AFFORDABLE DENTAL INSURANCE

In-Network Advantages

Delta Dental PPO and Delta Dental Premier network dentists agree to:

Treatment Guarantees: Restorations will be repaired or replaced should they fail within 24 months.

No Balance-Billing: If their normal charge is higher than the maximum fee, they can't pass the balance on to you.

Claims Processing: Claims are filed on your behalf and payments go directly to the dentist.

Special Plan Features

This dental plan includes additional features designed to encourage good oral health and promote overall health:

Evidence-Based Integrated Care Plan: Provides additional benefits for those with certain medical conditions that have oral-health implications. Conditions include: diabetes, pregnancy, cancer therapy, or specific heart conditions.

CheckUp Plus: Diagnostic and preventive services (exams, X-rays, regular cleanings, and other related treatments) don't apply to your individual annual maximum.

A Member Benefit of

STATE BAR OF WISCONSIN

BULTMAN Financial

DELTA DENTAL®

WHY YOU NEED DENTAL INSURANCE

FOR YOUR BUDGET: Ward off expensive dental emergencies.

Early-detected cavities, broken fillings, and gum disease are easily treatable. If left untreated, expensive root canals, gum surgery, tooth extractions, or worse may result.

FOR YOUR HEALTH: Spot potential health risks.

Oral health is directly linked to whole-body health. Dental professionals can spot symptoms of more than 120 diseases elsewhere in the body during a simple dental checkup.

FOR YOUR FAMILY: Start your children on the path to good oral health.

According to the Surgeon General, children miss 51 million school hours each year because of dental-related illnesses. The sooner your children begin learning good dental-health habits, the more likely they are to make going to the dentist part of their health regimen for life.

Immediate savings

See how much you'd pay without dental insurance for some typical dental services ... and how much you can save on out-of-pocket costs with one of our comprehensive dental plans.

Service	Cost without dental insurance*	Value of benefit**	Savings***
Adult checkup (cleaning with exam, bitewings, and no fluoride application)	$190	100%	**$190**
Child checkup (cleaning and fluoride application, exam, and bitewings)	$200	100%	**$200**
Full series X-rays	$100	100%	**$100**
Filling (adult, three surfaces)	$128	80%	**$102.40**
Full crown	$832	50%	**$416**
Root canal (molar)	$803	50%	**$401.50**

Dental insurance from Delta Dental can help you and your family save money every time you see the dentist, whether for preventive checkups and cleanings or unexpected expenses like fillings or crowns.

Delta Dental offers two dental networks: Delta Dental PPO and Delta Dental Premier. Both save you money. Dentists who belong to the Delta Dental PPO network offer the lowest agreed-upon fees. And the Delta Dental PPO network has more locations for members to access care than any other PPO network.

Dentists who belong to the Delta Dental Premier network also agree to discounts – just not as deep. But the network is much broader; more than 90 percent of Wisconsin's dentists belong to the Delta Dental Premier network – and 81 percent nationally. The Delta Dental Premier network is the nation's largest dentist network.

**Costs represent typical dental fees charged in the state of Wisconsin, from healthcarebluebook.com. Fees may vary by location and dentist.*
***Plan design shown has 100/80/50 coverage.*
****Savings shown reflect amount paid after deductible has been met. The plan will pay for all services up to your annual maximum.*

Delta Dental PPO Plus Premier

The summary below does not cover all plan details. Complete information can be found in the Summary Plan Description or Dental Benefit Handbook. These documents provide a thorough explanation of your dental plan, including any limitations or exclusions that may apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

Note: If you want benefits under this plan you must see a Delta Dental PPO or Delta Dental Premier network dentist. →	Delta Dental PPO Network	Delta Dental Premier Network
Individual Annual Maximum Includes CheckUp Plus™. With CheckUp Plus™, benefits paid for diagnostic and preventive services do not apply to the individual annual maximum.	$1,000	$1,000
Individual Annual Deductible (per person)	$50	$75
Diagnostic & Preventive Services Examinations, teeth cleanings, and fluoride treatments (twice per year). Bitewing X-rays once every 12 months and full-mouth X-rays once every five years. One-time application of sealants. Space maintainers as needed.	100%	80%
Basic Services Emergency treatment to relieve pain, fillings, and simple extractions.	80%*	50%*
Major Services Endodontics and periodontics (root canals and gum-disease treatment), extractions and oral surgery, crowns, complete and partial dentures, implants, fixed bridges, repairs and adjustments.	50%*	50%*
Orthodontic Services Coverage applies for dependent children to age 19.	50%*	50%*
Lifetime Orthodontic Maximum	$1,000	$1,000
Evidenced-Based Integrated Care Plan (EBICP) Delta Dental's Evidence-Based Integrated Care Plan provides expanded benefits for persons with diseases and medical conditions that have oral-health implications. These benefits address the unique oral-health challenges faced by persons with these conditions, and can play an important role in the management of an individual's medical condition.	Included	
Dependent Age Limit	Age 26, except as noted for orthodontics	
Waiting Periods Endodontics (root canals), periodontics (gum-disease treatment), extractions, and oral surgery. Crowns, complete and partial dentures, implants, fixed bridges, repairs and adjustments, orthodontics.	6 months 12 months	

**deductible applies*

Ready to enroll?

Fill out the enrollment form and fax it to your Bultman Financial Representative, or email it to CBultman@bultmanfinancial.com

Rates effective January 1, 2024 through December 31, 2024.	Monthly Rate
Member Only	$44.69
Member & Spouse	$91.60
Member & Children	$110.33
Member, Spouse & Children	$178.84

Plan Administered by: Bultman Financial Services, Inc.
13625 Bishop's Drive, Suite 100, Brookfield, WI 53005
Phone: (262) 782-9949 | Toll Free: (800) 344-7040
Fax: (262) 782-1454 | www.bultmanfinancial.com

DELTA DENTAL®

State Bar of Wisconsin

Enrollment/Change Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

ADMINISTRATOR USE ONLY

GROUP NUMBER 00215 _____ _____ _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

STATE BAR OF WISCONSIN MEMBER LAST NAME	FIRST	M.I.	SSN	DATE OF BIRTH MM	DD	YR	SEX F	M
							☐	☐

HOME ADDRESS - STREET	CITY	STATE	ZIP

PHONE NUMBER	EMAIL ADDRESS

GROUP NAME	EMPLOYER LOCATION	CITY	STATE	SBW MEMBER NUMBER
State Bar of Wisconsin				

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT)	FIRST		RELATIONSHIP SON	DAU.	DATE OF BIRTH	DD	YR
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			
			☐	☐			

REASON FOR SUBMITTING THIS FORM

☐ NEW ENROLLEE ☐ RE-ENROLL (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

	Date Occurred
☐ Birth/Adoption (Name:_____)	_____
☐ Marriage/ ☐ Divorce	_____
☐ Add/ ☐ Drop Dependent (Name: _____)	_____
☐ Termination of Benefits (Reason: _____)	_____
☐ Loss of Dental Benefits	_____
☐ Name Change (Former Name: _____)	_____
☐ Address Change (_____)	_____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

☐ Member Only ☐ Member & Spouse
☐ Member & Child(ren) ☐ Entire Family

YOUR MARITAL STATUS ☐ Single ☐ Married

☐ ACCEPT COVERAGE

X _____ _____
Signature Date

☐ By typing your name on the signature line, you are signing this agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature and you consent to be legally bound by this agreement's terms and conditions. I have reviewed and been provided a copy of my rights under the federal e-sign act.

Acceptance of Coverage

I accept the insurance provided by the State Bar of Wisconsin's group insurance plan. I authorize deductions from my checking or savings account for the required contributions toward the cost of insurance. I understand that by accepting insurance, I am required to remain enrolled as a covered member and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

FAX THIS FORM TO YOUR BULTMAN FINANCIAL REPRESENTATIVE AT (262) 782-1454 OR EMAIL TO CBULTMAN@BULTMANFINANCIAL.COM

13625 Bishops Drive, Ste 100
Brookfield, WI 53005
(262) 782-9949

ACH Recurring Payment Authorization Form

Schedule your payment to be automatically deducted from your checking or savings account. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking or savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be emailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Bultman Financial Services to charge my bank account

(full name)

indicated below on the 1st day of each Month for payment of my SBW Delta Dental Plan premium payment.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Checking ☐ Savings

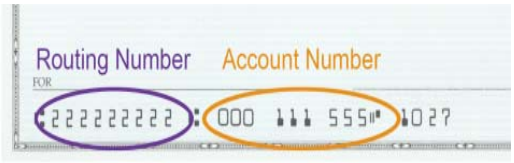
Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____



SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Bultman Financial in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that Bultman Financial may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.