

VSP Features Continued:

What if I don't use a Participating Doctor?

More than 90% of VSP patients receive services from participating doctors, although you may select any licensed vision care provider for services. Your reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction, when services are obtained from a non-participating provider.

Charges submitted to VSP for reimbursement by a non-participating provider will be reimbursed on the basis of prevailing fees, but not to exceed the following schedule of allowances subject to the selected deductible.

Professional Fees, Visual Examination up to:	\$45.00
Materials: Single Vision lenses up to:	\$45.00
Bifocal Lenses up to:	\$65.00
Trifocal Lenses up to:	\$85.00
Lenticular Lenses up to:	\$125.00
Frame	\$47.00
Contact Lenses (in lieu of all other materials, materials, fittings and evaluation only)	
Necessary, up to:	\$210.00
Elective, up to:	\$105.00

Important Information about Rates

Rates for all groups are pool rated. When they enroll, the employer group joins the Small Business Benefit Plan Trust II group policy.

The rates noted in this brochure are monthly and for clients that enroll for July 1, 2008 through to June 1, 2009 effective dates.

Groups who enroll July 1 through December 1 will renew July 1, 2009.

Groups who enroll January 1 through June 1 will renew January 1, 2010.

Administration Fee

A monthly administration fee of \$10.00 is charged to all groups of less than 20 enrolled employees.

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V.S.P. Vision, Limitations

Options - This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge: Blended lenses; Contact lenses(except as noted elsewhere herein; Oversize lenses; Progressive multifocal lenses; Photochromatic or tinted lenses other than, Pink 1 or 2; Coated or laminated lenses; A frame that exceeds the plan allowance; certain limitations on low vision care; cosmetic lenses; Optional cosmetic processes; UV protected lenses.

Not Covered -The following professional services or materials are not covered. Discounts may apply to some items: Orthoptics or vision training and any associated supplemental testing; Plano lenses (non-prescription); Two pair of glasses in lieu of bifocals; Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available; Medical or surgical treatment of the eyes; Any eye examination, or any corrective eyewear, required by an employer as a condition of employment; Corrective vision services, treatments, and materials of an experimental nature.

Delta Dental, Services Not Covered

The Delta Dental programs do not cover: Orthodontia, unless the option is selected; Service for injuries or conditions which are compensable under Workers' Compensation or Employer's Liability Laws; services which are provided to the Eligible Person by any Federal or State Government Agency or are provided without cost to the Eligible Person by any municipality, county or other political subdivision, except as provided in Section 1373(a) of the California Health and Safety Code; Services with respect to congenital (heredity) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth); Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusions, or for stabilizing the teeth. Such services including but are not limited to: equilibration and periodontal splinting; Prosthodontic services or any Single Procedure started prior to the date the person became eligible for such services under this contract; Prescribed or applied therapeutic drugs, premedication or analgesia; Experimental procedures; Prophylaxis, if the eligible patient has received two prophylaxes covered by the Program in the immediately preceding eleven months; All hospital costs and any additional fees charged by the Dentist for hospital treatment; Charges for anesthesia other than general anesthesia administered by a licensed Dentist in connection with covered Oral Surgery Services; Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues) except as provided under Limitations on Prosthodontics Benefits; Services with respect to any disturbance of the temporomandibular joint (jaw joint); Replacement of existing restorations for any purpose other than restoring active tooth decay; Charges for cost of replacement and/or repairs of an orthodontic appliance furnished in whole or in part under this program; Surgical procedures for correction of malalignment of teeth and/or jaws.

How To Enroll

1. Complete the application for Participation to the Small Business Benefit Plan Trust and the EZ enrollment form listing all employees to be covered.
2. Submit a copy of the Employer's State Wage and Earnings Report.
3. Send an employers check for the total premium and fees and all enrollment materials to Wolfpack Insurance Services, Inc.

Plan Rules

Eligibility: Employer groups must have two or more full-time, unrelated employees (Husband and wife count as one). Proof of a group medical insurance is required for groups of less than 5 employees. The employer must contribute 50% of the employee premium. 75% of the eligible employees must participate in the plan. 100% must participate if the employer contribution is 100% of the employee premium.

Employees: All employees of the employer who are performing active work on a full time basis (20 hours a week or over) are eligible for benefits including corporate officers, owners, or partners.

Dependents: All eligible dependents must enroll on the original effective date. Dependents will not be added for a later effective date unless newly eligible. Eligible dependents include legal spouse or domestic partner and unmarried children to age 19 or to age 25 if enrolled in an accredited school, college or university.

Effective Date: When a firm joins the Plan, the coverage of its current employees will be effective on the first day of the month following approval of the firm's application to participate.

This brochure constitutes only a summary of the Plans. The Plan Contract must be consulted to determine the exact terms and conditions of coverage.

WOLFPACK INSURANCE SERVICES, INC.

Reach us on the World Wide Web.

www.DentalandVisionIns.com

Enroll groups

Add, change or delete employees
Download forms, Quote new groups
Find providers, answer your questions
and more.

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dental and vision
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Delta Premier UCR Plans

We offer dental plans insured by
**Delta Dental
of California**
and vision products through
Vision Service Plan

With our array of plan options,
businesses can choose an
affordable plan that meets their
individual group's needs.

All plans may be written on groups of two or more full time, unrelated employees. Proof of a group medical plan is required for groups of less than 5 employees.

www.DVIns.com

Served by:
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License # 0814789

Delta Dental Premier Plans

You have the option of visiting any dentist, but if you visit a Delta Premier Dentist you'll enjoy the advantage of prenegotiated fees and convenient claims handling. Over 92% of California and 75% of U.S. dentists are participating. Visit www.DVINS.com to search for Delta Premier Providers. Plans are reimbursed on a UCR basis.

Plan Name.....	<u>2000</u>	<u>Plan I</u>	<u>1500</u>	<u>Plan II</u>	<u>Plan III</u>	<u>Plan IV</u>	
Calendar Year Deductible	\$25.00*	\$25.00*	\$50.00*	\$35.00	\$50.00	\$50.00	
	*No deductible for items covered at 100%						
Preventive and Diagnostic							
Emergency treatment for relief of pain	100%	100%	100%	80%	80%	80%	
Routine Exams, Cleanings (Prophylaxis)	100%	100%	100%	80%	80%	80%	
Bitewing X-rays, Full Mouth X-rays	100%	100%	100%	80%	80%	80%	
Fluoride Treatment	100%	100%	100%	80%	80%	80%	
Space Maintainers	100%	100%	100%	80%	80%	80%	
Basic Dental Services							
Restorative - Amalgam or Synthetic Fillings	80%	80%	80%	80%	80%	80%	
Sealants	80%	80%	80%	80%	80%	80%	
Oral Surgery							
Extractions, Impacted Teeth, Cysts and Neoplasms, Alveolar/Gingival Reconstructions	80%	80%	80%	80%	80%	80%	
Periodontics- Includes treatment for diseases of the gums	80%	80%	80%	80%	80%	Major Service 50%	
Endodontics- Root canals and Pulpal Therapy	80%	80%	80%	80%	80%	50%	
Major Dental Services							
Subject to a 12 month waiting period (See Below)							
Restorative - Inlays, Implants and Crowns	50%	50%	50%	50%	50%	50%	
Prostodontics- Dentures and Partial	50%	50%	50%	50%	50%	50%	
Calendar Year Maximum	Benefit per Individual	\$2,000	\$1,500	\$1,500	\$1,500	\$1,500	\$1,000
RATES:	Employee Only	\$ 68.80	\$ 64.00	\$ 61.80	\$ 54.50	\$ 51.60	\$ 41.10
	Employee + one	\$131.40	\$122.90	\$118.30	\$103.70	\$ 97.80	\$ 78.90
	Employee + two or more	\$193.30	\$183.10	\$175.80	\$147.20	\$136.90	\$114.40

Optional Orthodontic Benefit: (Not available with Plan IV) RATES: EE = \$2.10, EE + 1 = \$3.40, EE + 2 = \$11.60. Plan pays a co-payment of 50% to a lifetime maximum benefit of \$1500 per patient after a 12 month waiting period (See Below).

Can the waiting period be waived?

Waiting periods do not apply to groups of 20 or more. For groups of 5 employees or more, the 12 month waiting period for Major Dental and Orthodontia Services will be waived on all employees who had continuous Dental and Orthodontia coverage during the preceding 12 months.

Please contact us for special rates on groups with over 50 employees.

Vision Service Plans

Plan Features

Over 22,800 participating providers nationwide. You pay only the selected copayment for covered benefits. You can choose any provider of vision care (see non-participating provider benefits).

What are the Benefits?

You receive an Eye examination, Lenses and Frames according to the schedule of benefits you purchase. Choose from several copayment and waiting periods.

VSP A plans have a 12 month Exam, 24 month Lenses and a 24 month Frame waiting period

VSP B plans have a 12 month Exam, 12 month Lenses and a 24 month Frame waiting period

VSP C plans have a 12 month Exam, 12 month Lenses and a 12 month Frame waiting period

Rates for Voluntary Situations can be found on our web site. www.dvins.com

	Co-Payment Options	EE	EE + Spouse	EE + Child(ren)	EE + Family
VSP A	\$20 Exam/\$25 Materials	\$6.40	\$10.20	\$10.40	\$16.70
	\$25 Co-payment	\$9.30	\$14.80	\$15.10	\$24.30
	\$10 Co-payment	\$9.80	\$15.70	\$16.00	\$25.80
	No Co-payment	\$12.70	\$20.20	\$20.60	\$33.30
VSP B	\$10 Exam/\$25 Materials	\$9.90	\$15.80	\$16.10	\$25.90
	\$25 Co-payment	\$10.60	\$16.90	\$17.20	\$27.70
	\$10 Co-payment	\$13.20	\$21.20	\$21.60	\$34.80
	No Co-payment	\$14.90	\$23.80	\$24.30	\$39.10
VSP C	\$10 Exam/\$25 Materials	\$11.90	\$23.80	\$25.50	\$40.70
	\$25 Co-payment	\$12.30	\$24.50	\$26.20	\$41.80
	\$10 Co-payment	\$14.00	\$28.00	\$30.00	\$47.90
	No Co-payment	\$15.60	\$31.20	\$33.30	\$53.20

Exams: A complete initial vision analysis which includes an appropriate examination for visual functions, including the prescription of corrective eyewear where indicated. **Spectacle Lenses and Frame:** VSP provides a \$130 allowance toward a new frame. If you choose a frame valued at more than the plan's allowance, you will receive a 20% discount on the amount over your frame allowance. VSP also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating doctor about lens options which may be cosmetic in nature and may result in additional costs. **Contact lenses:** Elective and Medically necessary contact lenses may be provided instead of glasses. **Elective contact lenses:** The standard eye examination is covered in full, less any applicable co-payment. A \$120 in-network allowance will be provided toward the contact lens evaluation examination, fitting costs, and materials. Any costs exceeding the allowance are the patient's responsibility. Disposable contact lenses are reimbursed up to \$120 per frequency period. Contact lens frequency is the same as spectacle lenses. VSP's additional value is also extended to include a 15% discount off the participating doctor's professional services when you purchase prescription contact lenses. Materials are provided at usual and customary fees. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses. You may use these discounts for 12 months following the date of the covered eye examination. Also, these discounts are offered through the VSP participating doctor who provided the last covered eye examination.

How does the plan work?

1. Ready to use the plan? Call VSP at (800) 877-7195 or visit them at www.vsp.com to get a list of participating providers.
2. Call the participating provider and give them your VSP member ID.
3. Go to your appointment and pay your co-payment. The participating doctor will take care of all the necessary clearances and claim forms.

Laser VisionCare Services: As a Vision Service Plan member you have access to VSP's Laser VisionCare Program. This program includes comprehensive information on laser vision correction, as well as giving you substantial savings on the procedure. Please visit our website for more details.