LIBERTY Dental Plan of CALIFORNIA

LIBERTY Dental Plan has been providing and administering dental benefits in California for over ten (10) years. All of our contracted providers have undergone strict credentialing procedures, background checks and office evaluations. In addition, each provider must adhere to strict contractual guidelines. Our Provider Relations Department conducts a Quality Assessment Program which includes ongoing contract management to assure compliance with continuing education, accessibility for members, appropriate diagnosis and treatment planning.

LIBERTY Dental Plan contracts with quality dental professionals to provide services to you and your eligible dependents at no cost or for low fixed co-payments. We take pride in our relationship with our dental professionals. This relationship enables our members to receive the care they deserve when enrolling in our plans.

Dental Benefits should be simple to use for you and your family. Our CA1000 plan offers comprehensive dental coverage without claim forms, deductibles or annual maximum limitations.

Our goal is to provide you with the comprehensive dental benefits you purchase. We pledge to support your choice of LIBERTY Dental Plan by giving you confidence through the excellent customer service you deserve. After all, isn't that what it is all about?

Membership Eligibility: If you reside in our service area, you and your eligible dependents may enroll in this plan. Eligible dependents include your spouse, unmarried dependent children who are under the age of twenty-six (26), disabled children dependent upon you for support and are not able to support themselves due to physical or mental handicap (you must provide proof of disability or handicap at the time you enroll) and adopted or step-children meeting the above requirements.

Selecting a Dental Provider: You do not need to select a contracted Primary Care Dentist when you enroll in this plan. However, to receive benefits under this plan, you must receive services from a CA1000 contracted LIBERTY Dental Plan Dentist. To search for participating providers in your area, please visit www.libertydentalplan.com and click on "Find a Dentist", and select "CA1000" as your benefit plan.

Appointment Scheduling: Once you are enrolled and eligible under the Plan, you may call the CA1000 contracted LIBERTY Dental Plan Dentist of your choice directly to schedule an appointment. Be sure to identify yourself as a member of LIBERTY Dental Plan when you call. Co-payments are due and payable to your provider at the time services are rendered.

Specialty Referral: If your CA1000 contracted LIBERTY Dental Plan Dentist encounters a situation requiring the services of a Dental Specialist, he/she will contact LIBERTY Dental Plan to initiate the Specialty Referral process. Specialty services are available based on a separate co-payment schedule. See Schedule of Benefits for full disclosure.

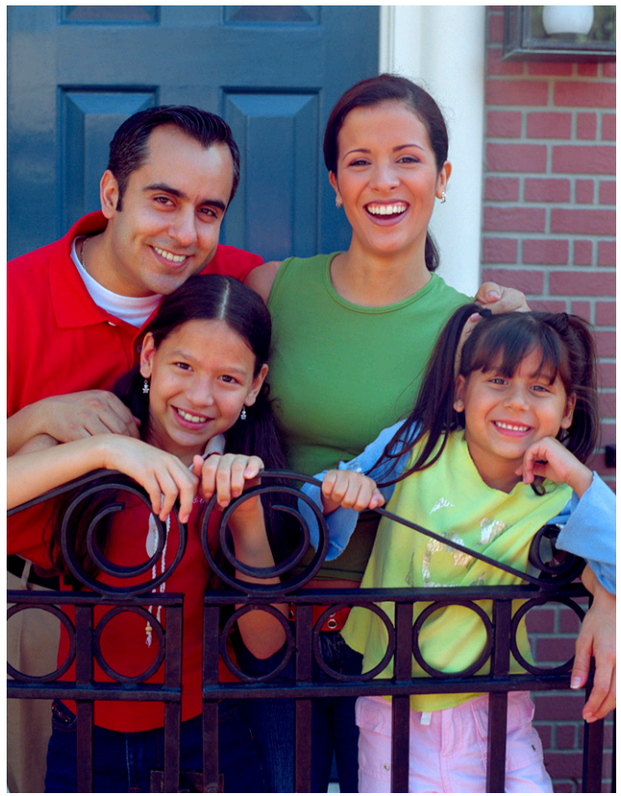
Emergency Dental Care: All contracted LIBERTY Dental Plan offices provide for emergency dental care twenty-four (24) hours per day, seven (7) days per week. If you are more than fifteen (15) miles or thirty (30) minutes from a CA1000 contracted LIBERTY Dental Plan Primary Care Dentist, or you cannot contact a CA1000 contracted LIBERTY Dental Plan Primary Care Dentist or LIBERTY Dental Plan Member Services, simply contact any licensed primary care dentist to receive care. LIBERTY Dental Plan will reimburse you for dental expenses for covered services related to the relief of pain only, up to a maximum of fifty dollars ($50), less any applicable co-payments.

PLAN CA1000

Discover the Advantage of "Simply Better Coverage" ™

LIBERTY Dental Plan

CA1000



LIBERTY Dental Plan

P.O. Box 26110
Santa Ana, CA 92799
(800) 72-SMILE

LIBERTY Dental Plan of CA

CA1000 Enrollment Form

Subscriber Information — **Group# 049015**

First Name: | Last Name: | ○ Male ○ Female

Address: | City: | State: CA | Zip Code:

Date of Birth: | SSN: | Primary Phone #:

Family Information / Dependents

		New Member	* Renewing Member
Spouse (First, Last):	Date of Birth:	○ Single: $104.30	○ Single: $93.87
Child (First, Last):	Date of Birth:	○ 2-Party: $133.72	○ 2-Party: $120.35
Child (First, Last):	Date of Birth:	○ Family: $183.99	○ Family: $165.59
Child (First, Last):	Date of Birth:		
Child (First, Last):	Date of Birth:		

Agent #:

Payment Information (Select One)

○ Check or Money Order (Pay to LIBERTY Dental Plan)

○ Credit Card (Complete Portion Below)

Card Type: ○ MasterCard ○ Discover ○ American Express ○ Visa

CC #:

Expiration Date:

I understand eligibility will begin on the first day of the month following receipt of this application and payment. However, I understand this application and payment must be received by LIBERTY Dental Plan by the 20th of the month for eligibility to be effective the first day of the following month. If application and payment is received after the 20th day of the month, eligibility will begin the first of the next following month.

Signature _____ Date _____

Mail Form & Payment to:
LIBERTY Dental Plan
P.O. Box 26110
Santa Ana, CA 92799

Fax: (888) 704-9930

*Renewal Fees are for Active Members only.

PLAN CA1000

Summary of Benefits*

Diagnostic and Preventative	Co-Pay
Periodic oral examination	$12
Office Visit	$0
X-rays, complete series	$35
Panorex Film	$35
Adult prophylaxis (1 every 6 months)	$28
Child prophylaxis (1 every 6 months)	$22
Topical flouride (1 every 6 months to age 18)	$7
Sealant, per tooth (to age 14)	$10

Restorative	Co-Pay
Amalgam filling, 1 surface	$35
Amalgam filling, 2 surfaces	$45
Amalgam filling, 3 surfaces	$56
Resin filling, 1 surface, anterior	$45
Resin filling, 1 surface, permanent posterior	$60

Crown and Bridge	Co-Pay
Crown, porcelain fused to base metal**	$383
Crown, full cast base metal**	$337
Core builup, includes any pins	$94
Cast post & core in addition to crown**	$139
Pontic, porvelain fuse to bast metal**	$383

Endodontics	Co-Pay
Pulp capping	$30
Therapeutic pulpotomy	$61
Root canal, anterior	$244
Root canal, bicuspid	$293
Root canal, molar	$387
Apicoectomy	$210

*This brochure is only a summary of the dental plan. You will receive a complete Summary of Benefits and Evidence of Coverage with an ID Card in the mail after your enrollment has been processed.

** Base metal is the benefit, the member may be charged additional lab costs for a) noble metal b) high noble metal or c) titanium

Oral Surgery	Co-Pay
SImple extraction	$53
Impaction, soft tissue	$150
Impaction, partial bony	$175
Impaction, complete bony	$206
Alveoplasty wtih extraction, per quad	$110

Periodontics	Co-Pay
Gingivoplasty/gingivectomy, per quad	$237
Osseoue surgery, per quad	$531
Periodontal scaling & root planing	$97
Full mouth debridement	$30

Removable Prosthodontics	Co-Pay
Complete denture, upper or lower	$549
Partial denture, resin base	$347
Adjust denture	$23
Replace missing or broken tooth	$63
Reline complete denture, chairside	$137

Adjunctive Services	Co-Pay
Emergency palliative treatment	$549
Local anesthesia	$0
Office visit, after regular hours	$70
Broken appointment (less than 24 hour notice)	$25

Orthodontics	Co-Pay
Start-up fees	$175
Class II & III malocclusion, full upper & lower	$2,300
Post treatment stabilzation (child)	$300

- **Orthodontic Coverage at Reduced Rates**
- **Pre-existing Conditions are Not Excluded**
- **No Annual Maximum Dollar Coverage**
- **No Claim Forms to Complete**
- **No Annual Deductibles**

A Dental Plan for Individuals, Couples, or Families

Rates for New Members

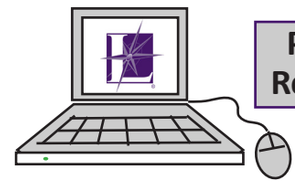
Single Plan	2-Party Plan	Family Plan
$104.30	$133.72	$183.99

New Members are those individuals who are purchasing this plan for the first time or who have not renewed their prior plan 30 days after the expiration date.

Rates for Renewing Members

Single Plan	2-Party Plan	Family Plan
$93.87	$120.35	$165.59

Renewing Members are those individuals who have previously purchased this plan and have maintained consistent coverage.



Purchase or Renew Online.

www.libertydentalplan.com/enrollca1000

LIBERTY Dental Plan

Address: P.O. BOX 26110
Santa Ana, CA 92799
Phone: (800) 72-SMILE
Fax: (888) 704-9930

EXCLUSIONS

1) Any procedure not specifically listed as a covered benefit. 2) Replacement of lost or stolen prosthetics or appliances including crowns, bridges, partial dentures, full dentures and orthodontic appliances. 3) Any treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes unless otherwise covered as a benefit. 4) Procedures considered experimental, treatment involving implants or pharmacological regimens. (See "Independent Medical Review" on page 6 of the Evidence of Coverage). 5) Oral surgery requiring the setting of bone fractures or bone dislocations. 6) Hospitalization is not covered. 7) Out-patient services are not covered. 8) Ambulance services are not covered. 9) Durable Medical Equipment is not covered. 10) Mental Health Equipment is not covered. 11) Chemical Dependency services are not covered. 12) Home Health services are not covered. 13) General anesthesia, analgesia, intravenous/intramuscular sedation or the services on an anesthesiologist are not covered services. 14) Treatment started before the member was eligible or after the member was no longer eligible. 15) Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorder, including but not limited to: myofuncional (e.g. speech therapy), myoskelatal, or temporomandibular joint dysfunctions (e.g. adjustments/correction to the facial bones) unless other wise covered as an orthodontic benefit. 16) Procedures which are determined not to be dentally necessary consistent with professionally recognized standards of dental practice. 17) Treatment of malignancies, cyst, or neoplasms. 18) Orthodontic treatment prior to member's effective date of coverage. 19) Appliances needed to increase vertical dimension or restore occlusion are not covered services. 20) Any services performed outside your assigned dental office, unless expressly authorized by LIBERTY Dental Plan or unless as outlined and covered in "Emergency Dental Care" section.

LIMITATIONS

1) Prophylaxis are covered once every 6 consecutive months. 2) Full mouth x-rays are limited to once every 36 consecutive months. Fluoride treatments are covered once every 6 consecutive months. 4) Sealants are covered only on the first and second permanent molars and up to the 14th birthdate. 5) Crowns, jackets, inlays and onlays are benefits on the same tooth only once every five years and consistent with professionally recognized standards of dental practice. 6) Replacement of existing full and partial dentures are covered once per arch every 5 years except when they cannot be made functional through reline or repair. 7) Denture relines are covered twice per year, and only when consistent with professionally recognized standards of dental practice. 8) Any routine dental services performed by a Primary Care Dentist or Specialist in an inpatient/outpatient hospital setting, under certain circumstances, will be considered for coverage.

ORTHODONTIC EXCLUSIONS

1) Lost, stolen or broken appliances. 2) Extractions for orthodontic purposes (will not apply if extraction is consistent with professionally recognized standards of dental practice or arises in the context of an emergency dental condition). 3) Temporomandibular joint syndrome (TMJ) surgical orthodontics. 4) Myofunctional therapy. 5) Treatment of cleft palate, micrognathia, and macroglossia.