COMFORT DENTAL GOLD MEMBERSHIP PLAN

Comfort Dental ***Gold Plan*** is a reduced-fee dental membership plan that allows individuals and families to receive quality dental services from Comfort Dental dentists at reduced costs. The ***Gold Plan*** offers the access of a network, plus the individualized attention of private care. You, your spouse, dependent children up to 26 years of age, and children over 26 with a developmental disability or physical handicap are eligible. Individuals under the age of 18 may only be members as the dependents of adults.

Members must choose a provider/office from the list of OFFICE LOCATIONS provided in this brochure. Provider information is also available at www.comfortdental.com or by calling the Gold Plan office. To receive care, simply call your selected office for an appointment after your effective date. All Comfort Dental Offices offer **EVENING AND SATURDAY** appointments. The Reduced Fee Schedule can be viewed at **www.comfortdental.com**

Members who enroll prior to the 10th of the month will have their membership begin on the first day of the following month. Those enrolling after the 10th will have their membership begin on the first day of the second month.

This discount program is NOT a health insurance policy and does not make payments directly to dental service providers. Members are obligated to pay for all dental services, but may receive discounts on dental services from participating providers and the discount range will vary depending on provider type, provider locations and dental services received. The program does not meet the minimum creditable coverage requirements under any law and is not a Qualified Health Plan under the Affordable Care Act. If you cancel within the first 30 days after activation you will receive a full refund, except for the enrollment fee where permitted by law. Program administered by Comfort Dental Gold Plan, LLC, 2540 Kipling St., Lakewood, CO 80215, **(303) 232-2300 or (303) 202-9449.** E-mail us at goldplan@ comfortdental.biz, www.comfortdental.com. Members who cancel after receiving benefits may be liable for the difference between the ***Gold Plan f***ee and the provider's normal and customary fee for treatment, payable to the provider.

Members may change providers or add additional family members by providing a written request and paying any additional membership fees. Changes will be effective 30-days from the receipt of written requests. Complaints should be addressed to: Comfort Dental Gold Plan Customer Service, 2540 Kipling St., Lakewood, CO 80215. Complaints will be addressed within 30-days of receipt. If a member remains dissatisfied he or she may contact his or her state's insurance department. The Gold Plan does not guarantee the quality of the services or products offered by individual providers.

Gold Plan Membership provides you with local anesthetics, examinations, x-rays, and other preventive services at NO CHARGE ($5.00 for Arizona members) plus reduced fees on most other dental services. The complete Reduced Fee Schedule can be viewed at **www.comfortdental.com** for full details on discounted services.

Members are charged an office visit fee of $30.00 for each appointment. Orthodontics (Braces) are provided at a $500 discount on the total treatment cost, and payments of just $99/month with NO DOWN PAYMENT. The reduced fees are paid directly by you to your selected provider. A complete list of dentists and offices is available at **www.comfortdental.com**

Members may receive emergency dental care for the relief of pain, bleeding or swelling from any Comfort Dental dentist at any Comfort Dental office when their selected provider is unavailable.

This contract is not protected by any state guaranty fund. The program and program administrator is not liable for providing or guaranteeing health services or for the quality of health services rendered. Membership and activation fees apply. The Gold Plan is governed by this Membership Agreement. Participating providers are not available in all areas and are subject to change without notice. Program is not available in all states. To join fill out the attached enrollment form and select one of the four methods of payment.

1. **ANNUALLY.** One lump sum payment by check or credit card.

2. **MONTHLY BY CREDIT/DEBIT CARD.** Enclose valid credit/debit card number with expiration date and name of cardholder. Your card will be charged the first month, last month fee to enroll. Remaining monthly payments will be automatically charged to the same card on the first of each month.

3. **MONTHLY BY CHECKING ACCOUNT DEBIT.** Enclose a check for the first and last month's payment. Also include a voided check. Remaining payments will be deducted from your checking account on the first of each month. Members choosing to pay in this way will be automatically renewed. A written request is required for cancellation.

Enrollment form and payment should be directed to:

COMFORT DENTAL GOLD PLAN
2540 Kipling Street
LAKEWOOD, CO 80215
303-232-2300
1-800-742-8710

All members fill out this portion completely - please print

MEMBER REGISTRATION

Last Name **First** **MI**

Mailing Address **Apt#**

City **State** **Zip Code**

Phone **Member Birth Date** **Email**

List Eligible Dependents	Birth Date	Relationship

Office Location Selected _____

Select type of Membership & Payment

❍ **ANNUAL**
- ❍ **Check** ❍ **Cash** ❍ **Credit/Debit card**

❍ **MONTHLY**
- ❍ **Credit/Debit card**
- ❍ **Bank Draft ACH - fill out right hand side of form**

Card # _____

EXP _____ **CVC #**_____

3 digits on back of card or 4 digits on front of AMEX.

If paying monthly, 1st and last month's payment will be charged & monthly payments will be automatically charged to this account on the 1st of each month.

I understand the benefits, limitations, exclusions and requirements of the Plan and I agree to the following: **I will remain in the planand pay membership fees for 12 months**.Where permitted by law, payment of less than 12 months' membership fees may result in my being charged usual and customary fees for all services (including those already provided) and my being charged remaining months' fees in lump sum. Fees for dental services are due to the dentist as services are rendered. Fees for prosthodontic and cast restoration services are due to the dentist at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs. Membership must be continuous. Missing monthly payments must be made up for interrupted membership.

Signature (Required) _____

Date _____

For a complete list of terms, conditions and exclusions please go to comfortdental.com/comfort-dental-gold-plan.html

TERMS AND CONDITIONS OF AUTHORIZATION TO HONOR DEBITS

Drawn by and Payable to Comfort Dental Gold Plan.

1. The member enrolling in the Gold Plan hereby lists and authorizes his/her bank to pay and charge to his/her account, checks drawn by and payable to Comfort Dental Gold Plan, Lakewood, CO, provided there are sufficient collectable funds in said account to pay the same upon presentation. The member agrees that his/her bank's responsibility in respect to each such check shall be the same as if it were a check drawn on his/her bank and paid personally by him/her. **This authority is to remain in effect until revoked by him/her in writing, member's bank shall be fully protected in paying such check.**
2. He/she further agrees that if any such check is dishonored, whether with or without cause and whether intentionally or inadvertently, his/her bank shall be under no liability whatsoever even though said dishonor results in the suspension of his/her membership.
3. To the Bank named, it is agreed that you may comply with the depositor's request, this Company agrees: a) To indemnify you and hold you harmless from any loss you may suffer as a consequence of further actions resulting from or in connection with the execution and issuance of any check, draft or letter, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith. b) In the event that any such check, draft or order shall be dishonored whether with or without cause, or whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a suspension of membership. c) To defend at your own cost and expense any action which might be brought by any depositor or any other persons because of your actions when pursuant to the foregoing request, or in any manner arising by reasons of your participation in the foregoing plan of statement of collection.
4. Member hereby agrees that payments will be withdrawn on the first day of the month, however, on your renewal month the first and last month's payment will be charged.

Authorization to Honor debits drawn by and payable to COMFORT DENTAL GOLD MEMBERSHIP PLAN

Bank Name _____

Address _____

City _____State _____ Zip_____

Phone (_____) _____

Checking _____ Savings _____

Acct.# _____ Routing # _____

*** Please include voided check from account to be drafted ***

I authorize you to pay and charge my bank account checks drawn by and payable to the order of Comfort Dental Gold Plan, Lakewood, CO and agree to remain in the Plan a minimum of one year. Less than one-year membership may result in my being billed usual and customary fees. **Cancelation of banking must be done in writing 30 days prior to end of 12 month term.**

Signature (**Required**) _____

Date: _____

Mail this form to: Comfort Dental Gold Plan
2540 Kipling Street Lakewood, CO 80215

DENTAL LIMITATIONS AND EXCLUSIONS

1. Services that, in the opinion of the attending dentist, are neither necessary nor recommended for the patient's dental health.

2. Restorations, splints or other appliances used to increase vertical dimension or restore occlusion.

3. Oral surgery requiring the setting of fractures or dislocations.

4. Treatment of malignant cysts or neoplasms or congenital malformations, except that teeth congenitally missing or congenitally malformed are covered for replacement and/or restoration.

5. Dispensing of drugs not normally supplied in a dental office.

6. Hospital benefits for any dental procedure.

7. Loss or theft of dentures or bridgework.

8. Any experimental procedures

9. Services for injuries or conditions that are covered under Worker's Compensation or Employer's Liability laws.

10. Services that are provided without cost to the member by any municipality, county or other political subdivision.

11. Services that cannot be performed because of the general health, physical or psychological limitations of the patient.

12. Periodontics, endodontics, oral surgery or pedodontics requiring the services of a non-participating dentist.

13. General anesthesia.

14. Those procedures requiring appliances or restorations that are necessary for full mouth rehabilitation, or to alter, restore or maintain occlusion, including without limitation, treatment of disturbances of the temporomandibular joint.

15. Fluoride application is limited to one per year to age 18.

16. Diagnosis and treatment of myofacial pain dysfunction syndrome.

17. Procedures performed in the hospital.

18. Gold Plan discounts cannot be used with other dental discount plans.

19. Demonstrated non-compliance with recommended course of treatment may result in cancellation.

ORTHODONTIC LIMITATIONS AND EXCLUSIONS

1. Treatment programs that began before the member enrolled in the Plan are not discounted nor can they be transferred to Gold Plan.

2. Lost or broken appliances are not subject to replacement.

3. Additional fees may be charged by the dentist for:

a) Gross and consistent non-cooperation by the patient/member.

b) Accidents occurring during the treatment.

c) Cases involving surgical orthodontics.

d) Cases involving myofunctional therapy.

e) Cases involving temporomandibular joint treatment.

f) Loose, broken or lost bands/brackets.

4. If the member relocates to an area and is unable to receive treatment from a participating dentist, membership under this program ceases and it becomes the obligation of the patient/member to pay the usual and customary fee of the non-participating dentist at whose facility treatment is completed.

5. Choice of dentist, initially, after treatment begins or upon change of residence is limited to practitioners participating in this program or who accept fees outlined.

6. Orthodontic extractions are not included in the monthly fee.