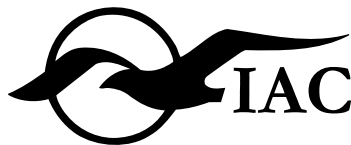


Producer's Guide to IAC's Group Dental Plans



MEMBER OF THE IHC GROUP

NYSE: IHC

**For IAC contracted producers only.
Not for public distribution.**

Producer Appointment

Before you sell your first IAC Group Dental case, you must have a current life/health insurance license for the state(s) in which you do business. Contact your IAC General Agent to determine licensing, appointment and contracting rules for the state(s) in which you do business prior to submitting any Group Dental Plan applications. Producers must be appointed by Standard Security Life Insurance Company of New York (SSL) and have completed a Producer's Agreement with IAC. Some states allow producers to submit the required appointment request with their initial case submission. Contact your IAC General Agent to verify whether the state(s) in which you do business allows this.

Producer Required Forms - Prior to or upon submission (as appropriate) of your first Group Dental case, please provide us with each of the following documents, properly completed, signed and dated:

- Legible photocopy of your current state life/health insurance license(s)
- IAC Requisition for Agent Appointment Form
- IAC Group Insurance Plans Producer's Agreement
- Any other state-required forms
- Appointment fee, if applicable*

***Resident appointment fees** may be deducted from your initial commissions or paid by you in advance. **Non-resident fees** are to be included with the initial case submission, along with any additional fees required for agency appointments. Contact your IAC General Agent if you have any questions about these fees. If you are already appointed through SSL to write IAC small group or personal plans, no additional appointment fee is required. Submit a completed Producer's Agreement with a dental commission schedule.

After SSL appoints you and IAC executes the Producer's Agreement, IAC will send you a completed copy of your Producer's Agreement for your records. If proper licensing and appointment procedures are not followed, submitted business may be closed-out and initial premium submitted will be returned. If you are not appointed, no commissions will be paid to you.

Commissions

You will receive monthly commissions, as earned, subject to the terms and conditions of the IAC Group Insurance Plans Producer's Agreement. Total commissions are paid on the 15th of the month for premium that has been received, posted and earned by the last day of the previous month, providing that the amount is greater than \$5. For amounts less than \$5, the balance will be forwarded to your next month's commission statement, subject to the same minimums.

If for any reason we refund any premium or part of a premium on any policy, you will be required to repay to IAC any commissions that you have received on that refunded amount. Such refunds may be shown as adjustments on your commission statement. To continue to receive commissions, the case must remain in-force, the premiums must be paid and you must actively service the account.

New Business Requirements

Please submit the following to your IAC General Agent, who will review the forms for completeness and forward them to IAC Underwriting.

- **Employer Application**, signed by owner or officer of the Participating Employer. (Please be sure to complete the Producer/General Agent Information portion on the back of the Employer Application.)
- **Employee Application** for each employee.
- **The Refusal of Group Dental Insurance portion of the Employee Application** must be completed and signed by each eligible employee not enrolling either: (1) himself/herself, or (2) any eligible dependents.

Note: When writing a Group Dental plan in conjunction with an IAC group medical plan, the producer may use either the above noted dental applications or the group medical/dental combination applications.

- **Copy of employer's most recent State Quarterly Unemployment Tax Report** including the summary page of the report with wage and tax totals (the complete wage listing page for employees). Please indicate current status of each employee: 1) "FT" if full-time; 2) "PT" if part-time or considered seasonal; or 3) date of termination if no longer employed. Have the employer or his/her representative sign the Quarterly Unemployment Tax Report.
- **Employer's check for the first month's premium.** Checks should be made payable to Insurers Administrative Corporation.

Employee Choice

Employers can allow their employees to choose different dental benefit plans to fit their needs, based on group size:

Groups enrolling 2-9 employees	1 plan
Groups enrolling 10-49 lives	up to 2 plans
Groups enrolling 50+ lives	up to 3 plans

Note: Groups enrolling 100+ lives must be quoted by the home office. In addition, takeover groups of 100+ must submit experience and, if requesting customization, must also submit plan specifications.

Eligibility

Employees - Employees who are directly employed on a full-time basis (minimum 30 hours per week) may apply for coverage through a participating employer. To be eligible for coverage under the plan, an employee must be engaged in active employment on a full-time basis as of the Certificate Effective Date.

Dependents - Also eligible to apply are the lawful spouse of an eligible employee and unmarried children under age 19 (under age 25 if unmarried and full-time students) who depend on the employee for support.

Newborn Children - The dependent child of an insured person will be insured from birth for a period of at least 31 days. Coverage will terminate at the end of 31 days if the insured does not complete and submit an application to have the newborn dependent added to his/her coverage.

Newly Adopted Children - A child who is adopted on or after the effective date of an insured's coverage under the Dental Plan will be insured for a period of at least 31 days from the earlier of the date of placement in the insured's home for the purpose of adoption or the date of an entry of an order granting the insured custody of the child for purpose of adoption.

Court-ordered Coverage for Dependent Children - To add a dependent for whom an insured person is mandated by court order to provide dental coverage, we must receive notification within 30 days of the issuance of a court order providing for the payment of dental expenses/dental insurance coverage for this dependent.

The following documents are required:

- A copy of the court order providing for payment of dental expenses and/or dental insurance coverage on behalf of the child by the non-custodial parent; or
- A release signed by the insured permitting us to communicate directly with the custodial parent.

Participation Requirements

Employer Paid

If the employer will be paying 100% of the premium, the following participation rule applies:

	Employee	Dependents
All case sizes	100%	100%

If the employer will be paying 50% or more (but less than 100%) of the premium, the following participation rules apply:

	Employee	Dependents
2-4 eligible employees	100%	100%
5+ eligible employees	75%	N/A

Voluntary

- No participation requirements
- No minimum employer contribution requirements
- Available to groups of 5+ eligible employees
- No minimum dependent participation requirements

Changes to Group Size

Group size is determined at case issue and is not recalculated until renewal. For groups whose add-on employees will effect participation requirements or waiting periods, employees will count towards group size at renewal.

Calculating Employee Participation in the Plan

- | | |
|----------------------|---|
| <input type="text"/> | a. Total of all full-time employees (including owners) |
| - | b. Minus full-time employees who are declining coverage because of other dental insurance |
| <input type="text"/> | c. Result is total "eligible" full-time employees (a minus b) |
| - | d. Minus full-time employees who are declining dental coverage and have no other coverage |
| <input type="text"/> | e. Result is total eligible full-time employees applying for coverage |
| % | f. Percentage of "eligible" employees participating in the plan (e divided by c) |

Calculating Dependent Unit Participation in the Plan

- | | |
|----------------------|--|
| <input type="text"/> | a. Total of dependent units (dependent "units" are counted as one unit if they are a family, spouse or child(ren)) |
| - | b. Minus dependent units declining coverage because of other dental insurance |
| <input type="text"/> | c. Result is total "eligible" dependent units (a minus b) |
| - | d. Minus eligible dependent units who are declining dental coverage and have no other coverage |
| <input type="text"/> | e. Result is total eligible dependent units applying for coverage |
| % | f. Percentage of "eligible" dependent units participating in the Plan (e divided by c) |

Requests to Decline Coverage, or "Waivers of Coverage"

Any eligible employee who is not applying for dental coverage must complete a waiver of coverage. For groups of 5+ eligible employees, employees who have alternate group dental coverage and waive coverage under the Group Dental plan will not be counted against participation requirements.

Effective Date of Coverage

Employers may request a coverage effective date of the 1st or the 15th of the month. However, the premium due date will always be the 1st of the

month. All applications must be signed and dated on or before the requested effective date and received by IAC no later than the day before the requested effective date. Any application received after the requested effective date, if approved, will be made effective the next available date. Newly hired employees added to the Dental Plan will have their coverage made effective the 1st of the month following completion of their benefit waiting periods. Applications that are more than 60 days old upon receipt will be returned unprocessed.

Industry Load

Dentist offices are ineligible.

The following have an industry load factor of 1.20:

8200	Services-Educational Services
8300	Services-Social Services
8351	Services-Child Day Care Services
8600	Services-Membership organizations
8700	Services-Engineering, Accounting, Research, Management
8711	Services-Engineering Services
8731	Services-Commercial Physical & Biological Research
8734	Services-Testing Laboratories
8741	Services-Management Services
8742	Services-Management Consulting Services
8744	Services-Facilities Support Management Services
8880	American Depository Receipts
8888	Foreign Governments
8900	Services-Services, NEC
9721	International Affairs
9995	Non-Operating Establishments

Benefit Waiting Period and Takeover Credit

There is no waiting period for any services except orthodontia. An insured person who had creditable coverage under the employer's group dental plan on the day immediately prior to that employer's effective date under the Group Dental Plan will have no waiting period for any services, excluding orthodontia.

Employees are eligible for second year level benefits for Basic and Major services if they are enrolled on the employer's prior dental plan or another group policy on the day immediately preceding the effective date of this Policy. This also applies to new hires and add-on employees after the Policy is in effect for groups of 10 or more covered employees only.

To receive prior carrier credit, submit the following:

- A copy of the present carrier's certificate booklet or a policy.
- The previous carrier's billing for the month in which coverage is requested under the Plan. Include each employee's effective date of dental coverage (and dependents' if applicable) under the present plan for proper credit.

Deductible Credit: Credit applied towards Lifetime Deductible for amount satisfied on the prior group plan. Purchase of add-on Package 4 waives Lifetime Deductible.

Maximums: The benefit amount accumulated toward the Annual Maximum on the prior dental plan is applied to this Policy.

Orthodontia waiting period and Takeover Credit

Waiting period is defined as the number of consecutive months a person must be covered under the plan before orthodontia is payable. Orthodontia is available only to dependents under 19. Waiting periods for orthodontia benefits are as follows:

Economy Plan PPO

Optional to groups of 10+ only

- 12 months

Superior Plan PPO and Superior Plan Indemnity

Included benefit once waiting period has been satisfied

- Groups of 2-4 employees: 24 months
- Groups of 5+ employees: 12 months

However, if orthodontia is a covered service with the employer's prior carrier, each covered person will receive the appropriate credit for the orthodontia waiting period and annual maximum, not to exceed the Policy's Lifetime Maximum of \$1,000.

Usual, Reasonable and Customary (UCR)

Superior Indemnity plan only

Usual, Reasonable and Customary Charge: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the Geographic Area in which the charge is incurred. The most common charge means the lesser of:

- the actual amount charged by the provider;
- the negotiated rate;
- the usual charge which would have been made by a provider (Dentist, Hospital, etc) for the same or a comparable professional services, drugs, procedures, devices, supplies or treatment within the same Geographic Area, as determined by Us.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

The UCR for the Superior Indemnity plan is based upon a valuation using the 90th percentile of MDR. If out of pocket costs are of concern to your clients, choose from our competitively priced PPO plan designs for maximum savings.

Maximum Allowable Charge (MAC)

Value, Economy and Superior PPO plans

In-network

Services received from an in-network dentist are subject to the Maximum Allowable Charge (MAC). The MAC for each covered procedure is the amount agreed to by the dentist. Insureds are never balance billed.

Out-of-network

Services received from an out-of-network dentist, are also subject to the MAC. However, if the out-of-network dentist charges more than the MAC, the insured is responsible for the balance.

State Availability and PPO Network Coverage

DenteMax: AL, AR, AZ, DC, GA, IL, MI, MO, MS, NC, NM, OH, OK, PA, SC, TN, TX, UT, WI, WV.

Connection Dental (PPO USA): IA, KS, NE.

Diversified Dental Services: NV

Maverest: IN

Coordination of Benefits

If a person covered under this plan is also covered under one or more other eligible plans, benefits will be coordinated with the benefits payable under those plans. For purposes of applying the Coordination of Benefits provision, an eligible plan is defined as: a) any group insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage; and b) any governmental program, or coverage required by or provided by law, except Medicaid.

Billing Mode and Monthly Administrative Fee

Employers are billed on a monthly direct-bill basis. Dental Plans may be billed on a stand-alone basis or in combination with an IAC medical plan. If billed on a stand-alone basis, a monthly administrative fee applies. This fee is \$15 for groups insuring 2-24 employees, and \$25 for groups insuring 25 or more employees. The monthly administrative fee for dental coverage is waived on Dental Plans that are billed along with an IAC medical plan.

Premium Payments and Grace Period

Premiums are due on the first day of the month and should be received at IAC no later than the 10th of the month for which the premium is due. A grace period of 31 days is allowed for any premium after the first premium. If the participating employer fails to pay the premium before the expiration of the 31-day grace period coverage will automatically lapse and coverage will cease as of the premium due date.

Termination of Insurance

An insured will cease to be covered under the Group Dental Plan on the earliest of the following events:

- the date the policy terminates
- the date the insured is no longer eligible for insurance under the policy
- the last day of the month for which premium has been paid, subject to the grace period provision
- the day the insured's employment terminates
- the date the employer's participation in the Trust terminates
- the day the insured enters the armed forces of any country or international authority on a full-time basis.

Coverage for dependents will terminate on the earliest of the following events:

- the date the policy terminates
- the date the insured requests that insurance for the dependent be terminated
- the last day of the month for which premium for the dependent has been paid, subject to the grace period provision
- the day the insured's coverage terminates
- the date the dependent is no longer a dependent, as defined in the certificate
- the day insurance coverage for dependents is no longer offered under the policy.

Benefits under the Group Dental Insurance Plan are provided under the master group policy form SSL-TDEN-POL 1005, certificate SSL-TDEN-CER-010 1005. This producer guide contains only a brief description of plan provisions. The exact provisions governing the insurance contract are contained in the Master Policy. This plan may not be available in all states. Please check with Insurers Administrative Corporation regarding availability. Each insured employee will receive an individual certificate which will describe benefits in full.