Exhibit A-5

LIBERTY Dental Plan of Florida, Inc. Provider Agreement
Adult Medicaid Fee for Service Programs Addendum
General Dentist and Specialist

This Adult Medicaid Fee for Service Programs Addendum (the "Addendum") to the LIBERTY Dental Plan of Florida, Inc. Provider Agreement (the "Agreement") between LIBERTY Dental Plan of Florida, Inc. ("LIBERTY") and the legal entity or individual qualified and licensed to practice dentistry in the state of Florida as defined in the Agreement and as specified on the signature page of this Addendum ("Dentist") is meant to supplement the Agreement. Except as expressly modified by this Addendum, the Agreement remains in full force and effect and all capitalized terms in this Addendum (which are not otherwise defined) shall have the meaning ascribed to them in the Agreement. LIBERTY and Dentist agree as follows:

1. *Reimbursement/Compensation.* LIBERTY shall pay Dentist certain Fees for covered Services (whose procedural codes are expressly listed below) that are rendered to eligible Members by qualified dentists in the contracted facilities of Dentist in accordance with the terms of the Agreement. For purposes of this Addendum, "Fee" is defined as the amount of the applicable fees listed below minus the amount of any applicable Member copayment.

Code	Description of Services	Fee
	DIAGNOSTIC	
D0120	Periodic oral evaluation – established patient	$22.29
D0140	Limited oral evaluation – problem focused	$8.00
D0150	Comprehensive oral evaluation – new or established patient	$16.00
D0210	Intraoral – complete series of radiographic images	$32.00
D0220	Intraoral – periapical first radiographic image	$4.00
D0230	Intraoral – periapical each additional radiographic image	$3.00
D0240	Intraoral – occlusal radiographic image	$8.00
D0272	Bitewings – two radiographic images	$13.38
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image	$32.00
D0330	Panoramic radiographic image	$30.00
	PREVENTIVE	
D1110	Prophylaxis – adult	$26.75
D1330	Oral hygiene instructions	$8.92
	PROSTHODONTICS (REMOVABLE)	
D5110	Complete denture – maxillary	$310.00
D5120	Complete denture – mandibular	$310.00
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$165.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$165.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$315.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$315.00
D5410	Adjust complete denture – maxillary	$14.00
D5411	Adjust complete denture – mandibular	$14.00
D5421	Adjust partial denture – maxillary	$14.00
D5422	Adjust partial denture – mandibular	$14.00
D5510	Repair broken complete denture base	$44.00
D5520	Replace missing or broken teeth – complete denture (each tooth)	$39.00
D5610	Repair resin denture base	$44.00
D5620	Repair cast framework	$47.00
D5630	Repair or replace broken clasp - per tooth	$56.00
D5640	Replace broken teeth - per tooth	$39.00
D5650	Add tooth to existing partial denture	$42.00
D5660	Add clasp to existing partial denture - per tooth	$52.00
D5730	Reline complete maxillary denture (chairside)	$63.00

Code	Description of Services	Fee
D5731	Reline complete mandibular denture (chairside)	$63.00
D5740	Reline maxillary partial denture (chairside)	$63.00
D5741	Reline mandibular partial denture (chairside)	$63.00
D5750	Reline complete maxillary denture (laboratory)	$113.00
D5751	Reline complete mandibular denture (laboratory)	$113.00
D5760	Reline maxillary partial denture (laboratory)	$113.00
D5761	Reline mandibular partial denture (laboratory)	$113.00
	ORAL AND MAXILLOFACIAL SURGERY	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$27.00
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40.00
D7220	Removal of impacted tooth – soft tissue	$62.00
D7230	Removal of impacted tooth – partially bony	$77.00
D7240	Removal of impacted tooth – completely bony	$79.00
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	$82.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$54.00
D7260	Oroantral fistula closure	$168.00
D7261	Primary closure of a sinus perforation	$120.00
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$45.00
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$56.00
D7472	Removal of torus palatinus	$175.39
D7473	Removal of torus mandibularis	$175.39
D7510	Incision and drainage of abscess – intraoral soft tissue	$47.00
D7520	Incision and drainage of abscess – extraoral soft tissue	$67.00
D7970	Excision of hyperplastic tissue - per arch	$84.00
	ADJUNCTIVE GENERAL SERVICES	
D9223	Deep sedation/general anesthesia – each 15 minute increment	$41.61
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$28.00
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$41.61
D9248	Non-intravenous conscious sedation	$40.00
D9420	Hospital or ambulatory surgical center call	$56.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$22.29

2. *Eligibility.* All payments made pursuant to this Addendum are based on Member eligibility at the time services are rendered and on current plan benefits, subject to all limitations and exclusions specified in applicable plan documents.

3. *Claims.* Dentist is encouraged to submit all claims subject to this Addendum within one hundred and eighty (180) days after the date such services were rendered; provided, however, that Dentist agrees to submit claims within the time period required by any applicable claims timeliness laws, regulations or rules. Late submissions by Dentist that do not comport with applicable claims timeliness laws, regulations or rules may, in the sole discretion of LIBERTY, be rejected by LIBERTY.

4. *Term and Termination.* This Addendum shall become effective as of the date specified below by LIBERTY as the "Effective Date" and shall remain in effect until the earlier of either termination of the Agreement in accordance with the terms of the Agreement or termination of this Addendum in accordance with the terms herein. LIBERTY may terminate this Addendum at any time with or without cause by providing at least sixty (60) days' written notice to Dentist.

[Signatures on Next Page]

The parties have executed this Addendum as of the Effective Date written below:

("Dentist"):

Authorized Signature

Print Name

Title

Date

Dental Office Address

City, State Zip

Medicaid Individual #

Medicaid Group # *(if applicable)*

LIBERTY Dental Plan of Florida, Inc. ("LIBERTY"):

Signature

Print Name

Title

Effective Date