

Affordable Health Insurance Agency, LLC.

Kevin Truebenbach



Specialist In Health/Life Insurance, Critical Illness, Medicare Supplements, & Long Term Care

April 16, 2008

Prospective Dental Client
Nationwide Dental Program

Dear Client:

Enclosed is information on dental insurance through Guardian Life Insurance. Liberty Insurance Group, Inc. administers this dental plan which is specifically designed to meet the needs of individuals and small companies. Minimum enrollment is one person.

PPO Plan VP is a PPO dental plan which allows you to receive care from any dentist. If you use a PPO dentist, routine exams, x-rays, and cleanings are covered at 100%. Other services including fillings, periodontics, endodontics, crowns and bridgework are covered at reasonable coinsurance levels after a \$50 plan year (June - May) deductible. Please refer to the enclosed comparison for more detailed information. You can use any dental provider you want, but you receive better benefits and a lower cost per service if you use a dentist within the PPO network. To find PPO providers in your area, contact us or visit www.GuardianLife.com. (Resources: Provider Online Search; Find a Dentist; Select a Plan = PPO. Enter zip code; Choose a Network = DentalGuard Preferred.)

Quarterly premiums (3 months) for PPO Plan VP are as follows:

Direct Invoice: Single Coverage:\$122.00 Husband & Wife Coverage:\$239.00 Family Coverage:\$302.00

Credit Card: Single Coverage:\$126.00 Husband & Wife Coverage:\$247.00 Family Coverage:\$311.00

Monthly Automatic Withdrawal premium for PPO Plan VP are as follows:

Single Coverage:\$40.00 Husband & Wife Coverage:\$79.00 Family Coverage:\$100.00

The quarterly premiums quoted above include a \$5 administration fee per invoice. Credit card payments include an additional 3% convenience fee. Monthly automatic withdrawal premium includes a \$1 per month per invoice fee.

Vision Access is included with either dental plan at no additional cost. It offers discounts on most vision services when you use a VSP provider. See enclosed flyer for more information.

To apply please return: A completed enrollment application, a signed enrollment agreement, and either a check for one quarter's premium, credit card authorization, or a check for one month of premium along with an authorization for future automatic withdrawals. Checks are payable to Liberty Insurance Group. Your completed application, signed agreement and payment must be received in our office by the end of the month prior to your requested effective date.

The above quoted rates and benefits are subject to change June 1, 2009. **This is not temporary dental coverage.** The expectation is that you keep coverage for at least one year. If you have any questions regarding benefits or application, please call me personally.

Sincerely,

Kevin Truebenbach
Health Insurance Specialist

Reference # 00000

First Commonwealth Benefit Summary Comparison

Liberty Insurance Group

	Out-of-Network PPO Plan VP	<i>In-PPO Network</i>	<i>Out-of- Network</i>
Diagnostic & Preventive	Dental Exams (every 6 months) Dental X-Rays Cleanings (every 6 months) Emergency Oral Exams Fluoride Treatments Tooth Sealants	100% 100% 100% 100% 100%	80% 80% 80% 80% 80%
Basic Services	Fillings Endodontics Periodontics Please Note: Maintenance Procedures (every 3 months); Combined Cleanings & Perio Maintenance – 4 in 12 months Minor Oral Surgery Anesthesia (when medically necessary) Repair & Maintenance of Crowns, Bridges, Dentures Deductible Applies to This Category	80% 80% 80% 80% 80% 80%	80% 80% 80% 80% 80% 80%
Cosmetic Services	Labial Veneers Posterior Composite Resins	50% Not Covered	50% Not Covered
Major Services	Crowns, Bridges, Dentures Major Oral Surgery Dental Implants Deductible Applies to This Category	50% 50% 50%	50% 50% 50%
Orthodontics	Limited to Dependent Children Age 18 and Under	50% to \$1000 Lifetime Benefit	50% to \$1000 Lifetime Benefit
Miscellaneous	Claim Forms Deductibles Office Visit Copayment Annual Benefit Maximum	Yes \$50 x3/family None \$1,000	Yes \$75 x3/family None \$1,000
Claims Payment	Claims Payment Basis	Negotiated Fee Schedule	90 th Percentile of UCR
Network	Dental Network	DentalGuard Preferred	
Rates*	Single Family	\$39.00 \$99.00	

Note: Effective 6/1/08, dependent age limits will be 20, or 26 if a full-time student.
Maximum Rollover benefit is included with this plan. See attached information for details.

* Rates are valid from 6/1/08 through 5/31/09.

Summary of PPO Plan Limitations & Exclusions

PPO Option

- Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect or injury.
- This plan does not pay for:
 - ◆ Any restoration procedure, appliance or dental prosthesis used solely to: a) alter vertical dimension; b) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; c) splint or stabilize teeth for periodontal reasons; or d) treat a condition caused by abrasion or attrition.
 - ◆ Cosmetic or experimental treatments, unless specifically listed in the certificate of coverage as a covered cosmetic service.
 - ◆ Replacing a lost, stolen or missing appliance or prosthetic device; or making a spare appliance or device.
 - ◆ Treatment needed due to: a) an on-the-job or job-related injury; or b) a condition for which benefits are payable by Workers' Compensation or similar laws.
 - ◆ Treatment for which no charge is made.
 - ◆ Replacing an appliance or prosthetic device with a like appliance or device, unless: a) it is at least ten years old and can't be made usable; or b) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be fixed.
 - ◆ The replacement of extracted or missing third molars/wisdom teeth.
 - ◆ Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
 - ◆ Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
 - ◆ Any procedure performed in conjunction with, as part of or related to a non-covered procedure.
 - ◆ Any procedure not specifically listed in the certificate of coverage as a covered benefit.

This brochure is a summary outline only and is not intended to serve a legal interpretation of benefits. Reasonable effort has been made to have this brochure present a characteristic overview of the plan. However, this brochure does not amend, supplement, or replace the contract, and all statements are subject to the benefits, limitations, and exclusions of the contract.

Benefit Summary

for Vision has been prepared for the members of:

Liberty Insurance Group

Vision Access *

An eligible person can receive discounts on vision care services or supplies from a vision provider that is under contract with Vision Service Plan's (VSP's) Preferred Provider Organization (PPO) network. The eligible person must pay the entire discounted fee directly to the VSP network doctor.

Discounts are not available from providers who are not members of VSP's network.

DISCOUNTS:

- **Eye Exams** – 20% off of the VSP doctor's usual charge.
- **Frames, Standard Lenses and Lens Options** – 20% off the VSP doctor's usual charge, when a complete pair of prescription glasses is purchased.
- **Contact Lens Professional Services** – 15% off the VSP doctor's usual charge for professional services. The lenses are not discounted.
- **Laser Surgery** -- an average of 15% off the laser surgeon's usual charge.

No ID cards are required, but the patient must notify the VSP network doctor that they have Guardian VSP Access Plan coverage at the time of service to receive their discount.

Discounts are only available from the VSP network doctor that provided the eye exam to the patient within the last 12 months.

NOTES:

- There is no charge for Discount Vision Access.
- To find a VSP network doctor, visit www.vsp.com or call 1-800-877-7195.
- A person must be enrolled for dental coverage in order to be eligible for Discount Vision Access.
- When a person is no longer enrolled for dental coverage, access to the network discounts ends.

* This is not insurance. The eligible person must pay the entire discounted fee directly to the VSP network doctor.

This handout is for illustrative purposes.



GUARDIAN®



Check reason for completing form:
 New Subscriber Change Address
 Change Name Add a Family Member
 Terminate Family Member



PLEASE RETAIN A PHOTOCOPY OF YOUR APPLICATION FOR YOUR RECORDS AND SUBMIT THIS FORM TO LIBERTY INSURANCE GROUP

PLANHOLDER NAME (COMPANY NAME) LIBERTY/SBIT TRUST		GROUP PLAN NO 378450	REFERENCE #	
PLANHOLDER STREET ADDRESS 17100 W. Bluemound Road, Suite 202		CITY Brookfield	STATE WI	ZIP 53005
NAME (LAST, FIRST, MI)		SEX	BIRTHDATE	SOC. SEC. NO.
STREET ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE NUMBER
E-MAIL ADDRESS	FAX NUMBER		WORK TELEPHONE NUMBER	
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED				CELL PHONE NUMBER

Please provide the following information for each dependent if they are applying for coverage:

NAME (LAST, FIRST, MIDDLE INITIAL)	GENDER	SOCIAL SECURITY #	BIRTHDATE	FT STUDENT
SPOUSE	<input type="checkbox"/> MALE			
	<input type="checkbox"/> FEMALE			
CHILD	<input type="checkbox"/> MALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
CHILD	<input type="checkbox"/> MALE			<input type="checkbox"/> YES <input type="checkbox"/> NO
	<input type="checkbox"/> FEMALE			<input type="checkbox"/> YES <input type="checkbox"/> NO

COVERAGE ELECTION

FAMILY STATUS

PLAN CHOICE

Single
 Family
 Husband & Wife
 (2 Single Plans)

PPO PLAN VP

I hereby request coverage for the Group insurance and/or coverage for which I am or may become eligible; I understand that, in order to be accepted for coverage, my signed and completed application must be received by Guardian at least 1 day before my requested effective date for coverage. I understand that my choice indicated above is for a minimum of twelve (12) months. I authorize any provider, insurer, and/or HMO or other organization to release the necessary information regarding my dental history, treatment or benefits to Guardian or its subsidiary or authorized agent, for the purpose of plan administration.

SIGNATURE:	DATE:	EFF DATE:

Mail completed form and premium check (or credit card authorization) to:

Liberty Insurance Group, Inc.
 17100 W. Bluemound Road, Suite 202
 Brookfield, WI 53005
 262-785-1221 Phone 262-821-0508 Fax

PLEASE COMPLETE PAYMENT INFORMATION ON THE BACK OF THIS APPLICATION

AGENT: Kevin Truebenbach

Billing Options Liberty Insurance Group
Guardian Dental Program

Payment Method (select one)

Quarterly Direct Invoice – Must submit quarterly premium with initial application

- Send quarterly invoice to home address on application. (\$5 admin fee per invoice)
- Send semi-annual invoice (\$5 fee per invoice) Send annual invoice (\$5 fee per invoice)
- Send direct invoice to this address (\$5 admin fee per invoice)

Name Address City State Zip

Monthly Automatic Bank Draft – Must submit one month of premium with initial application

- Monthly Automatic Bank Draft (\$1 admin fee per month per invoice)
Premium will be drafted on the 20th of each month. Please attach "void" check.

I authorize Liberty Insurance Group, Inc. to initiate premium deductions from the account indicated below and my financial institution to debit the same account. I understand that this authorization is in effect until I notify Liberty Insurance Group, Inc. in writing that I no longer desire this service. My notification must afford Liberty Insurance Group and my financial institution reasonable opportunity to act on it.

Transit Number: _____ Account Number: _____

Signature

Date

Credit Card – Premium will be charged to your credit card

\$5 admin fee plus 3% service fee per invoice

- Initial Premium Only – (charged on the 10th prior to effective date)
Direct invoice thereafter (see above).
- Recurring Quarterly
(charged on the 20th prior to due date)
- Recurring Semi-Annual Recurring Annual
(charged on the 20th prior to due date) (charged on the 20th prior to due date)

Select One: Visa MasterCard Discover

Credit Card Number

____ / ____
Expiration Date

Amount: \$ _____

I authorize Liberty Insurance Group, Inc. to bill my credit/debit card account indicated above for payment of dental insurance premium.

Signature

Date

**GROUP MASTER CONTRACT
MEMBER GROUP ENROLLMENT AGREEMENT**

**First Commonwealth Limited Health Service Corporation
100 N. Corporate Drive, Suite 150
Brookfield, WI 53045**

THIS AGREEMENT is made and entered into this ____ day of _____, 20____, by and between First Commonwealth Limited Health Service Corporation, hereinafter referred to as "First Commonwealth", and _____, hereinafter referred to as "Member Group".

RECITALS:

A. First Commonwealth is a Wisconsin Limited Service Health Organization licensed under the Wisconsin Statutes 611 and authorized to operate a dental service plan in accordance with said statutes and the applicable provisions of the Wisconsin Administrative Code, hereinafter referred to as "Plan";

B. First Commonwealth has previously entered into a Group Master Contract with the **Small Business Insurance Trust**, hereinafter referred to as "Group", on the 1st day of June, 2003, hereinafter referred to as "Contract";

C. Member Group desires to obtain Plan Benefits under said Contract for and on behalf of Subscribers and their Dependents enrolled hereunder; and

D. First Commonwealth and Member Group agree that in consideration of the agreements by the parties and the payment of the Premium, First Commonwealth will provide Plan Benefits in accordance with the terms, conditions, and provisions of the Contract and this Agreement to the extent that such Plan Benefits are consistent with and necessary for the diagnosis and treatment of Subscribers and their Dependents;

NOW, THEREFORE, in consideration of the promises and mutual covenants herein contained, the parties have each executed this Member Group Enrollment Agreement.

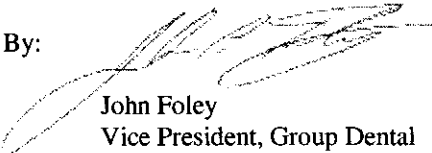
Name of Member Group

By: X _____
Authorized Signature

(type or print name after signature)

Title: _____

First Commonwealth Limited Health
Service Corporation

By: 
John Foley
Vice President, Group Dental