OMNI

Preferred Provider Organization (PPO) Plan

An Affordable Care Act (ACA) Compliant Dental Plan

Plans using this network are underwritten by:

DENTCARE
DELIVERY SYSTEMS, INC.

Plan Administered by:

HEALTHPLEX®
THE DENTAL BENEFIT EXPERTS℠

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OMNI PPO Dental Plan

For businesses of any size, the Omni Preferred Provider Organization (PPO) Plan offers comprehensive coverage using one of our largest networks.

- Small deductible of $50/individual and $150/family (not applicable to Preventive and Diagnostic Services)
- An annual maximum of $1,500 per person
- A vision discount plan for all Omni PPO plan members is provided by Healthplex.

In-Network Coverage

You may select any dentist from the Capital Network. Some services are rendered without any cost, while others have a minimal copayment that you pay directly to the dentist. Members who receive care through the Healthplex Capital PPO network have their benefits automatically paid to their participating dentist. Members have reduced out-of-pocket expenses at these offices because PPO dentists have reduced their fees for plan members.

- No charge for Exams, Prophylaxis, and X-rays
- No referrals required

Out-of-Network Coverage

If you choose to go Out-of-Network, you will be reimbursed according to the Schedule of Benefits for covered procedures and will be responsible for the difference between the dentist's charge and the reimbursement. This plan requires claim forms to be submitted in order to be reimbursed for covered services rendered.

The Omni PPO Plan is ACA compliant and includes the Pediatric Dental Essential Health Benefits, as defined in the Patient Protection Affordable Care Act, for dependent children under the age of 19.

Do You Have Questions? Are You Interested in Enrolling?

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Schedule of Benefits

Procedure	In-Network PPO Copayment	Out-of-Network Reimbursement
Diagnostic & Preventive Services		
Oral Examination	No Charge	$40.00
Full Mouth X-rays	No Charge	$85.00
Panoramic Film	No Charge	$75.00
Prophylaxis, Adult	No Charge	$80.00
Prophylaxis, Child	No Charge	$55.00
Fluoride Treatment	No Charge	$35.00
Emergency Treatment	No Charge	$75.00
Sealants, Per Tooth	No Charge	$40.00
Restorative Dentistry		
Amalgam, 1 Surface	$9.00	$56.00
Amalgam, 2 Surfaces	$12.00	$80.00
Amalgam, 3 Surfaces	$15.00	$104.00
Composite Filling, 1 Surface, Anterior	$10.00	$76.00
Composite Filling, 2 Surfaces, Anterior	$14.00	$104.00
Composite Filling, 3 Surfaces, Anterior	$17.60	$144.00
Oral Surgery		
Routine Extraction	$13.20	$100.00
Surgical Extraction	$22.00	$148.00
Soft Tissue Impaction	$31.00	$200.00
Partial Bony Impaction	$37.60	$240.00
Full Bony Impaction	$48.00	$308.00
Alveolectomy w/ Extraction, per quad	$12.40	$160.00
Root Canal Therapy		
Pulpotomy	$13.00	$120.00
Root Canal Therapy – Anterior	$70.00	$320.00
Root Canal Therapy – Bicuspid	$85.00	$472.00
Root Canal Therapy – Molar	$100.00	$564.00
Apicoectomy, Anterior	$42.00	$280.00

Schedule of Benefits

Procedure	In-Network PPO Copayment	Out-of-Network Reimbursement
Periodontics		
Scaling/Root Planning of Teeth, per Quad	$45.00	$62.50
Gingivectomy, Per Quad	$90.00	$200.00
Osseous Surgery, Per Quad	$230.00	$412.50
Prosthetics[1] – Crowns		
Porcelain Crown	$212.50	$400.00
Porcelain w/Metal Crown	$297.50	$375.00
Stainless Steel Crown	$55.00	$87.50
Recementation, per Crown	$19.00	$35.00
Prosthetics[1] – Fixed Bridges		
Porcelain w/Metal Abutment	$297.50	$375.00
Porcelain w/Metal Pontic	$297.50	$380.00
Recementation Bridge	$31.00	$45.00
Prosthetics[1] – Removable		
Full Upper Denture, inc. Adjustments	$325.00	$450.00
Full Lower Denture, inc. Adjustments	$325.00	$450.00
Partial Upper Denture, Cast Base/Cast	$347.50	$500.00
Partial Lower Denture, Cast Base/Cast	$347.50	$517.50
Prosthetics[1] – Repairs		
Repair Broken Denture	$32.50	$62.50
Replacing Broken/Missing Teeth	$27.50	$50.00
Orthodontics *(No Out-of-Network Benefit)*		
Case Fee 24 Months	$2,910.00[2]	Not Covered

[1]There is a 12-month waiting period for prosthetic services, excluding single crowns. Waiting periods are waived for prior coverage.

[2]Dependent Children up to age 19 will receive reduced fees available at participating orthodontic offices.

Exclusions

1. A service not furnished by a dentist unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an x-ray ordered by a dentist.
2. Treatment of a disease, defect, or injury covered by a major medical plan, Workers' Compensation Law, occupational disease law, or similar legislation.
3. General anesthesia, analgesia, or sedation for services rendered in a hospital environment.
4. Dental procedures undertaken primarily for cosmetic reasons (including composite fillings in back teeth), or dental care to treat accidental injuries, congenital or developmental malformations.
5. Restorations, crowns or fixed prosthetics when results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, the Plan will allow for the least costly alternative and the patient is responsible for all additional fees.
6. Services started prior to becoming covered under this plan.
7. Implants, grafts, precision attachments or other personalized restorations or specialized techniques.
8. Replacement of an existing crown, bridge or denture that can be made serviceable according to common dental standards.
9. Procedures, appliances or restorations for which the main purpose is to change vertical dimension, diagnose or treat conditions or dysfunction of the temporomandibular joint, stabilize periodontally involved teeth, or restore occlusion.
10. Treatment of unmanageable children and/or unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or the parent/guardian of the patient.
11. Services not listed in the Schedule of Benefits are not covered.

Limitations

1. Oral exams, bitewing x-rays, prophylaxes, and fluoride treatments: once every 6 months.
2. Full mouth and panoramic x-rays: once every 36 months.
3. Crowns and bridges (per tooth), dentures (per arch), and periodontal surgery (per quadrant): once every 60 months.
4. Orthodontic treatment of Class II/Class III malocclusions: one 24-month case when seen by a Healthplex PPO Orthodontist.
5. Under family coverage, dependent children are covered up to the end of the month of their 26th birthday.

Certain other procedures may have age or time limitations. A list of such services is available on request.

This brochure contains a general description of your dental care program for your use as a convenient reference. **Due to certain Exclusions and/or Limitations, all member copayments may not be applicable**. Prior to receiving any treatment, please obtain the Certificate of Insurance from your benefit administrator for Exclusions and Limitations. A copy of your Certificate of Insurance may also be obtained from our website at www.healthplex.com. All benefits are governed by the provisions of your group's contract.

Administered by
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