

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 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

_____/_____

Agents Name: _____

Agents Address: _____

Phone Number: _____

Wolfpack Agent Number (if known) _____

Limitations of Benefits

Prophylaxis is limited to two treatments in any 12 consecutive months; Full upper and /or lower dentures are not to exceed one each in any five-year period; Partial dentures are not to be replaced within any five-year period, unless necessary due to natural tooth loss where the addition or replacement of teeth in the existing partial is not feasible; Denture relines are limited to one per denture during any 12 consecutive months; Periodontal treatments (root planing/subgingival curettage) are limited to five quadrants during any 12 consecutive months; Bitewing x-rays are limited to not more than one series of four films in any six-month period; Full mouth x-rays are limited to one set every 24 consecutive months; Sealants are limited to noncarious, nonrestored permanent first and second molars to age 14.

Exclusions of Benefits

This plan does not include the following: General anesthesia and the services of a special anesthesiologist; Cosmetic dental care; dental conditions arising out of and due to enrollee's employment for which Worker's Compensation is payable. Services which are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, country or other subdivision; Treatment required by reason of war; Dental services performed in a hospital and related hospital fees; Treatment of fractures and dislocations; Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures); Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; Any service that is not specifically listed as a covered expense; Dental expenses incurred in connection with any dental procedure started prior to enrollee's eligibility with the Delta Care Program. Example: teeth prepared for crowns, root canals in progress, orthodontic treatment; Congenital malformations; Cysts and malignancies; Dispensing of drugs not normally supplied in a dental office; (Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits); Cases in which, in the professional judgement of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded; Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by PMI or as cited under "Out of Area Emergency Treatment"; Prophylactic removal of impactions (asymptomatic non-pathological); Specialist Consultants for non covered benefits; Implant placement or removal, appliances placed on or services associated with implants.

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

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 provider's dental office 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.

Monthly Rates

Single	\$ 29.60
Two Party	\$ 50.30
Family	\$ 74.00

Rates of all applicants that enroll January 1, 2004 through December 1, 2004 are pool rated and will renew January 1, 2005.

Reach us on the World Wide Web.
www.DentalandVisionIns.com
Wolfpack Insurance Services, Inc

www.DentalandVisionIns.com

DELTACARE PMI Program

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

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

www.DVIns.com

Serviced by:
WOLFPACK INSURANCE SERVICES, INC.
1510 Folger Drive
P O Box 156
Belmont CA 94002
(800) 350-8041 FAX: (650) 591-4022
License # 0814789

DeltaCare Program

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.

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. 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 PMI 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 PMI, 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.

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 during each 12 calendar months. "Out-Of-Area" means 35 miles or more from your PMI participating dentist's office.

DESCRIPTION OF BENEFITS AND COPAYMENTS

Diagnostic		Prosthetics (Crowns, bridges and dentures)	
Oral examination	No Cost	Crown – resin (laboratory)	\$ 50.00
Emergency oral examination	\$ 10.00	Crown – Porcelain/ceramic	\$180.00
Intraoral radiographs —complete series (including bitewings)	No Cost	Crowns – porcelain fused to metal*	\$180.00
Intraoral periapical films	No Cost	Crown – full cast metal*	\$180.00
Intraoral occlusal films	No Cost	Crown – ¾ cast metallic*	\$180.00
Bitewing radiograph(s)	No Cost	Recement inlay	\$ 10.00
Panoramic film	No Cost	Recement Crown	\$ 10.00
Preventive		Crown-prefabricated stainless steel – primary/permanent	\$ 35.00
Prophylaxis (adult/child) two per 12 month period	No Cost	Crown buildup (restorative material and pins)	\$ 15.00
Topical application of fluoride including/excluding prophylaxis (to age 19)	No cost	Cast post and core* (including canal preparation)	\$ 15.00
Oral hygiene instructions	No Cost	Prefabricated post with core buildup (includes canal prep, restorative materials and pins)	\$ 15.00
Sealant, per tooth – to age 14	\$ 10.00	Denture – complete upper or lower	\$225.00
Space Maintainers	\$ 40.00	Denture – upper or lower partial with metal lingual or palatal bar, clasps and acrylic saddles, and acrylic base or cast metal framework	\$275.00
Restorative		Denture adjustment (no charge if within six months of initial placement)	\$ 10.00
(includes indirect pulp capping, bases, liners and acid etch procedures)		Denture repair – laboratory	\$ 25.00
Amalgam – one surface, primary	\$ 4.00	Partial denture repairs (per repair)	\$ 25.00
Amalgam – two surfaces, primary	\$ 7.00	Adding teeth to existing partial denture	\$ 10.00
Amalgam – three surfaces, primary	\$ 10.00	Denture reline/rebase – chairside (complete/partial)	\$ 30.00
Amalgam – four surfaces, primary	\$ 12.00	Denture reline/rebase – laboratory (complete/partial)	\$ 50.00
Amalgam – one surface, permanent	\$ 4.00	Tissue conditioning, per denture	\$ 10.00
Amalgam – two surfaces, permanent	\$ 7.00	Bridge pontic – metal*	\$180.00
Amalgam – three surfaces, permanent	\$ 10.00	Bridge pontic-porcelain fused to metal*	\$180.00
Amalgam – four surfaces, permanent	\$ 12.00	Bridge retainer-crown-porcelain fused to metal*	\$180.00
Resin – One surface anterior	\$ 10.00	Bridge retainer-crown-full cast metal*	\$180.00
Resin – two surface anterior	\$ 15.00	Recement bridge	\$ 15.00
Resin – three surface anterior	\$ 20.00	Stress breaker, per unit	\$ 25.00
Sedative Filling	\$ 5.00	Cast post and core* (includes canal preparation)	\$ 25.00
Pin Retention – per tooth, in addition to restoration	\$ 15.00	Prefabricated post with core buildup (including canal prep, restorative material & any pins)	\$ 15.00
Oral Surgery (includes preoperative and post operative evaluations and treatment under local anesthetic.)		*Precious and semi-precious metals, if used, will be charged to the enrollee at the additional cost of the metal. This applies to crowns, bridges and cast post and cores.	
Routine extraction – single tooth/each additional	\$ 6.00	Endodontics	
Surgical removal of erupted tooth	\$ 10.00	Pulp capping (direct/indirect)	\$ 5.00
Removal of impacted tooth-soft tissue	\$ 50.00	Therapeutic pulpotomy (excluding final restoration)	\$ 5.00
Removal of impacted tooth-partially bony	\$ 70.00	Root canal therapy – anterior	\$ 55.00
Removal of impacted tooth-completely bony	\$ 90.00	Root canal therapy – bicuspid	\$110.00
Biopsy of oral tissue – soft	\$ 20.00	Root canal therapy – molar	\$165.00
Alveoplasty in conjunction with extractions per quadrant	\$ 50.00	Apicoectomy – per tooth	\$ 85.00
Alveoplasty not in conjunction with extractions per quadrant	\$ 70.00	Retrograde filling – per root	\$ 50.00
Removal of exostosis-maxilla or mandible	\$ 50.00	Root amputation – per root	\$ 60.00
Frenulectomy-(frenectomy or frenotomy) separate procedure	No Cost	Adjunctive General Services	
Periodontics		Palliative (emergency) treatment of dental pain	\$ 10.00
(Includes preoperative and postoperative evaluations and treatment under a local anesthetic)		Regional block anesthesia	No Cost
Minor Periodontics (General Dentist/Specialist)		Trigeminal division block anesthesia	No Cost
Root planing, subgingival curettage, per quadrant	\$ 40.00	Local anesthesia	No Cost
Major Periodontics (Specialist)		Consultation	\$ 20.00
Gingivectomy or gingivoplasty, per quadrant	\$150.00	Office visits after regularly scheduled hours	\$ 20.00
Gingivectomy or gingivoplasty, per tooth (fewer than 6 teeth)	\$ 30.00	Failed appointment without 24 hour notification, per 15 minutes of appointment time	\$ 10.00
Gingival flap procedures including root planing (per quadrant)	\$135.00		
Osseous surgery, flap entry and closure, per quadrant	\$275.00		
Orthodontics			
Start up fees	\$350.00		
Dependent children to age 19	\$1600		
Adults and covered full time students	\$1800		

Please review the Exclusions and Limitations on the back of this brochure. After you enroll, you will receive a full listing giving procedure codes for the services listed above. This brochure constitutes only a summary of benefits. The plan contract must be consulted to determine the exact terms and conditions of coverage.

Delta Care Enrollment Form, Side 1

Wolfpack Insurance Services, Inc.

P.O. Box 156 Belmont CA 94002

First Name: _____

Last Name _____

Social Security Number: _____

Birth Date: _____ Gender _____

Mailing Address: _____

City: _____

State: CA ZIP Code _____

Phone Number _____

Selected DeltaCare Provider Name _____

Provider Office Number _____

Please list dependents to be covered.

Spouse

First Name: _____

Last Name _____

Birth Date: _____ Gender _____

Child

First Name: _____

Last Name _____

Birth Date: _____ Gender _____

Child

First Name: _____

Last Name _____

Birth Date: _____ Gender _____

Child

First Name: _____

Last Name _____

Birth Date: _____ Gender _____

Child

First Name: _____

Last Name _____

Birth Date: _____ Gender _____

(over please)