Frequently Asked Questions

Is this plan ACA compliant?

The Omni PPO Plan is ACA compliant for all groups with 50 or fewer employees 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.

What expenses will I have?

See Schedule of Benefits for the In-Network Copayments and Out-of-Network Reimbursements. Your out-of-pocket expenses will always be less when you are treated by Healthplex's PPO dentists.

Are there any added features?

A vision discount plan for all Omni PPO plan members is provided by Healthplex.

All dentists in our network are credentialed by Healthplex, a Credentials Verification Organization certified by the National Committee for Quality Assurance for 10 out of 10 credentialing services. We conduct site visits to ensure all offices are well equipped, adequately staffed and are following proper sterilization techniques.

EXCLUSIONS

1. Services not furnished by a dentist unless 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 general 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 acceptable 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 whose 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. 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 & panoramic x-rays: Once every 36 months.
3. Crowns, bridges, dentures, periodontal surgery: Once every 60 months.
4. Orthodontic treatment of Class II/III malocclusions: One 24-month case when seen by a Healthplex PPO Orthodontist.
5. Under family coverage, children are covered to age 19 (25 if a full-time student). Proof of student status must be submitted every semester.

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. All benefits are governed by the provisions of your group's contract.

Plans using this network are underwritten by

DENTCARE
DELIVERY SYSTEMS, INC.

Omni

Comprehensive Dental Benefits at Very Reasonable Premiums

An Affordable Care Act (ACA) Compliant Dental Plan

Administered by
Healthplex, Inc.
333 Earle Ovington Boulevard, Suite 300
Uniondale, NY 11553-3608
www.healthplex.com

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OMNI PPO Dental Plan

Schedule of Benefits

In the Omni PPO Dental Plan, members have only a small deductible of $50/individual and $150/family (not applicable to Preventive and Diagnostic Services), and an annual maximum of $1,250 per person and $3,750 per family.

- 12-Month Waiting Period for Prosthetics (Excluding Single Crowns)
- Discounted fee for Orthodontic care (In-Network Only)

In-Network Coverage

You may select any dentist from the Capital Directory of Participating Providers. 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.

Out-of-Network Coverage

When services are received from an Out-of-Network dentist, you will be reimbursed up to the Maximum Out-of-Network Reimbursement and you will be responsible for costs exceeding your reimbursement. **Out-of-Network Reimbursements are based on Healthplex's Omni Out-of-Network Schedule of Allowances.**

The Omni Plan is ACA compliant and includes the Pediatric Dental Essential Health Benefits, as defined in the Patient Protection Affordable Care Act for all groups with 50 or fewer employees, for dependent children under the age of 19.

Do you have questions? Are you interested in enrolling?
Please call our **Sales Department** at **1-800-468-0466** or visit **www.healthplex.com**

Are you already a member?
Please call our **Customer Service Department** at **1-800-468-0600** or visit **www.healthplex.com**

Procedure	In-Network PPO Copayment	Out-of-Network Reimbursement
Preventive & Diagnostic Services		
Periodic Oral Exam	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
Topical Fluoride	No Charge	$35.00
Palliative Treatment	No Charge	$75.00
Sealants, Per Tooth	No Charge	$40.00
Restorative Dentistry		
Silver Amalgam, 1 Surface	$9.00	$56.00
Silver Amalgam, 2 Surfaces	$12.00	$80.00
Silver Amalgam, 3 Surfaces	$15.00	$104.00
Composite, 1 Surface	$10.00	$76.00
Composite, 2 Surfaces	$14.00	$104.00
Composite, 3 Surfaces	$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
Full Bony Impaction	$48.00	$308.00
Root Canal Therapy		
Root Canal Therapy – Anterior	$70.00	$320.00
Root Canal Therapy – Bicuspid	$85.00	$472.00
Root Canal Therapy – Molar	$100.00	$564.00

Procedure	In-Network PPO Copayment	Out-of-Network Reimbursement
Periodontics		
Gingivectomy, Per Quad	$90.00	$200.00
Osseous Surgery, Per Quad	$230.00	$412.50
Prosthetics * – Crowns		
Porcelain Crown	$212.50	$400.00
Full Cast High Noble Metal Crown	$212.50	$377.50
Stainless Steel Crown	$55.00	$87.50
Prosthetics * – Fixed Bridges		
Porcelain w/High Noble Metal Pontic	$297.50	$375.00
Porcelain w/High Noble Metal Abutment	$297.50	$380.00
Full Cast High Noble Metal Abutment	$262.50	$375.00
Prosthetics * – Removable		
Full Dentures	$325.00	$450.00
Partial Upper Denture, Cast	$347.50	$500.00
Partial Lower Denture, Cast	$347.50	$517.50
Prosthetics * – Repairs		
Repair Broken Denture	$32.50	$62.50
Orthodontics *(No Out-of-Network Benefit)***		
Case Fee 24 - Months	$2,910.00	Not Covered

**There is a 12-month waiting period for prosthetics, excluding single crowns. Waiting periods waived for prior coverage.*

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

HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

CAPITAL PANEL
PPO Dentist Search

Minimize your time on the phone. Visit **Healthplex.com** to easily access the most current dental panel, your dental coverage, and other important and interesting information about your oral health.

In order to locate participating providers, please follow the instructions listed below.

1. Go to **www.healthplex.com**
2. Click on "**Our Dentists**" to view the most current listing of participating providers available to you.
3. Under the "**Prospective Members**" section on the left-hand side:
   - Click on "**PPO Panels**"
   - Click on "**Capital Panel**"
   - Choose "**General Practice**" or "**Specialty**"
   - Enter either your Zip Code or City/County and State

If you have any questions or need further assistance, please contact Customer Service at 1 800 468 0600.

Information about Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating provider's normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit us at www.davisvision.com or call 1.800.999.5431.

Mail Order Contact Lenses:

LENS123
Replacement Contact Lenses By Mail

Free membership and access to a mail order replacement contact lens service, LENS123, provides a fast and convenient way to purchase replacement contact lensesat significant savings. For more information, please call 1.800. LENS.123 (1.800.536.7123) or visit the LENS123 website at www.LENS123.com.

Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Services not performed by licensed personnel.

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

For more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1.800.999.5431 to:

- Learn more about your benefits
- Locate a Davis Vision provider
- Verify eligibility
- Print an enrollment confirmation
- Request an out-of-network provider reimbursement form
- Contact a Member Service Representative

Member Service Representatives are available:

- Monday through Friday, 8:00 AM to 11:00 PM, Eastern Time
- Saturday, 9:00 AM to 4:00 PM, Eastern Time
- Sunday, 12:00 PM to 4:00 PM, Eastern Time

Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling 1.800.523.2847.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of Your Rights and Responsibilities as a Patient, please visit Davis Vision's website at: **www.davisvision.com** or call **1.800.999.5431.**

"All insured products are underwritten by either HM Life Insurance Company or HM Life Insurance Company of New York."

Davis Vision may operate as Davis Vision Insurance Administrators in California

SP00949 HP/001 2/22/12

Vision Care Plan Benefit Description

For members and dependents of

Healthplex Administered Dental Plans

For information prior to enrolling visit Davis Vision's website at: **www.davisvision.com**, select the member option and enter client code **2313** or call **1.877.923.2847** (toll free).

Once enrolled, please visit Davis Vision's website: **www.davisvision.com**, or call **1.800.999.5431** with questions.

DAVISVISION®
SEE LIFE

Davis Vision, Inc., a leading national administrator of vision care programs. Eligibility for vision care benefits is determined by the same rules that apply to your health care benefits..

What are my services?

Through special arrangements, this plan provides discounts on an eye examination, eyewear, and contact lenses to members and their covered dependents once every 12 months. Please see the "Member Discount Fee Schedule" for pricing information.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision and Healthplex Administered Dental Plan member or dependent.
- Provide the office with the member's ID number and the name and date of birth of any covered children needing services.

It's that easy! The provider's office will verify your eligibility for services, and claim forms or ID cards are not required!

100% OF YOUR CALLS & CLAIMS ARE PROUDLY ADMINISTERED IN THE USA

Who are the network providers?

They are licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please access Davis Vision's website at **www.davisvision.com** and utilize the "Find a Doctor" feature, or call **1.800.999.5431** to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

What if my usual provider does not participate in the Davis Vision network?

You may recommend your provider for participation by writing to:

Provider Recruitment
Davis Vision
159 Express Street
Plainview, NY 11803

Member Discount Fee Schedule:*

Eye Examinations	**Member Cost:**
Routine Eye Examination with Dilation (Once Every 12 months)	15% off provider's usual and customary
Contact Lens Examination	15% off provider's usual and customary
Frames	
Priced up to $70 retail	$40
Priced above $70 retail	$40, plus 10% off the amount over $70
Spectacle Lenses	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Lens Options (Add to spectacle lens prices above)**	
Standard Progressive	$75
Premium Progressive	$125
Glass Lenses	$18
Polycarbonate Lenses	$30
High Index Lenses	$55
Polarized Lenses	$75
Blended Invisible Bifocals	$20
Intermediate Vision Lenses	$30
Photochromic Glass Lenses	$35
Scratch-resistant Coating	$20
Standard ARC (anti-reflective coating)	$45
Ultraviolet (UV) Coating	$15
Solid Tint	$10
Gradient Tint	$12
Plastic Photosensitive Lenses	$65
Contact Lenses	
Conventional	20% off Usual and Customary
Disposable/Planned Replacement	10% off Usual and Customary
LENS123® Mail Order Contact Lens Replacement Program	up to 50% off Retail Prices
Other Products	
Laser Vision Care Services	Up to 25% off Usual and Customary †
Non-Prescription Sunglasses	20% off Usual and Customary
Other Ancillary Products/Solutions	10% off Usual and Customary

Please Note: Special lens designs, materials, powers and frames may require additional cost.

† Or receive an additional 5% discount on any advertised specials -- whichever is lower. Please note that some providers have flat fees that are equivalent to these discounts.

BROKER APPOINTMENT LETTER

This serves to confirm that I, _____,
Authorized Representative of Group

have appointed _____
Broker / SS# or Tax ID #

to act as my Dental Insurance Broker and Conference Associates, Inc. to act as General Agent.

Going forward, any and all commissions should be paid to _____
Broker

on all group numbers listed below.

Group Numbers:	Group Numbers:
_____	_____
_____	_____
_____	_____

Kindly furnish _____, with any information that
Broker

they may require, as long as it falls within HIPAA Guidelines.

Sincerely,

_____,
Authorized Representative Signature

_____ _____,
Print Name Title

F-2282

Attestation

Group Information

_____
Group Name

A. Employer Premium % Contribution *

Please indicate the total number of employees and the employer contribution toward the following employee classifications below.

Classification	Employer % Contribution	Total # of Employees
Single		
Two Party		
Family		

**Must attach a copy of the most recent quarterly NYS-45.*

B. Gender

Please list the total number of employees enrolling and the breakdown by gender.

Male	
Female	
Total	

C. Prior Coverage**

Please indicate your group's prior coverage with another dental insurance carrier and the length of such coverage:

_____ _____
Prior Insurer Length of Coverage

***Must attach proof of prior dental insurance coverage (i.e. most recent vendor invoice).*

I, _____, _____ (Name,Title), hereby certify that the information contained herein for the period _____ (Indicate Contract Year), is accurate, complete and truthful. I understand and agree that any misrepresentation concerning this information will constitute a breach of my agreement with (Healthplex, Inc.), (Healthplex Insurance Company), (Dentcare Delivery Services, Inc.), (International Healthcare Services) and will result in the immediate termination of my group's policy.

_____ _____
Signature Date

_____
Name

_____
Title

If you have any questions or need assistance, please contact the Sales & Marketing Department at 800 468-0466.
Please return completed form to:

Attn: Sales & Marketing
Healthplex, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553-3608

HEALTHPLEX
THE DENTAL BENEFIT EXPERTS

DENTCARE
DELIVERY SYSTEMS, INC.

Send Completed Form To:
Dentcare Delivery Systems, Inc.
333 Earle Ovington Blvd., Suite 300
Uniondale, New York 11553-3608
P 800-468-0466 • F 516-228-9572

Small Business Group Application

Employer Information

Company Name				Group #	
Address	Suite #	City		State	Zip Code
Contact Person	Title			Phone	

Group Enrollment Census				Email Address:	Effective Date
Single	Two Party	Family	Total Enrollment		

Monthly Premium Rates

Single:$33.50 Two Party:$65.00 Family:$87.50

Payment Options

Check

Check enclosed in the amount of $_____ payable to Dentcare Delivery Systems, Inc. representing initial month's premium.

Credit Card - An Additional $5.00 processing fee will be added to recurring monthly credit card charges

☐ Visa ☐ Mastercard ☐ Discover → ☐ Initial monthly charge ☐ Recurring monthly charge (check one or both)

Name on Card_____

Card Number_____Exp. Date_____

Direct Debit

☐ Direct Debit **Allow 30 days for processing. First payment must be made by check.*

Routing Number	Account Number
Financial Institution	
Name on Account	

Checklist of Enclosures

☐ Signed Group Application.
☐ Initial monthly premium payment by check (enclosed) or credit card.
☐ Group Enrollment form(s) for each employee.
☐ Enrollment data provided electronically, if applicable.
☐ Most recent NYS-45 Quarterly Tax Report.

By signing below, I acknowledge that I have read and agree to the terms and conditions on the reverse side.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Broker Information

Broker/Agent	Company Name	SSN/Tax ID#
Broker/Agent	Company Name	SSN/Tax ID#

-OVER-

Plan Selection

☐ CapDent	☐ CapDent Plus	☐ Select	☐ Select Plus	☑ Omni	☐ Comprehensive Voluntary
Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	Minimum Enrollment of 3 Employees	Minimum Enrollment of 2 Employees	☐ Low Option ☐ Medium Option ☐ High Option ☐ High Enhanced Option

Supplemental Information (Internal Use Only)

Age Limits	Age Ends on	Ortho Age	End of Calendar Year
_____/_____	☐ Birthday ☐ End of Month		☐ Yes ☐ No ☐ End of Month

Benefits are per: ☐ Contract Year ☐ Calendar Year

Assignment of Benefits: ☐ Yes ☐ No

Billing Period: ☐ Monthly ☐ Quarterly ☐ Annually

Billing Format: ☐ Paper ☐ Email ☐ FTP

Term of Agreement: ☐ 12 ☐ 24 ☐ 36

Days to Renew: ☐ 30 ☐ 60 ☐ 90

Claims Group

Vision

☐ V0 - No Vision ☐ V2 - Comprehensive Funded II ☐ V4 - Designer Materials

☐ V1 - Comprehensive Funded I ☐ V3 - Affinity Hybrid ☐ V5 - Comprehensive Designer ☐ VV - Embedded

Major Service Waiting Periods

☐ None ☐ 12 Months ☐ 24 Months

Dentcare Delivery Systems, Inc.
Account Representative

Terms and Conditions

Dental Plan Information

This plan is underwritten by Dentcare Delivery Systems, Inc. The Group Dental Agreement can be found on the Healthplex, Inc. (Third Party Administrator) website. A hard copy is available upon request. It is understood and agreed that all benefit levels, exclusions and limitations are detailed in the Certificate of Insurance, and the general provisions of this Agreement are detailed in the General Dental Agreement. It is further understood that, upon the applicant signing this application and upon its acceptance by Dentcare Delivery Systems, Inc., the Group Dental Agreement is binding between the applicant and Dentcare Delivery Systems, Inc.

Application, enrollment cards and payment must be received by the 20th of the month for coverage to begin on the first of the following month. The payment can be made by direct debit, credit card (Visa, Discover or MC) or ACH wire.

Minimum Participation Requirement

CapDent and Select: The group agrees to maintain a minimum of two (2) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.

CapDent Plus and Select Plus: The group agrees to maintain a minimum of three (3) enrollees in this dental plan for the entire coverage period. If minimum enrollment is not maintained, it is understood that the group's policy will be cancelled at the end of the policy term.

Comprehensive Voluntary: Groups with ten (10) or more employees may offer multiple options and are not required to select a single option. Groups with less than ten (10) employees must select a single option. Groups with less than three (3) employees may not select the High or High Enhanced Option.

Payment Authorization

Should recurring payment of monthly premium be made through the credit or debit card option, the group authorizes Dentcare Delivery Systems, Inc. to charge its corporate credit or debit card automatically each month on a recurring basis for the 12-month period. Should payment be made through direct debit, the group authorizes Dentcare Delivery Systems, Inc. to directly debit the designated bank account each month.

There is an additional monthly premium of $10.00 for each family member in excess of five (5).

Cancellation Policy

If dental coverage lapses due to non-payment of premium, it is understood that the group's policy will be terminated in accordance with NYS insurance law.

Renewal Conditions

The group is aware that this dental plan is an annual policy. Upon renewal, Dentcare Delivery Systems, Inc. reserves the right to change monthly premium rates.

-OVER-

DENTCARE
DELIVERY SYSTEMS, INC.

Dental Plan Enrollment Form

Employer Information

Employer's Name	
Group Number	Effective Date

Member Information

Last Name	First Name		M.I.	SSN/ID Number	
Address	City			State	Zip Code
Home Phone	Work Phone		Gender	D.O.B.	
Other Dental Coverage: ☐NO ☐YES	Name of Other Plan (if applicable):				

Plan Selection

☐ CapDent Select *	☐ CapDent Plus New York*	☐ EZ Choice	☐ Omni PPO	☐ Comprehensive Voluntary*
☐ CapDent Select Plus*	☐ CapDent Plus Ultra*	☐ EZ Choice Plus	☐ CapDent NY*	☐ *Low Option* ☐ *Medium Option* ☐ *High Option* ☐ *High Enhanced Option*

Coverage Selected

☐ **Single** ☐ **Two-Party** ☐ **Family**

Dental Selection

Dentist Name	**Dentist Site Code**	***For Managed Care Plans - Please choose one Primary Care Dentist from the CapDent Directory - One Per Family**

Dependents To Be Covered - Spouse, Domestic Partner & Unmarried Dependent Children under 19 years of age/25 if Full-Time Student. Attach Student Documentation to Enrollment Form.

Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
*Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
*Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.

***There is an additional monthly premium of $10.00 for each family member in excess of five (5).**

I agree to maintain enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a 12-month period.

Signature	Date

Broker Information

Broker Name	SSN/Tax ID #

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

"PLEASE PRINT OR TYPE ALL INFORMATION"

DENTCARE DELIVERY SYSTEMS, INC.

333 Earle Ovington Blvd., Suite 300 ◆ Uniondale, New York 11553-3608

P 800-468-0608 (Press Option 1) ◆ F 516-227-0582 ◆ www.dentcaredeliverysystems.org

Healthplex Group Submission Checklist

- [ ] Broker Appointment Letter (printed on company letterhead)
- [ ] Attestation/Group Information form
- [ ] Group Application

  -All fields must be completed, including e-mail address.

  -Payment information must be included, or a binder check enclosed.

  -Must be signed by company owner or authorized plan administrator.
- [ ] Employee Applications for each enrollee.
- [ ] Most Recent NYS-45 Quarterly Tax Report attached.

Submit completed enrollment packets to:
Conference Associates, Inc.
180 East Main St., Suite 205
Patchogue, NY 11772
Fax: 1-631-654-0840
Email: UnderwritingCAI@ConferenceNY.com