

Dental Plans: What You Need to Know

What is a Dental Plan?

Most medical plans do not include coverage for dental services. Often, routine dental services are covered through a separate plan.

Like medical plans, most dental plans have certain defined out-of-pocket costs for members, like co-insurance, co-payments, and deductibles. These cost-sharing elements help control costs and keep plan premiums at affordable levels. However, dental plans differ in that they typically reimburse plan participants based on the “class of service.” For example, preventive and diagnostic services are often covered at 100% of the cost of the procedure, basic restorative services (such as fillings) may be covered at 80% and plan participants must pay more for major services such as crowns, which are covered at a lower rate, such as 50%.

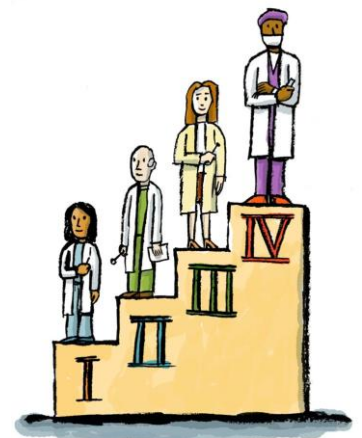


In addition, there may be limitations on the number of times you can receive a procedure (for example some plans cover up to two cleanings a year) and your age (some services will be reimbursed for children, but not for adults, or vice versa). In addition, most dental plans have an annual maximum that they will pay for care in a plan year (which may be different than a “calendar year”). Once the annual maximum is reached, the plan will not cover any additional services until the start of the next plan year. If you only need routine care, such as exams, cleanings, and x-rays, you probably won’t reach your annual maximum. However, if you need complex dental services, you may reach your annual dollar limit.

What is a “class of service”?

Dental plans usually characterize the type of dental care you receive into a “class of service.” The four typical classes of service depend on whether the treatment is considered to be diagnostic and preventive, basic restorative, or major and complex. A separate class applies to orthodontic procedures when covered by the plan.

- **Class I:** Diagnostic and preventive care, such as cleanings, exams and x-rays. These services are usually covered in full for in-network care (100%).
- **Class II:** Basic restorative care, such as fillings, periodontal work and root canals are typically reimbursed at a lower rate — 80% is common among many dental plans).
- **Class III:** Major restorative care, such as crowns, bridges and dentures are often covered at 50%.
- **Class IV:** Orthodontia, such as braces. This class of service usually has a separate lifetime maximum, which applies to the entire course of treatment, and is not part of your annual dollar maximum, which applies to all other dental services. Not all plans provide coverage for orthodontia. Those that do may limit orthodontia services to plan members under the age of 19.



Your plan's actual provisions may be different. Be sure to check your dental plan booklet or your insurer's website, or call your insurer so you can understand how your plan works and what types of cost-sharing elements you can expect.

Are there coverage limits?

Dental plans generally set an annual limit on the amount of dollars that are spent for your dental care. In addition, there is usually a separate lifetime maximum that applies to orthodontic procedures, such as braces.

Services may have frequency limits. Other limitations may apply as well:

- A limit on the number of exams, cleanings and bitewing x-rays that will be covered by the plan each year.
- A limit (usually 36 or 60 months) on how often a full series of x-rays will be covered.
- Time limits on the replacement of crowns, prosthetics (bridges, dentures and implants).
- A waiting period, or even an exclusion, may apply for the replacement of teeth lost prior to coverage.
- Many dental plans include an alternate benefit provision. This means that if your dentist proposes a dental service, the plan may cover another lower-cost dental service that provides a professionally acceptable result. You have the choice to get the original service, but if you do, your out-of-pocket costs will be higher. For example, under an alternate benefit provision, a plan may cover a:
 - Silver filling (amalgam) instead of the higher-cost composite resin (tooth-colored) filling on a back tooth.
 - Large filling (silver or white material) on a tooth instead of a full coverage crown.

Like medical plans, dental plans may not cover every dental service that may be suggested by your dentist. For example, some plans may not cover implants. In addition, services for strictly cosmetic reasons, such as teeth whitening, are rarely covered by dental insurance. However, discounts for these services may be available if you're in a dental discount plan or if network discounts (negotiated rates) extend to services not covered by the plan.

What Are the Different Types of Dental Plans?

Dental plans are set up similarly to medical plans. Most have a network of contracted providers that offer discounted services based on rates negotiated by the plan. Your choice of providers and your out-of-pocket costs will depend on the type of plan you have.

Dental Health Maintenance Organization (DHMO)

What is it?

In a DHMO, just like a medical HMO, you receive all your care from providers in your plan's network. When you join a DHMO, you select a primary care dentist who coordinates your care, and who refers you to specialists if needed. When you need care, you must visit your primary care dentist first. There's generally little or no paperwork for you if you belong to a DHMO. You simply pay your co-payment and your deductible (if you have one) when you visit your network dentist. DHMOs often do not have an annual dollar maximum on coverage.

What are my costs?

In a DHMO, you will generally have a specific co-pay for services. You may also have to meet a

deductible. But, your out-of-pocket costs are usually lower in a DHMO than with other dental plans as long as you stay in-network. If you get non-emergency care out-of-network, you will usually have to pay the full cost of the dental visit or service. And that may become very expensive.

Dental Preferred Provider Organizations (DPPO)

What is it?

In a DPPO, just like a medical PPO, you have the choice of using providers inside or outside your plan's network. You don't need to choose a primary dentist, or get referrals to see specialists. But, if you do go out-of-network, your costs will usually be higher. You won't have to pay the full cost of your care, but you'll pay a bigger share.

There's not much paperwork in a DPPO if you stay in-network. You simply pay your co-payment or co-insurance up front when you visit your dentist, and your dentist in turn sends claims directly to your insurer. But, if you go out-of-network, you may need to pay the dentist in full yourself, and then submit the claim to your insurer to be reimbursed.

What are my costs?

In a DPPO, you will generally have a modest deductible. You will also usually pay co-insurance, which is a percentage of the cost of the service. The amount of co-insurance you pay depends on whether your dentist is in the network or not, and the class of service you receive.

In some DPPOs, the amount that your plan pays for out-of-network care is the same as the contracted rate that they pay their in-network dentists. Other plans may base their out-of-network reimbursement on the "recognized charge," or "recognized amount," which is the amount that dentists in the area generally charge for the same service. But either way, if your out-of-network dentist charges more than your plan allows, you will likely have to pay the difference yourself.

In fact, if you go out-of-network for your care, you will usually pay more. That's because:

- Dentists outside your network have not agreed to any set rate with your insurer, and may charge more.
- Your dental plan may require higher co-insurance for out-of-network care. So, if you normally have to pay 20% of the cost in-network, you may have to pay 40% out-of-network.
- You'll also have to pay any difference between your plan's recognized charge and what the provider charges.

Let's look at some examples, based on what a typical DPPO may cover.

Here is an example of a basic DPPO plan:

| | In-Network Services | Out-of-Network Services |
|--|---------------------------|---------------------------|
| Your Annual Deductible | \$50 combined | |
| Your Annual Benefit Maximum | \$1,500 combined | |
| Class I (Diagnostic & Preventive) | Plan pays 100%/You pay 0% | Plan pays 80%/You Pay 20% |
| Class II (Basic Restorative) | Plan pays 80%/You pay 20% | Plan pays 60%/You pay 40% |

| | In-Network Services | Out-of-Network Services |
|--------------------------------------|--|---------------------------|
| Class III (Major Restorative) | Plan pays 50%/You pay 50% | Plan pays 40%/You pay 60% |
| Class IV (Orthodontia) | Plan pays 50%, with a separate lifetime maximum of \$1,000 | |

In this case, you can see that for most services, you will pay a higher percentage of the cost out of your own pocket if you go to an out-of-network dentist.

Let's say you need a new crown, which is a "Class III," or major restorative service. How much will it cost?

In this example, providers in your plan's network have agreed to a \$600 rate. One particular out-of-network provider, on the other hand, charges \$1,200 for the service, and your plan's "recognized maximum charge" is \$1,000. We'll assume you've met your deductible already.

| Class III (Major Restorative Care) | In-Network Dentist | Out-of-Network Dentist |
|--|--------------------------------|--------------------------------|
| Coverage: | Plan pays 50%/You pay 50% | Plan pays 40%/You pay 60% |
| Your Dentist's Charge | \$600 | \$1,200 |
| Your Plan's Negotiated or Recognized Rate | \$600 | \$1,000 |
| Your Plan Pays | 50% of negotiated rate = \$300 | 40% of recognized rate = \$400 |
| You pay | 50% co-insurance = \$300 | 60% co-insurance = \$600 |
| Your balance bill (the difference between your plan payment and co-insurance, and what the dentist charges) | \$0 | \$200 |
| Your Total Cost | \$300 | \$800 |

So, in this case, if you go to this out-of-network dentist, you will have to pay:

- A higher percentage of the cost of the service, plus
- The difference between your plan's recognized charge and the amount that your dentist charges.

This will equal an extra \$500.

It's also important to keep track of what your plan pays. Remember, in this case, you have a \$1,500 annual benefit maximum. So, if you go to an out-of-network dentist, your plan will pay \$400 instead of \$300 for your care, and you'll be \$100 closer to your coverage limit.

Again some plans may not require you to pay higher co-insurance for out-of-network care. If you pay 50% of the cost in-network, you'll also pay 50% out-of-network. But that doesn't mean your costs will be the same for in-network and out-of-network care. Why? We'll look at the same example for your crown.

| Class III (Major Restorative) | In-Network Dentist | Out-of-Network Dentist |
|---|---------------------------|---------------------------|
| Coverage: | Plan pays 50%/You pay 50% | Plan pays 50%/You pay 50% |
| Your Dentist's Charge | \$600 | \$1,200 |
| Your Plan's Negotiated or Recognized Rate | \$600 | \$1,000 |
| Your Plan Pays | \$300 | \$500 |
| You pay | 50% co-insurance = \$300 | 50% co-insurance = \$500 |
| Your balance bill (the difference between your plan's payment and co-insurance, and what the dentist charges) | \$0 | \$200 |
| Your Total | \$300 | \$700 |

In this case, even though your co-insurance rate is the same for in-network and out-of-network providers, your costs are higher for out-of-network care because, in this example, this provider charges more than the plan's recognized rate. You have to pay the difference between that charge and the amount your plan covers. Also, as you can see in this example, in-network providers often charge lower fees that they have negotiated in advance with your dental plan.

Dental Indemnity Plan

What is it?

With a Dental Indemnity Plan, you can choose any dentist you want, and you don't need a referral to visit a specialist. There is no network of providers in this type of plan.

What are my out-of-pocket costs?

You will generally be responsible for a deductible and co-insurance for services. Most indemnity plans also have an annual benefit maximum.

Discount Dental Plan

What is it?

A discount dental plan *is not* insurance. Instead, your plan contracts with a network of providers who have agreed to provide you with care at discounted rates. Since these plans are not insurance and they generally provide discounts on all services, these discount plans may also give discounts on cosmetic services, or other services that may not be covered by a dental plan.

What are my costs?

In a discount dental plan, you cover the full cost for every service. The plan does not pay for any services you receive. You pay for all of your care at the plan's discounted rates.

How Can I Avoid Surprise Costs?

It's always important to ask about your costs up front so that you're not confused by a dental bill.

Before you receive a comprehensive treatment, ask your dentist to provide you with a pre-treatment estimate that includes details on the services and how much each service will cost. Then, ask your dentist to submit the treatment plan to your insurer for an estimate of payments by the plan (sometimes called a "claims review"). Your dentist may have to submit x-rays or supporting documents so that the service can be pre-approved.



Your insurer will give you an estimate that shows:

- How much the plan will pay
- Your share of the dentist's charges
- The amount remaining toward your deductible
- How close you are to your benefit maximum

It's important to remember that this is not a guarantee of payment – it is only an estimate. The final payments will depend on whatever dental work is actually performed. But, it will give you a ballpark of how much you may owe.

Your Action Plan: Finding the Dental Plan for You

When you choose a dental plan, and you intend to stay in-network for your care, be sure that the type of plan you choose covers the services you need and includes providers that you want to see. If you select a DHMO plan, you can only use in-network providers for routine care.

Before choosing a plan, ask your dentist or insurer these questions:

- Is your current dentist in the network?
- How many network dentists are in the network in your area, and are all specialties you may need represented? How many of these dentists are close to where you live or work?
- Do they have a list of services in each class of service? And, what is your co-insurance for each class of service?
- Do you need pre-authorization for certain services? Which ones?
- Do they have a simple explanation of plan benefits and limits that they can send you or provide online?

After choosing a plan, and visiting a dentist, if you need a significant amount of work:

- Ask your dentist for a treatment plan in advance, including the estimated charges, and submit it to your insurer for a pre-treatment estimate, which shows potential plan payments and your out-of-pocket costs.
- Ask your insurer how long the pre-treatment estimate is valid, and whether you will be balance-billed for any of these services.

Every dental plan is required to provide you with a written description outlining all of its service coverage, requirements, limitations, and exclusions. These are often available on your insurer's website. Read these carefully, and ask questions about anything you don't understand.

And most importantly – remember that you are your own best advocate. Speaking up and asking questions up front will help you get the care you need and avoid being confused by a dental bill.

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