

## HOW TO ENROLL IN SUNOCO, INC. (RETIREES) DENTAL PLAN

1. Complete the Enrollment Form below. Be sure to complete all the information requested on the form, including the type of enrollment you would like to choose (i.e., Retiree only, Retiree and one dependent, Retiree and family).
2. Make your check for the first month's premium payable to *Wolfpack Insurance Services, Inc.* The amount of the check will depend on the type of enrollment you choose. The chart below lists the MONTHLY rates for each type of enrollment.
3. Send your completed enrollment form and your payment to:  

*Wolfpack Insurance Services, Inc.*  
P.O. Box 720  
Belmont, CA 94002-0720
4. In order for you to be eligible for benefits beginning the first of any month, your Enrollment Form and payment must be postmarked by the 15<sup>th</sup> of the month prior to the month in which you would like to be enrolled.
5. If you have any questions about enrolling in the dental program, please call Wolfpack Insurance Services at 1-888-837-7511.
6. You must enroll in the dental plan within 60 days of retirement. Please note that if you enroll in the dental plan and then opt out of coverage, you must wait two years before re-enrolling in the dental plan.

ENROLLMENT TYPE	MONTHLY RATES*
Retiree only	\$45.17
Retiree and One Dependent	\$86.73
Retiree and Family	\$129.98

\*Dental rates are guaranteed from January 1, 2016 through December 31, 2016

SERVICES	PLAN BENEFITS**	PLAN BENEFITS**
	DELTA DENTAL PPO <sup>SM</sup> DENTISTS	DELTA DENTAL PREMIER <sup>®</sup> & NON-DELTA DENTAL DENTISTS
Diagnostic	100%	100%
Preventive	100%	100%
Basic Restorative	80%	60%
Oral Surgery	80%	60%
Endodontics	80%	60%
Periodontics	80%	60%
Major Restorative	50%	40%
Prosthodontics	50%	40%
Denture Repair and Relining	80%	60%
DEDUCTIBLE (Diagnostic and Preventive services are exempt from deductible)	\$50 per person not to exceed \$150 per family per contract year	\$75 per person not to exceed \$225 per family per contract year
MAXIMUM BENEFITS	\$1,500 per person per contract year	\$1,000 per person per contract year

\*\*Percentages apply to Delta Dental's Allowed Amount.



**DELTA DENTAL ENROLLMENT FORM**  
**Sunoco, Inc. Retirees Dental Plan**

**PLEASE PRINT**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

GENDER \_\_\_\_\_

TYPE OF ENROLLMENT:  Retiree     Retiree & One Dependent     Retiree & Family

RETIREMENT DATE: \_\_\_\_\_ EFFECTIVE DATE OF COVERAGE: \_\_\_\_\_

**Please list eligible dependent(s) to be covered in addition to yourself:**

Spouse Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Dependent Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Dependent Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Dependent Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Remit your first month's payment and this completed form to:

Wolfpack Insurance Services, Inc.  
P.O. Box 720  
Belmont CA 94002-0720

Your enrollment form must be postmarked by the 15<sup>th</sup> of the month prior to the month in which you would like to be enrolled

Please make check payable to: **WOLFPACK INSURANCE SERVICES, INC.**

# Standard Limitations and Exclusions

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## Limitations

- Full mouth x-rays and panorex x-rays accompanied by bitewing x-rays are limited to once in any 3-year period.
- Bitewing x-rays are limited to twice in any 12-month period.
- Periodic examinations of the full mouth are limited to twice in any 12-month period.
- Prophylaxis and fluoride application may be performed either together or separately.
- Prophylaxes are limited to twice in any 12-month period.
- Fluoride applications as a benefit are limited to twice in any 12-month period up to age 19.
- Sealants are a benefit limited to age 14 once in any 36-month period on unfilled permanent first and second molars.
- Space maintainers are a benefit up to age 14.
- Replacement of restorative crowns, inlays and onlays is a benefit once only in any 5-year period irrespective of who provided previous restoration or paid benefits therefore.
- Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services which are necessary to make such appliances fit will be provided in accordance with the Group Dental Service Contract.
- Prosthodontic appliances and abutment crowns will be replaced only after 5 years have elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.
- Benefits for specific oral surgery procedures, such as the reduction of fractures, removal of tumors, and removal of impacted teeth, which are benefited under a medical insurance contract or a medical or hospital service contract for which premiums are paid by the Plan Administrator by which you are covered shall be determined first under that contract. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under the other contracts up to the Allowed Amount for the procedure less the applicable deductible and patient copayment. When coverage is not paid for by the Plan Administrator or there is no medical or hospital coverage, Delta Dental's obligation shall be subject to coordination of benefits or limited to the Allowed Amount for the procedure less the applicable deductible and patient copayment.
- Benefits for periodontal surgery in the same quadrant are limited to once in any 5-year period. The 5-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this Contract, under any prior dental contract, or by you.
- Dental benefits may be based on the least costly treatment that conforms to generally accepted dental practice.
- General anesthesia and IV sedation are benefitted with all covered oral surgery procedures and with select endodontic and periodontal surgeries.

## **Exclusions**

- Services or supplies which are provided to patient by any federal or state government agency or by any municipality, county or other political subdivision.
- Charges for which benefits or services are provided to the patient by any hospital, medical or dental service corporation, any group insurance, franchise, or other prepayment plan for which an employer, union, trust or association makes contributions or payroll deductions (unless the coordination of benefit provisions provide otherwise).
- Charges for dental practice administrative services including but not limited to preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton, swabs, gauze, bibs, masks or relaxation techniques such as music.
- Composite restorations in molar posterior teeth. If posterior composite restorations are provided on molar teeth, Delta Dental will pay the allowance for an amalgam restoration and the patient will be responsible for the additional cost.
- Procedures to correct congenital or developmental malformations except for dependent children or newborn children eligible at birth.
- Treatments or devices that increase the vertical dimension of an occlusion, restore an occlusion to normal, replace tooth structure lost by attrition or erosion, or otherwise.
- Treatments or supplies primarily for cosmetic purposes.
- Services provided or supplies furnished or devices started prior to the effective eligibility date of a patient.
- Preventive plaque control programs, including oral hygiene programs.
- Periodontal splinting, equilibration and gnathological recordings.
- Myofunctional therapy.
- Temporomandibular joint dysfunction, unless covered under the group contract.
- Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.
- Prescription drugs, pre-medication, analgesias, and general anesthesia, unless covered under the group contract.
- Treatment or supplies for which the patient would have no legal obligation to pay in the absence of this or any other similar coverage.
- Experimental procedures which have not been accepted by the American Dental Association.
- Orthodontic services, including tooth guide appliances