of its receipt.

It is the responsibility of the Enrollee or their representative to notify GDP of the nature of the grievance, the names and dates of the parties involved with the grievance (i.e.) The name of the facility, the dentist, if known, that rendered or did not render the treatment, any known witnesses and if known their job title or function, the facts of the claim and any other facts that the Enrollee believes are important so that the grievance can be resolved in an expedited manner. Within two (2) business days after receipt of the DIFS determination, GDP will provide the enrollee or the person authorized in writing to represent the enrollee a written response. The notification will be timely and will be written in plain English.

8.3 ANNUAL REPORTING REQUIREMENTS

GDP will keep summary data on the number and types of complaints and grievances filed. Each year, by April 15th, summary data for the prior calendar year will be filed with the commissioner on forms provided by the commissioner. This information will also be provided to the Quality Assurance Committee who will report the results of their review and actions taken to the Board of Directors at each quarterly meeting.

Should the member desire to contact DIFS at anytime, they may use the following information:

Department of Insurance and Financial Services (DIFS)
Department of Labor and Economic Growth
611 West Ottawa Street, 3rd
P.O. Box 30220
Floor
Lansing, MI 48933
877-999-6442
Website: www.michigan.gov/difs

RECORDS

GDP will maintain a complete file of all grievances and responses for a period of two (2) years. They shall be available for inspection by DIFS and other regulatory agencies.

HIPAA Notice of Privacy Practices Statement

How We Collect Information About You: Golden Dental Plans, Inc. and its employees collect data through a variety of means, including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information: Information about your financial situation and dental/medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence. We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or members who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Use Your Information: Information is only used as is reasonably necessary to process your application or to provide you with dental services, which may require communication between Golden Dental Plans, Inc. and dental health care providers and/or insurance companies. Communications are necessary to verify your dental information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of dental supplies, devices, medications, insurance, etc.

If you apply or attempt to apply to receive insurance through us and provide information with the intent or purpose of fraud or that results, in either an actual crime of fraud for any reason including willful or un-willful acts of negligence, whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-dental information can be given to legal authorities, including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Web Site Cookie Usage: We use cookies on our web sites only to make the web sites easier to use and to better tailor our web site and our products to your interests and needs. Cookies may also be used to help speed up your future activities and experience on our web sites. We also use cookies to compile anonymous, aggregated statistics that allow us to understand how people use our web sites and to help us improve the structure and content of our web sites. No personally identifiable information is placed in the cookies used by our web sites and we cannot track or identify you personally from this information.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of Golden Dental Plans, Inc. We reserve the right to use non-identifying information about our members (those who receive services or goods from or through us) for promotional purposes that are directly related to our mission. Members will not be compensated for use of this information. No identifying information will be used without a member's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

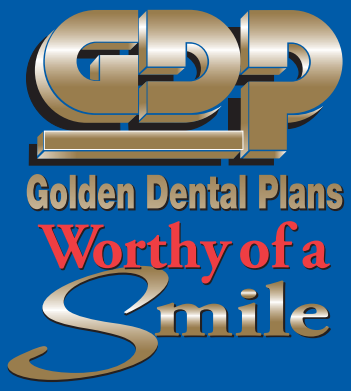
Your Member Rights: You have the right to ask us to restrict how we use or disclose your member information for treatment, payment, or dental care operations. You have the right to ask to receive confidential communications of information. You have the right to inspect and obtain a copy of member information that we maintain about you. You have the right to ask us to amend member information we maintain about you, which must be accurate information. We cannot delete any part of a legal record, such as a claim submitted by your dentist. You have the right to receive an Explanation of Benefits detailing the percentage covered by your dental plan on claims received from your dentist.

We periodically review and update our privacy policies and security measures. When we do so, we may need to change or update this statement and reserve the right to do so. All updates and changes automatically apply to you without notice. When we change the policy in a material way, a notice will be posted on our website along with the updated Privacy Policy at:

https://www.goldendentalplans.com/privacy/member-privacy.aspx

Please retain this notice with your Golden Dental Plans Enrollee Handbook. Direct questions to: **1-800-451-5918** or **www.goldendentalplans.com**.

NOTES



GOLDEN DENTAL PLANS

800.451.5918 toll-free
586.573.8118 phone
586.573.8720 fax
29377 Hoover Road, Warren, MI 48093

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