Application

Side 2.

Please pick a billing option

_____Monthly Electronic Funds Transfer

Monthly Electronic Funds Transfer (EFT) is the automatic withdrawal of the dues from your checking or savings account. The funds will be deducted on the 15th of the month prior to the coverage month. 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: _____

ABA Routing number:_____

Account Number:_____

The routing number is the first 9 digits on the left hand bottom of the check. The account number is the second series of numbers on the bottom of the check that are not the check number. Please call your bank if you have any questions. You may include a voided check for us to review.

If you do not include a premium check we will draft the initial premium and fees from the above account.

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: Gordon Paul

Phone Number: (888) 492-7245

Wolfpack Agent Number: 22156

Description of Benefits and Copayments, Continued

Orthodontia Continued	
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
Adjunctive General Services	
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 that 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 sucessful result and reasonable longevity based on the condition of the tooth or teeth and/or surronding structures; or is onconsistent 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, procelain 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 pr permanent soft bases for complete dentures, procelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances assiciated therewith) and personalization and charachterization of complete and partial dentures; Implant-supported dental appliances and attachments, implant placement, maintenance, removal and allother 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 ore 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/family.htm.**

Enrollment

Complete the attached application. Eligible dependents include your spouse, domestic partner or children to age 26.

Make sure you 'Find a Dentist' from Delta Dental's web site, www.deltadentalins.com. The network to select is DeltaCare USA.
Please write down the Dentists DeltaCare provider name and office number on the form.

If you elected the Quarterly or Employer List Bill Option, 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. Should you voluntarily cancel enrollment and subsequently desire to re-enroll, all premiums retroactive to the date of cancellation (but not to exceed 12 months) must be paid before you can re-enroll. If you cancel after your initial 12 month enrollment period and wish to re-enroll you will have to wait 13 months from your last date of coverage.

Monthly Rates

Single	$ 34.20
Two Party	$ 60.70
Family	$ 89.10

Rates of all applicants that enroll January 1, 2017 through December 1, 2017. Premiums are pool rated and will renew January 1,2018.

Enroll Online at:

www.DentalandVisionIns.com/family.htm

WOLFPACK INSURANCE SERVICES, INC.
P O Box 156
Belmont CA 94002

DentalandVisionIns.com

DELTACARE 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/family.htm

(800) 350-8041 FAX: (650) 591-4022
License # 0814789

DESCRIPTION OF BENEFITS AND COPAYMENTS

How it Works

When you enroll in DeltaCare you select a panel dental office from the list provided by your agent or from Delta Dental's web site at www.deltadentalins.com. The network to select is DeltaCare USA. 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 DeltaCare 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	No Cost
extensive oral evaluation, Re-evaluation - limited,	No Cost
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 (resorbabla 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, unrestorable 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 accidently 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 survay, Panoramic film, Celhalometic 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. Available for viewing and download on www.DVIns.com, Dental Plans for a Family

DeltaCare Enrollment Form, Side 1

Enroll online at: www.DVINs.com/family.htm
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.deltadentalins.com

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)