DENTAL PLAN SUMMARY

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PLAN NAME: Pappas Telecasting Companies
SUMMARY PLAN DESCRIPTION

As a service to our clients, we provide benefits and eligibility for dental benefits payable under their plan.
The following provides you with the most common questions and answers regarding their benefits and level of reimbursement.
Ultimately, the patient is responsible for all charges, balances, excluded procedures and unpaid claims.
If further clarification is needed please call 949 398-8111.

ORTHODONTIC COVERAGE: No [√]
COVERAGE: Preventive 100% Basic 80% Major 50% (Not affiliated with a PPO Network)
Reimbursement level based on U & C
DEDUCTIBLE: Individual: $100.00 Family $300.00 Does deductibles apply to preventive services? [Yes]
The deductible on this plan is based on a **calendar year** [√] fiscal year [ ]. **Calendar Year Maximum:** $1,000.00
Is there a waiting period for **Basic**: [No] **Major**? [No] Missing Tooth Clause? [No]
Is coverage provided for replacement of teeth extracted prior to Insurance Coverage? Yes [√] No [ ]
Are benefits paid to the Provider? Yes [√] No [ ] PPO Network: **None**

PREVENTIVE	BASIC	MAJOR	ORTHODONTIA
Routine oral exams and Prophylaxis 2/yr	Anesthesia-w/oral surgery	Crowns	NONE
Fluoride limited to under age 19 & 1/yr	Consultations and Non routine Visits	Endodontia-Periodontia	
Sealants limited to under age 14 & 1/3 years Max of $12.00/tooth	Extractions	Inlays, Onlays & Gold Fillings	
FMX **or** Panoramic 1/60 consecutive months	Non-Precious Fillings	Occlusal Guard (only when provided w/surgical periodontal therapy)	
BW 4 films/calendar year	Injections (antibiotics)	Prosthetics	
Palliatives	Oral Surgery		
Space Maintainers under age of 16 yrs	Pathology, Exam and Study Models		
X-rays	Repairs, Relines and Adjustments		
Thumb sucking appliances under age of 16 yrs	Stainless Steel Crowns		
	Relining, Rebasing & Repairs		

IMPORTANT: All Major Services must be authorized before they are rendered. If Prior authorization is not obtained, the Non-Network benefit levels will apply even if a Network provider is used. Eligible dental expenses are the Usual, and Customary charges for the dental services and supplies listed above, which are: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed. For benefit purposes, a dental expense is incurred on the **date of treatment**, service or purchase.

DENTAL LIMITATIONS AND EXCLUSIONS
Except as specifically stated, no benefits will be payable under this plan for:

Congenital or Developmental Conditions	Myofunctional Therapy
Cosmetic Dentistry	Non-Professional Care
Customized Prosthetics- Personalization or Characterization of Dentures	Occlusal Restoration
Discoloration Treatment	Oral Hygiene Instruction and Supplies, Etc.
Excess Care	Orthodontia
Experimental Procedures	Orthognathic Surgery
Grafting	Prior to Effective Date/After Termination Date
Hospital Expenses	Splinting
Implants	Temporary Restoration and Appliances- including Night guards
Lost or Stolen Prosthetics/Appliances	TMJ Treatment/Jaw Surgery
Medical Expenses (including prescription drugs)	

MAIL CLAIMS TO: Orange County Foundation for Medical Care
P.O. Box 18948, Irvine, Ca. 92623

PLAN NAME: ***San Diego-Imperial Counties Developmental Services, Inc***
SUMMARY PLAN DESCRIPTION

As a service to our clients, we provide benefits and eligibility for dental benefits payable under their plan.
The following provides you with the most common questions and answers regarding their benefits and level of reimbursement.
Ultimately, the patient is responsible for all charges, balances, excluded procedures and unpaid claims.
If further clarification is needed please call 949 398-8111.

ORTHODONTIC COVERAGE: Yes [√] (**Dependant Children Only**) Lifetime Maximum $1,000.00 (**Network Providers Only**)
COVERAGE: ***In Network:*** Preventive 100% Basic 90% Major 60%
Non-Network: Preventive 100% Basic 75% Major 45% Reimbursement level based on U & C
DEDUCTIBLE: Individual: $25.00 Family: $75.00 Does deductibles apply to preventive services? [No]
The deductible on this plan is based on a **calendar year** [√] fiscal year [ ].
Calendar Year Maximum: $1,500.00
Is there a waiting period for **Basic:** On the plan for 6 consecutive months for late enrollees
Major: On the plan for 12 consecutive months for late enrollees and dependants
Missing Tooth Clause? Prior extractions are covered if done while enrolled in the Plan.
Is coverage provided for replacement of teeth extracted prior to Insurance Coverage? Yes [ ] No [√]
Are benefits paid to the Provider? Yes [√] No [ ] PPO Network: **First Dental Health 1-800-334-7244**

PREVENTIVE	BASIC	MAJOR	ORTHODONTIA
Routine oral exams and Prophylaxis 2/yr	Anesthesia-w/oral surgery	Crowns (no replacement limitation)	Initial Consultation
Fluoride limited to under age 19 & 2/yr	Consultation	Implants	Models
Sealants limited to under age 19 & one application per 3 year period (permanent molars only)	Endodontia	Inlays	X-rays
FMX or Panoramic 1/36 months	Extractions	Onlays	Diagnostic services
BW 2 set/calendar year	Non-Precious Fillings (posterior composites downgraded to amalgams)	Prosthetics (5 yr replacement)	Removal of teeth for correction of bite
Palliatives	Injections (antibiotics)		Initial banding
Pathology	Medicines & Drugs		Orthodontic appliances
Space Maintainers	Oral Surgery		Periodic adjustments
X-rays	Periodontia (no visit max)		Retainers
	Relining, Rebasing & Repairs		

IMPORTANT: **All Major Services must be authorized before they are rendered. If Prior authorization is not obtained, the Non-Network benefit levels will apply even if a Network provider is used.**

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed above, which are: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed. For benefit purposes, a dental expense is incurred on the date of treatment, service or purchase.

DENTAL LIMITATIONS AND EXCLUSIONS ***Except as specifically stated, no benefits will be payable under this plan for:***	
Cosmetic Dentistry	Medical Expenses and Non-Professional Care
Customized Prosthetics-including night guards	Myofunctional Therapy
Discoloration Treatment	Occlusal Restoration
Excess Care and Experimental Procedures	Oral Hygiene Counseling, Etc.
Grafting	Personalization or Characterization of Dentures
Hospital Expenses	Prior to Effective Date and After Termination Date
Infection Control	Splinting
Lost or Stolen Prosthetics/Appliances	Temporary Restoration and Appliances
ALL CLAIMS GO TO: First Dental Health P.O. Box 919029 San Diego, Ca. 92191	