

## Application

Side 2.

Please pick a billing option

### Electronic Funds Transfer, Monthly

Monthly Electronic Funds Transfer (EFT) is the automatic withdrawal of the dues from your checking or savings account. You must pay for the first month's coverage by check; thereafter, the funds will be deducted on the 15th of the month prior to the coverage month from your account. I hereby authorize Wolfpack Insurance Services, Inc. to charge the applicable monthly dues for the Delta Care coverage from the account designated below. I understand that coverage will become and remain effective only if there are sufficient funds at the time of the deduction. This authority is to remain in force until I notify Wolfpack in writing 30 days prior to termination.

Deduct from my:

\_\_\_\_\_ Checking Account \_\_\_\_\_ Savings Account.

Bank Name: \_\_\_\_\_

Branch: \_\_\_\_\_

Please enclose a voided check or pre-printed deposit slip if this information is different from your first month's premium check.

**OR**

### Quarterly Invoice

Wolfpack will send you a calendar year quarterly invoice for the Delta Care coverage. You will be charged a \$3.00 billing fee per invoice. Please include one month's premium to start coverage.

**OR**

### Employer List Bill.

(Voluntary Employee Coverage)

Wolfpack will invoice the employer monthly for the employees who voluntarily established coverage. Group Invoices are charged an administration fee of \$5.00 per month.

Please give the employer's name and address below:

Employers Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employers Phone Number (\_\_\_\_) \_\_\_\_\_

### Applicants' Signature / Date

\_\_\_\_\_/\_\_\_\_\_  
The minimum enrollment period is for 12 months

Agents Name: \_\_\_\_\_

Agents Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Wolfpack Agent Number (if known) \_\_\_\_\_

### Description of Benefits and Copayments, Continued

<b>Orthodontia Continued</b>	
Limited orthodontic treatment of the adult dentition	\$1,150.00
Interceptive orthodontic treatment of the primary or transitional dentition	\$950.00
Comprehensive orthodontic treatment of the transitional or adolescent (to age 19) dentition	\$1,700.00
Comprehensive orthodontic treatment of the adult dentition	\$1,900.00
Pre-orthodontic treatment visit	\$25.00
Orthodontic retention (removal of appliances, construction & placement of removable retainers)	\$275.00
Unspecified orthodontic procedure, by report - includes treatment planning session	\$100.00
<b>Adjunctive General Services</b>	
Palliative (emergency) treatment of dental pain	\$5.00
Regional block anesthesia	No Cost
Trigeminal division block anesthesia	No Cost
Local anesthesia	No Cost
Deep sedation/general anesthesia-first 30 minutes	\$165.00
Deep sedation/general anesthesia - each additional 15 minutes	\$80.00
Intravenous conscious sedation analgesia - first 30 minutes	\$165.00
Intravenous conscious sedation analgesia - each additional 15 minutes	\$80.00
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$10.00
Office visit for observation	\$5.00
Office visit - after regularly scheduled hours	\$25.00
Occlusal guard by report - limited to 1 in 3 years	\$100.00
Occlusal adjustment, limited	\$35.00
Occlusal adjustment, complete	\$55.00
External bleaching - per arch - limited to one bleaching tray and gel for two weeks of self treatment	\$125.00
Unspecified adjunctive procedure, by report - includes failed appointments without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00	\$10.00

### Emergency Services

You are also covered for out-of-area dental emergencies. This program will pay dental expenses incurred up to a maximum of \$100.00 per emergency.

### Exclusions of Benefits

Any procedure not specifically listed under the Description of Benefits and Copayments; Any procedure that in the professional opinion of the Contract Dentist: has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures; or is inconsistent with generally accepted standards for dentistry.;Services solely for cosmetic purposes, with the exception of procedure D9972, external bleaching, per arch or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities; Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers and crowns and fixed partial dentures (bridges); Procedures, appliances or restoration if the purpose is to change vertical dimension or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ); Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures; Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant; Consultations for non-covered benefits; Dental Services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for Emergency Services as described in the Contract and/or Evidence of Coverage; All related fees for admission, use or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility; Prescription Drugs; Dental Expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare program; Lost, stolen or broken orthodontic appliances; Changes in orthodontic treatment necessitated by accident of any kind; Myofunctional and parafunctional appliances and/or therapies; Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances; Treatment of appliances that are provided by a Dentist whose practice specializes in prosthodontic services. **This brochure constitutes only a summary of the plan and is not a full list of the Limitations and Exclusions. The plan contract must be consulted to determine the exact terms and conditions of coverage. A plan contract will be sent to you upon enrollment or is available for viewing on our web site www.DVIns.com. Please click on Family Plans.**

## Enrollment

1. Complete the attached application. Eligible dependents include your spouse, domestic partner or unmarried children to age 19 and full time students to age 23. Make sure you have selected a dentist from the DeltaCare Dental Directory or from Delta Dental's web site, www.deltadentalca.org, under the DeltaCare provider search. Please write down the Dentists DeltaCare provider number on the form.

2. Attach a voided check for the Electronic Funds Transfer of the dental premium. If you wish to be invoiced on a calendar year quarterly basis, you will be charged a \$3 administration fee with each invoice. Voluntary group invoices are charged an administration fee of \$5 per month.

3. Send a check for the first month's premium and a one time \$5.00 enrollment fee along with the completed application to:

WOLFPACK Insurance Services, Inc.  
PO Box 156  
Belmont CA 94002

If your fully completed materials are received by the 15th of the month, your coverage will be effective the first of the next month. The minimum enrollment period is for 12 months.

Monthly Rates

Single	\$ 30.30
Two Party	\$ 53.50
Family	\$ 78.60

*Rates of all applicants that enroll January 1, 2008 through December 1, 2008 are pool rated and will renew January 1, 2009.*

Enroll Online at:

www.DentalandVisionIns.com

Click on Family Plans

WOLFPACK INSURANCE SERVICES, INC.

1510 Folger Drive, P O Box 156

Belmont CA 94002

Wlfpk 6-18-2007, plan 11B

www.DentalandVisionIns.com

## DELTA CARE USA Family Plan

In an age of rising health care costs, DeltaCare USA offers an alternative way to provide for you and your family's dental care needs economically and conveniently.

### Advantages:

#### No Claim Forms...

The dental location you choose provides all primary dental services. There are no claim forms to complete.

#### No Deductibles...

In the Delta Care program there are no required deductibles to pay, so your benefits begin immediately.

#### No Dollar Limit of Dental Benefits...

No annual maximum

#### No Pre-Existing Conditions Restricted...

These conditions are not excluded in the DeltaCare program. Exception: Work in progress.

#### Prepaid Plan Saves on Dental Costs...

Your out-of-pocket savings are substantial. You know the exact cost prior to treatment, and this aids in better fiscal planning for you and your family.

#### Quality Review of Dental Providers...

On-site audit of participating dental locations to insure that established standards of quality are maintained.

#### Specialty Services...

The Dental Care program offers services in dental specialty areas. These include periodontics (treatment of diseased gums and bone), endodontics (root canal therapy), and oral surgery procedures.

This plan can be written on individuals or as a voluntary benefit to employees of a group.

Enroll online at : [www.DVIns.com](http://www.DVIns.com)

Click on Family Plans

(800) 350-8041 FAX: (650) 591-4022

License # 0814789

# DESCRIPTION OF BENEFITS AND COPAYMENTS

## How it Works

When you enroll in DeltaCare, select a panel dental office from the list provided by your agent or from Delta Dental's web site at [www.deltadentalca.org](http://www.deltadentalca.org). Make sure you review only the DeltaCare Dental office search. This location is now the center for all of your dental needs. After you have enrolled, you will receive a membership card and an Evidence of Coverage that fully describes the benefits of your dental plan. For your convenience, the card will have the address and telephone number of your panel dentist. Remember to always contact your selected panel dentist. Dental services which are not performed by your panel dentist, or not authorized by DeltaCare, will not be covered by the DeltaCare program.

## Summary of Benefits

The DeltaCare program provides all reasonable and customary dental care (subject to the master contract provisions, limitations and exclusions) if care is rendered by your PMI panel dentist. *There is no cost for covered services except for copayments on certain procedures.*

*The following is a full list of benefits and copayments.*

### Diagnostic Services

Periodic oral evaluation, Limited oral evaluation,	No Cost
Comprehensive oral evaluation, Detailed and extensive oral evaluation, Re-evaluation - limited, Comprehensive periodontal evaluation	No Cost
Intraoral radiographs - complete series (including bitewings limited to 1 series every 24 months), Intraoral periapical film, Intraoral occlusal film	No Cost
Extraoral - first film, each additional film	No Cost
Bitewing radiograph, single file, two films, four films - limited to 1 series every 6 months, vertical bitewings - 7 to 8 films	No Cost
Panoramic film	No Cost
Collection of microorganisms for culture and sensitivity, Caries susceptibility tests	No Cost
Pulp vitality tests	No Cost
Diagnostic casts	No Cost
Accession of tissue, gross examination (microscopic and including assessment of surgical margins for presence of disease), preparation and transmission of written report	No Cost
Unspecified diagnostic procedure, by report	No Cost

### Preventive

Prophylaxis adult, 1 per 6 month period, additional cleaning will be charged a \$45.00 copayment	No Cost
Prophylaxis child, 1 per 6 month period, additional cleaning will be charged a \$35.00 copayment	No Cost
Topical application of fluoride including/excluding prophylaxis to age 19, one per 6 month period, additional application will be charged a \$35.00 copayment	No Cost
Oral hygiene instructions, Nutritional counseling for control of dental disease	No Cost
Sealant, per tooth - limited to permanent molars through age 15	\$10.00
Space maintainers - removable and fixed, unilateral and bilateral	\$25.00

### Restorative

Amalgam -1 to 4 anterior surfaces, primary or permanent	No Cost
Resin-based composite - 1 to 3 anterior surfaces	No Cost
Resin-based composite crown, anterior	\$35.00
Resin-based composite - one surface, posterior	\$55.00
Resin-based composite - two surfaces, posterior	\$65.00
Resin-based composite - three surfaces, posterior	\$75.00
Resin-based composite-four + surfaces, posterior	\$85.00
Inlay & Onlay, metallic, 1 to 4 surfaces	No Cost
Inlay-porcelain/ceramic - 1 surface	\$165.00
Inlay-porcelain/ceramic - 2 surfaces	\$190.00
Inlay-porcelain/ceramic - 3 surfaces	\$200.00
Onlay-porcelain/ceramic - 2 surfaces	\$185.00
Onlay-porcelain/ceramic - 3 surfaces	\$205.00
Onlay-porcelain/ceramic - 4 or more surfaces	\$220.00

### Restorative, Continued

Inlay - resin-based composite - 1 surface	\$105.00
Inlay - resin-based composite - 2 surfaces	\$120.00
Inlay - resin-based composite - 3 surfaces	\$145.00
Onlay - resin-based composite - 2 surfaces	\$140.00
Onlay - resin-based composite - 3 surfaces	\$155.00
Onlay - resin-based composite - 4 + surfaces	\$185.00
Crown - resin based composite	\$50.00
Crown - 3/4 resin-based composite	\$50.00
Crown - resin with high noble metal	\$195.00
Crown - resin with predominantly base metal	\$95.00
Crown - resin with noble metal	\$135.00
Crown - porcelain/ceramic substrate	\$240.00
Crown - porcelain fused to high noble metal	\$240.00
Crown - porcelain/predominantly base metal	\$140.00
Crown - porcelain fused to noble meta	\$180.00
Crown - 3/4 cast high noble metal	\$210.00
Crown - 3/4 cast predominantly base metal	\$110.00
Crown - 3/4 cast noble metal	\$150.00
Crown - 3/4 porcelain/ceramic	\$240.00
Crown - full cast high noble metal	\$210.00
Crown - full cast predominantly base metal	\$110.00
Crown - full cast noble metal	\$150.00
Crown - titanium	\$240.00

Recement inlay, onlay or partial coverage restoration. Recement Cast or prefabricated post and core. Recement Crown	No Cost
Prefabricated stainless steel crown - primary or permanent tooth	\$15.00
Prefabricated resin crown - anterior primary tooth	\$25.00
Prefabricated stainless steel crown with resin window - anterior primary tooth	\$20.00
Sedative filling	\$5.00
Core buildup, including any pins	\$15.00
Pin retention - per tooth in addition to restoration	\$10.00
Cast post and core in addition to crown- includes canal preparation	\$35.00
Each additional cast post - same tooth- includes canal preparation	\$25.00
Prefabricated post and core in addition to crown - base metal post; includes canal preparation	\$20.00
Each additional prefabricated post - same tooth - base metal post includes; canal preparation	\$15.00
Additional procedures to construct new crown under existing partial denture framework	\$28.00
Crown repair, by report	\$15.00

### Endodontics

Pulp capping (indirect or direct)	No Cost
Therapeutic Pulpotomy (excluding final restoraton) - removal of pulp coronal to the dentinocemental junction and application	No Cost
Pulpal debridement, primary and permanent teeth	\$10.00
Pupal therapy (resorbable filling) - anterior or posterior, primary tooth (excluding final restoration)	\$20.00
Root canal - anterior (excluding final restoration)	\$55.00
Root canal - bicuspid (excluding final restoration)	\$120.00
Root Canal - molar (excluding final restoration)	\$250.00
Treatment of root canal obstruction; non-surgical access	\$55.00
Incomplete endodontic therapy; inoperable, unresterable or fractured tooth	\$55.00
Internal root repair of perforation defects	\$55.00
Retreatment of previous root canal - anterior	\$85.00
Retreatment of previous root canal - bicuspid	\$150.00
Retreatment of previous root canal - molar	\$280.00
Apexification/recalcification - initial visit	\$75.00
Apexification/recalcification - interim medication replacement	\$50.00
Apexification/recalcification - final visit	\$50.00
Apicoectomy/periradicular surgery - anterior	\$60.00
Apicoectomy/periradicular surgery - bicuspid	\$70.00
Apicoectomy/periradicular surgery - molar	\$80.00
Apicoectomy/periradicular surgery - each additional root	\$50.00
Retrograde filling - per root	\$60.00
Root amputation, per root	No Cost
Costisection not including root canal therapy	\$30.00

### Periodontics

Gingivectomy or gingivoplasty-four + contiguous teeth or bounded teeth spaces/quadrant	\$130.00
Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	\$80.00
Gingival flap procedure, including root planing - four + contiguous teeth or bounded teeth spaces per quadrant	\$130.00
Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	\$80.00
Apically positioned flap	\$125.00
Clinical crown lengthening - hard tissue	\$125.00
Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	\$280.00
Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant	\$225.00
Bone replacement graft - first site in quadrant	\$205.00
Bone replacement graft - each additional site in quadrant	\$70.00
Pedicle soft tissue graft procedure	\$205.00
Free soft tissue graft procedure (including donor site surgery)	\$205.00
Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$45.00
Periodontal scaling and root planing - four or more teeth per quadrant	\$25.00
Periodontal scaling and root planing - one to three teeth per quadrant	\$20.00
Full mouth debridement to enable comprehensive evaluation and diagnosis	\$25.00
Periodontal maintenance - limited to 1 treatment each 6 month period	\$15.00
Additional periodontal maintenance (within 6 month period)	\$55.00

### Prosthodontics (removable)

Complete denture - maxillary & mandibular	\$145.00
Immediate denture - maxillary & mandibular	\$165.00
Maxillary or Mandibular partial denture-resin base	\$120.00
Maxillary or Mandibular partial denture - cast metal framework with resin denture bases	\$160.00
Maxillary or Mandibular partial denture -flexible base	\$210.00
Adjust complete or partial denture	\$10.00
Repair broken complete denture base	\$20.00
Replace missing or broken teeth (each tooth)	\$10.00
Repair resin denture base or cast framework	\$20.00
Add tooth or clasp to existing structure	\$10.00
Replace all teeth and acrylic on cast metal framework	\$135.00
Rebase complete or partial denture	\$55.00
Reline complete or partial denture (chairside)	\$20.00
Reline complete or partial denture (laboratory)	\$60.00
Interim partial denture - limited to 1 in any 12 consecutive months	\$75.00
Tissue conditioning	No Cost

### Prosthodontics,

Fixed each retainer and each pontic constitutes a unit in a fixed partial denture (bridge) When a crown and /or pontic exceed six units, an enroll may be charged an additional \$100.00 per unit, beyond the 6th unit.	
Pontic - cast high noble metal	\$210.00
Pontic - cast predominantly base metal	\$110.00
Pontic - cast noble metal	\$150.00
Pontic - porcelain fused to high noble metal	\$240.00
Pontic - porcelain/ predominantly base metal	\$140.00
Pontic - porcelain fused to noble metal	\$180.00
Pontic - porcelain/ceramic	\$240.00
Pontic - resin with high noble metal	\$195.00
Pontic - resin with predominantly base metal	\$95.00
Pontic - resin with noble metal	\$135.00
Inlay - porcelain/ceramic, two surfaces	\$190.00
Inlay - porcelain/ceramic, three or more surfaces	\$200.00
Inlay - Cast high noble metal	\$100.00

### Prosthodontics Continued

Inlay - cast predominantly base metal	No Cost
Inlay cast noble metal	\$40.00
Onlay - porcelain/ceramic, two surfaces	\$185.00
Onlay - porcelain/ceramic, three or more surfaces	\$205.00
Onlay - Cast high noble metal	\$100.00
Onlay - cast predominantly base metal	No Cost
Onlay cast noble metal	\$40.00
Crown - resin with high noble metal	\$195.00
Crown - resin with predominantly base metal	\$95.00
Crown - resin with noble metal	\$135.00
Crown - porcelain/ceramic	\$240.00
Crown - Porcelain fused to high noble metal	\$240.00
Crown - porcelain/ predominantly base medal	\$140.00
Crown - porcelain fused to noble metal	\$180.00
Crown - 3/4 cast high noble metal	\$210.00
Recement fixed partial denture	No Cost
Stress Breaker	No Cost
Cast post and core in addition to fixed partial denture retainer	\$35.00
Cast post as part of fixed partial denture retainer	\$35.00
Prefabricated post and core in addition to fixed partial denture retainer	\$20.00
Core buildup for retainer, including any pins	\$15.00
Each additional cast post - same tooth	\$25.00
Each additional prefabricated post - same tooth - base metal post	\$15.00
Fixed partial denture repair, by report	\$15.00

### Oral and Maxillofacial Surgery

Extraction, coronal remnants - deciduous tooth	No Cost
Extraction, erupted tooth or exposed root	\$5.00
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$25.00
Removal of impacted tooth - soft tissue	\$50.00
Removal of impacted tooth - partially bony	\$70.00
Removal of impacted tooth - completely bony	\$90.00
Removal of impacted tooth - completely bony with unusual surgical complications	\$110.00
Surgical removal of residual tooth roots	No cost
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$85.00
Surgical access of an unerupted tooth	\$90.00
Mobilization of erupted or malpositioned tooth to aid eruption	\$90.00
Placement of device to facilitate eruption of impacted tooth	No Cost
Biopsy of oral tissue - soft	No Cost
Alveoloplasty in conjunction with extractions	\$50.00
Alveoloplasty not in conjunction with extractions	\$70.00
Removal of benign odontogenic cyst or tumor	No Cost
Removal of lateral exostosis	No Cost
Removal of torus	No Cost
Incision and drainage of abscess	No Cost
Frenulectomy - separate procedure	No Cost
Excision hyperplastic tissue - per arch	\$55.00
Excision of pericoronal gingiva	\$55.00

### Orthodontics

Orthodontic treatment must be provided by a PMI Orthodontists; Plan Benefits cover 24 months of usual and customary orthodontic treatment. The benefit for pre-treatment records and diagnostic services includes: Intraoral - complete series (including bitewings), Tomographic survey, Panoramic film, Celhalometric film, Oral/facial photographic images, diagnostic casts \$200.00

The benefit for post-treatment records includes: Intraoral - complete series, diagnostic casts \$70.00

Limited orthodontic treatment of the primary dentition \$950.00

Limited orthodontic treatment of the transitional or adolescent (to age 19) dentition \$950.00

**Orthodontics and Adjunctive General Services are continued on the back of this brochure**

This brochure constitutes only a summary of benefits. The plan contract must be consulted to determine the exact terms and conditions of coverage. This is available for viewing and download on [www.DVIns.com](http://www.DVIns.com), Family Plans

# DeltaCare Enrollment Form, Side 1

Enroll online at [www.DVIns.com](http://www.DVIns.com), Click on Family Plans  
Wolfpack Insurance Services, Inc. P.O. Box 156 Belmont CA 94002

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Social Security # : \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ CA ZIP \_\_\_\_\_

Phone Number: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

DeltaCare Provider Name \_\_\_\_\_

Find DeltaCare providers at [www.deltadentalca.org](http://www.deltadentalca.org)

DeltaCare Office # \_\_\_\_\_

(Application cannot be processed without an office number)

Please list dependents to be covered.

Spouse

First Name: \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender \_\_\_\_

Child 1

First Name: \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender \_\_\_\_

Child 2

First Name: \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender \_\_\_\_

Child 3

First Name: \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender \_\_\_\_

Child 4

First Name: \_\_\_\_\_

Last Name \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender \_\_\_\_ (over)