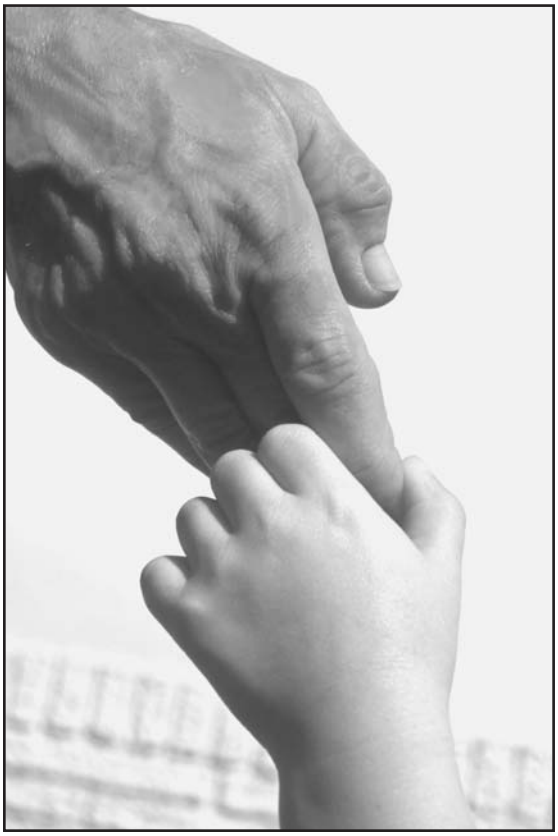
Delta Dental of New Jersey



With Delta Dental, You Get These Important Features

- ✔ Comprehensive preventive, basic and major dental coverage
- ✔ Choice of two excellent plans... so you can select the one that best meets your needs
- ✔ You choose your own dentist and dental specialists
- ✔ Economically priced to give you maximum value for your insurance dollar
- ✔ Available to IIANJ Member firms with as few as one enrolling employee

For IIANJ Members

Administered by:
Kelsey National Corporation
3030 South Bundy Drive
Los Angeles, CA 90066

DELTA DENTAL

Underwritten by:
Delta Dental of New Jersey, Inc. rated A- (Excellent) by A.M. Best Company for financial stability
Group #3325

3-05

IIANJ members and employees may select one of two excellent plans offered by Delta Dental:

Delta Dental Premier combines the best in managed care and cost containment services with the traditional fee-for-service indemnity approach to dental care. Over 6,000 New Jersey dental offices, representing a clear majority of the state's licensed, practicing dentists, participate with Premier. Each dentist agrees to pre-file his/her usual fee for each procedure commonly performed. You also have the freedom to select a non-network provider at a competitive level of benefits.

Delta Dental PPO is a deep-discount PPO that generally means lower out-of-pocket costs to employees using network dentists. More than 3,000 New Jersey dental offices have agreed to accept the deeply discounted schedule of maximum allowable charges as payment in full, offering guaranteed copayments to employees who use network dentists. You may also select a non-PPO dentist. Non-PPO dentists may, however, bill you for an amount above the maximum allowable charge. Delta Dental participating dentists can only charge up to the dentist's filed fee or Delta Dental's, whichever is less.

Delta Dental Plan Pays

		Premier	PPO
Preventive and Diagnostic	Routine exams, consultations, teeth cleaning (1 every 6 months), full mouth X-rays (1 every 3 years), bitewing X-rays (1 every 6 months), topical fluoride (to age 19, 1 every 12 months), space maintainers	**100%** No Deductible	**100%** No Deductible
Basic	Fillings, oral surgery (extractions, impactions), root canal treatment, periodontics, sealants to age 16	**60%**	**60%**
Major	Crowns, inlays, bridges, dentures	**50%**	**50%**
Orthodontic	Straightening of teeth (children under age 19)	**50%**	**50%**
Deductible (per Calendar Year)	Per patient Per family	**$50** **$150**	**$50** **$150**
Calendar Year Maximum	Per Insured	**$1,200**	**$1,200**
Lifetime Maximum (per insured)	Dental Orthodontic	**Unlimited** **$1,200**	**Unlimited** **$1,200**

Here are some examples of Approximate Employee Out-Of-Pocket Costs*

	Delta Dental Premier	Delta Dental PPO
Initial Oral Exam	$0.00	$0.00
X-Rays, Complete Series	$0.00	$0.00
2 Bite-Wing X-Rays	$0.00	$0.00
Adult Prophylaxis (Cleaning)	$0.00	$0.00
2 Surface Filling	$56.00	$33.60
1 Surface Comp. Resin Filling	$44.00	$28.00
Porcelain/Gold Crown	$440.00	$345.00
Anterior Root Canal	$228.00	$152.00
Scaling & Root Planning/Quad	$72.00	$40.00
Complete Upper Denture	$550.00	$412.50
Abutment Crown	$445.00	$345.00
Single Extraction	$52.00	$32.00
Orthodontics**	$3,200.00	$3,200.00

* Assumes utilization of a network dentist in each program. Costs are estimated on average dental charges for each procedure based on information from Delta Dental.

**Based upon a $4,400.00 charge.

IIANJ DELTA DENTAL EMPLOYER APPLICATION

FIRM INFORMATION

Firm Name: _____

Street address: _____

City _____ State _____ ZIP _____

Phone (_____) _____ FAX (_____) _____

Individual to contact for routine information: _____

Email _____

Individual to contact for special information: _____

Email _____

FIRM QUESTIONAIRE

1. Our firm has chosen a . . . . . ❑ 1 month ❑ 2 month ❑ 3 month New Employee Waiting Period
2. Our firm is a. . . . . ❑ Sole Owner ❑ Partnership ❑ Corporation
3. Our firm has chosen the . . . . . ❑ Premier ❑ PPO
4. We certify that the total number of full-time eligible employees (including owners & partners) is _____ of which the total number enrolled is _____ individuals and _____ dependents.
5. Our firm pays the following portion of Premiums: Employee _____% Dependent _____%
6. We would like the insurance to become effective on _____, 20_____. We understand that you will confirm an effective date and bill us later.
   Note: Your requested effective date may not be your actual effective date.
7. Our firm is enrolled in another group plan administered by Kelsey National Corporation. . . . . ❑ Yes ❑ No
   (If "Yes") Our account number is: _____

TO COMPLETE YOUR ENROLLMENT STEPS BE SURE TO COMPLETE THE CHECKLIST BELOW:

❑ We have completed this Employer Application.
This form constitutes application by your firm for participation in the IIANJ Group Delta Dental Plan.
This form should be signed by the owner, a partner or a corporate officer.

❑ We have distributed enrollment APPLICATIONS to all eligible employees.
All full-time employees including owner, partners, officers, agents, brokers, solicitors, etc. who work 30 hours or more per week at your firm are eligible. Applications should be signed by all eligible employees whether or not they wish to enroll. *(Note: Please make sure your firm meets the minimum participation requirements listed on the previous page.)*

❑ Please indicate the number of Enrollment Applications you are returning with your Employer Application: _____
(There should be one for each eligible employee.)

❑ Completed applications should be mailed to:

IIA Group Insurance Trust
Kelsey National Corporation
3030 S. Bundy Dr., Los Angeles, CA 90066

Fiduciary Liability and ERISA Bond Option: Fiduciary liability and ERISA bond coverage is automatically included unless already in force or waived by applicant initialing here _____ (not available in Kentucky).

IMPORTANT: *Send no money at this time. You will receive written acceptance from the IIA Group Insurance Trust and an itemized premium statement showing individual monthly premiums and an administration fee, which covers all group plans included on the premium statement.*

Member firm name: _____ Date: _____

Signature: X _____ Title: _____

IIANJ — Delta Dental Employee Enrollment Application

Employees you wish to add to the plan must complete the employer, employee and family information section below and sign and date the enrollment form. Employees refusing or discontinuing coverage under this plan must complete the employer, employee and refusal or discontinuance of coverage section.

EMPLOYER SECTION

Please check one box only: ❑ Initial Request ❑ Request for a Change	Firm Name:	
	Firm Phone:	Account #:

EMPLOYEE SECTION *(Please print all information, sign and date)*

Employee's Name: (last) (first) (initial)				SS#:
Home Address: (street) (city) (state) (zip)				
Date of Birth:	Age:	Date Employed:	Sex: ❑ Male ❑ Female	
Email Address:				
Job Title:				

FAMILY INFORMATION

Please Choose One: ❑ Married ❑ Not Married	I want to Insure:	a. Employee Only	❑ Yes ❑ No
		b. Employee + 1 Dependent	❑ Yes ❑ No
		a. Employee + 2 or more Dependents	❑ Yes ❑ No

LIST OF DEPENDENT NAMES AND BIRTHDATES

DEPENDENT NAME	BIRTHDATE
1.	
2.	
3.	
4.	
5.	

All dependent children listed above over age 18 are full-time students: . . . . . ❑ Yes ❑ No
If No, who is not? _____

Do you claim a tax exemption for all eligible dependents listed above? . . . . . ❑ Yes ❑ No
If No, who not? _____

PLEASE SIGN AND DATE HERE

I hereby declare that I am an active full-time employee of the employer indicated above and that I regularly work at least 30 hours per week at or from the employment location indicated. I hereby request the group insurance for which I am or may become eligible under the policies issued to the Trustee of the Independent Insurance Agents Group Insurance Trust by the Insurance Company. I authorize the deductions from my earnings of any contributions I may have to make toward the cost. I understand that my request shall include this form. All information given by me on this form is true and complete and is offered as an inducement to grant insurance.

Dated this _____ *day of* _____ *20*_____ *Signature of Applicant* **X**_____

Coverage provided by Delta Dental

REFUSAL OR DISCONTINUANCE OF COVERAGE

1. a. ❑ I hereby decline Group Coverage described further in Section 2 below.
   b. ❑ I hereby request discontinuance of the Group Coverage described further in Section 2 below, effective on _____

2. Applies to: ❑ My coverage ❑ My spouse's coverage ❑ My children's coverage

3. Reason for refusal: ❑ Covered under a Military Insurance Plan
   ❑ Covered under spouse's Employer Group Insurance Plan with
   (Name of Insurer and/or Employer): _____
   ❑ Other (Specify):_____

I understand that if I later wish to enroll or re-enroll in the Plans, I will be subject to late entrant provisions of the plan.

Employee's Signature **X**_____ Date _____

Name of Employer Firm _____

All completed applications should be sent by the Employer to:
KELSEY NATIONAL CORPORATION
3030 South Bundy Drive
Los Angeles, CA 90066

DELTA DENTAL

Delta Dental of New Jersey, Inc.
IIANJ Marketing Program

OTHER PROVISIONS

Eligibility and Enrollment

Enrollment simply requires an Employer Application and completed enrollment cards for all eligible employees. The firm's effective date will be the first day of the month per the firm's request. Application is postmarked by the requested effective date. Final acceptance of the group is subject to approval by the Insurance Company.

Available to all firms that are active Independent Insurance Agents Association members: all active, full-time employees (working 30 hours or more per week); their legal spouses and unmarried children age 2 to 19 (or to age 23 if full-time students) not in the military. If both husband and wife are insured as employees, eligible children may be insured only as dependents of the principal wage earner.

Commission-only employees and independent contractors are also eligible and are included with all other eligible employees for participation requirements providing: actual commissions combined with any draw against commissions must equal at least 150 hours per month times the minimum wage, and the employer verifies full-time status (30 or more hours per week) with the participating firm to Kelsey National Corporation.

Also available to full-time employees who work for divisions or subsidiaries affiliated through common ownership such as real estate, banking, mortgage lenders or escrow firms.

Covers mentally or physically handicapped children over age 19, provided child remains handicapped, dependent on the Insured for support and Insured notifies the Insurance Company in writing within 31 days after child reaches termination age.

New employees are eligible on the first day of the month following approval after the 1-2-or-3 month waiting period selected by employer.

Participation

In firms of 1-3, 100% of eligible employees must enroll. In firms of 4 or more, 75% of eligible employees must enroll.

Covered Eligible Expenses

Delta Dental pays benefits for covered services when they are rendered by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practices.

Requirements and Limitations

***Coordination of Benefits**:* If benefits provided under this plan and another plan not purchased by the employee exceed actual dental expenses incurred, the combined benefits payable will not exceed "allowable expenses".

***Limitations**:* Complete mouth x-rays are provided only once in a three-year period, unless special need is shown. Supplementary bite-wing x-rays are provided not more than once in a six month period. Replacement of crowns, inlays, gold restorations and prosthodontic appliances will be made only after five years have elapsed following any prior provision of such appliances under any Delta Dental program. (Replacement will be made of prosthodontic appliances not provided under a Delta program only if it is unsatisfactory and cannot be made satisfactory.)

***Services Not Covered*:** Services for injuries or conditions that are compensable under Workers' Compensation or Employers' Liability Laws; services which are provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision. Services with respect to congenital or developmental malformations (including TMJ), cosmetic surgery and dentistry for purely cosmetic reasons. Minor tooth movement, consultation fees, prescribed drugs, analgesics, experimental procedures, oral hygiene instruction, services performed prior to effective date of coverage, charges for hospitalization including hospital visits, broken appointments, laboratory tests.

***Termination of Coverage**:* Coverage terminates on the earliest date that premium payments end, full-time employment ends, death of the employee, the employer firm no longer meets participation requirements or the policy is terminated.

Monthly Rates

*Rates are **guaranteed** through November 30, 2018.*

	Premier	PPO
Employee only	$64.51	$52.91
Additional for:		
1 dependent	$47.73	$39.11
2 or more	$142.53	$116.83

This is not a contract but is intended to provide a general description of the coverage. The actual policy should be consulted for complete details of policy provisions. Where state regulations vary from benefits, state regulations will apply. Cost and further details of coverage, including exceptions, reductions or limitations and the term under which the policies may be continued in force will be furnished by Kelsey National Corporation. Final acceptance of the group will be subject to approval by the carrier.

FIDUCIARY LIABILITY AND ERISA BOND OPTION

(Underwritten by an American International Surplus Lines Insurance Co.)

Covers employer liability for errors and omissions in handling employee benefit plans to $1 million per loss with $1,000 deductible. Provides a $100,000 ERISA bond. Automatically issued unless waived on Employer Application.