



**Do you really understand your dental insurance and its benefits?**

**The Purpose of Dental Plans:**

Employers and other plan's sponsors offer dental benefits for a number of reasons, including promotion of oral health, attraction, and retention of employees.

Regardless of why the plan is offered, its intent is the same: to help individuals by paying for a very small portion of the cost of their dental care.

Mostly all dental benefit plans are the consequence of a contract between the plan supporter (usually an employer or a union) and the third-party (usually an insurance company). **For this reason, concerns about your dental plan should first be directed toward your plan's sponsor.**

Limitations in coverage are the result of the financial commitment the plan's sponsor has agreed to make and the benefits the third-party payer will offer in exchange for that commitment.

Treatment decisions must be made by you and your dentist. **While dental benefit coverage should be taken into account, it should not be the deciding factor in your choice of treatment.**

**Determining Your Dental Benefits:**

**You should know how your plan is designed, since this can affect significantly the plan's coverage and your out-of pocket expense.**

Some employers now offer more than one dental plan to their employees. In fact, the right to choose between two plans could be the law in your state. To understand and make decisions about your dental benefits, it is important to remember that dental plans are often very different. To make the best decision for you and your family, you should understand exactly how the different kinds of dental benefit plans work and how they derive their cost savings.

There are many ways to design a dental benefits plan. Although the features of plans may differ somewhat, the most common designs can be grouped in one of the following categories:

**Direct Reimbursement** programs reimburse patients a percentage of the dollar amount spent on dental care, regardless of treatment category. This method typically does not exclude coverage based on the type of treatment needed and allows the patients to go to the dentist of their choice.

**Usual, Customary and Reasonable (UCR) programs** usually allow patients to go to the dentist of their choice. These plans pay a set percentage of the dentist's fee to the plan administrator's reasonable or customary fee limit, whichever is less. These limits are the result of a contract between the plan purchaser and the third-party Payer. Although these limits are called customary, they may or may not accurately reflect the fees that area dentists charge. There is wide fluctuation and lack of government regulation on how a plan determines the customary fee level.

**Table or Schedule of Allowance** programs determine a list of covered services with an assigned dollar amount. That dollar amount represents just how much the plan will pay for those services that are covered. Most often, it does not represent the dentist's full charge for those services. The patient pays the difference.

**Preferred Provider Organization (PPO)** programs are plans under which contracting dentists agrees to discount their fees as a financial incentive for patients to select their practices. If the patient's dentist of choice does not participate in the plan, the patient will have a reduction or complete loss of benefits.

**Capitation** programs pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or patient. In return, the dentists agree to provide specific types of treatment to the patients at no charge (for some treatments there may be a patient co-payment). The capitation premium that is paid may differ greatly from amount the plan provides for the patient's actual dental care. These plans typically only allow the patient to be listed with one dentist at a time and have limitations of what types of procedures the patients can receive.

Your plan sponsor should be able to explain the individual design features of your plan. Design features to understand include: exclusions, limitations, patient co-payments and

annual or lifetime benefit maximums. **The American Dental Association has received numerous questions and complaints from patients regarding their dental benefits. To correct some of this confusion about dental coverage, the following questions and answers are provided by American Dental Association to help you better understand your dental benefits.** If you have additional concerns or questions, they should be directed to your group benefits department. Your personal dentist may also be able to explain dental benefit issues and options for you.

*My dentist recommends a treatment that my plan will not pay for. Does this mean the treatment really isn't necessary?*

It is common for dental plans to exclude treatment that is covered under the company's medical plans. Some plans however, go on to exclude or discourage necessary dental treatment such as sealants, pre-existing conditions, adult orthodontics, specialist referrals and other dental needs. Some also exclude treatment by family members. **Patients need to be aware of the exclusions and limitations in their dental plan but should not let those factors determine their dental plan, and should not let those factors determine their treatment decisions. Many technologies allowing for better treatment and care are not usually covered by dental insurance.**

*Who is covered by my dental benefit plan? What does my dental plan cover?*

This information should be provided by the plan purchaser, often your employer or union, and by the third-party payers. In order that you and the dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles co-payments, and co-insurance factors explained to you. This should be communicated in advance of treatment. The plan document should describe the benefit levels of the plan and list any exclusions or limitations to that coverage. This document should also specify who is eligible for coverage under the plan and when that coverage is in effect.

Your dentist cannot answer specific questions about your dental benefit or predict what your level of coverage for a particular procedure will be. This is because plans written by the same third-party payer or offered by the same employer may vary according to the contracts involved. Therefore, you should ask the plan purchaser or the third-party payer to answer your specific questions about coverage.

***My dentist is not on the list of dentist provided by my employer. Can I still go to him or her for treatment?***

You can always go to the dentist of your choice. The question is whether you will have benefit coverage for the treatment you receive if a dentist who is not listed on the plan provides it. This depends on contractual agreements between the plan purchaser (often your employer), the dentists on the list and the plan administrator. Under certain contracts, such as a PPO ( Preferred Provider Organization) program, patients are given a financial incentive to go to certain dentists, but do receive some level of dental benefit, regardless of the treating dentist. Other plans, such as capitation programs, do not provide any benefit coverage for treatment given by non-participating dentists. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of a dentist, with comparable benefits and equal premium dollars.

***My spouse and I each have a dental benefit plan. Whose program covers whom? Can we decide whose program covers our children?***

Your program covers you. Your spouse's program covers him or her. You may have additional coverage from each other's programs if they cover spouses and dependents. In no case should the benefit derived from the two coordinated programs exceed 100 percent of the dentist's charges for treatment.

The primary plan for covering your children depends on the regulations in your state. Most plans use the birthday rule (spouse with birthday occurring earlier in the calendar year is primary). Others consider the father's plan primary. The American Dental Association has recognized the birthday rule as the preferred method for coordinating benefits, but which rule applies to your family depends on the language in your dental plan documents.

If you have two or more potential sources of coverage, check the coordination of benefits available.

***Does my dentist have to send a description of my treatment plan to the third-party payer before I have any dental work done?***

Third-party payers often request a predetermination of benefits on certain treatment plans. Usually this means a dental consultant will review your dentist's treatment plan and determine what benefits your plan will provide. But this predetermination is not a guarantee of payment. You may want to review your benefit prior to receiving treatment, but the final treatment decision should be a matter between you and your dentist, regardless of your benefit.

There may be a provision in your plan that will deny your normal dental benefit, or reduce the level of coverage if you do not submit the treatment plan purchaser and the plan administrator and is contrary to the policy of the American Dental Association. The American Dental Association is opposed to any dental clause that would deny or reduce payment to the beneficiary, to which he/she is normally entitled, solely on the basis or lack of preauthorization.

### **ASCENT DENTAL'S INSURANCE PHILOSOPHY**

It is Ascent Dental Group's policy not to allow dental insurance to direct treatment decisions. Dental insurance is a business which ultimately profits. We will file and help you fight your insurance for reimbursement of treatment as a courtesy to you and will also plan treatment to the best of our abilities to maximize your insurance. We do not know what the insurance will cover or deny. We simply make an estimated guess on what they will pay. They always seem to throw surprises at us with denials we don't expect. In no way does a denied claim mean you didn't get the best care possible from Ascent Dental Group, it simply means the dental insurance company does not want to pay for it. Dental insurance companies are made up of business people who sit at a desk and look at paperwork. They do not know or understand treatment decisions clinicians face and make daily. If you have any questions about your dental insurance we will be glad to answer it, but also know we do not directly work for your dental insurance. After our second time of filing the claim for you and its denied, all denied claims must be paid in full by the guarantor of the account at Ascent Dental Group.

**Dental Insurance - Does it really make sense?**

**Would you pay \$160,000 per year  
to insure your \$320,000 house?**



**Would you pay \$500 per year  
for \$1,000 of dental insurance?**

**Here's a typical group dental insurance plan ...**

Premium = \$42 per month = \$500 per year  
(rate shown is for an individual)  
Maximum Annual Benefit = \$1,000

Preventive Services:	100%
Restorative Services:	80%
Major Services:	50%

**Let's say you need an \$800 root canal (restorative) ...**

You first pay the \$50 deductible.  
The dental insurance pays \$600 (80% of \$750).  
You then pay the remaining \$150 (20% of \$750).

You've now paid \$500 for the dental insurance, \$50 for the deductible, and \$150 for the root canal. That means you've paid out a total of \$700 to receive \$600 from the dental insurance. Does it really make sense?

**What if you didn't need dental care** other than maybe a couple of cleanings during the year? And, how many people really have two cleanings each and every year? If you did have those two cleanings (about \$100 each), you'd still have \$300 in your wallet instead of having paid out the entire \$500 to the dental insurance company.

**There's a lot more to this equation ...**

The [American Dental Association](#) tells us that "almost 35% of people with dental plans do not receive dental care in a given year. Of those who do receive dental care, most incur dental care of less than \$300 annually."

We can now make a case for dental insurance, no dental insurance, partial self-funding by the employer, no partial self-funding and voluntary dental insurance. Which one fits you?

**One thing is clear ...**

As dental care plans, dental care and dental insurance costs continue to increase along with health insurance, gas prices, food prices and everything else, we should begin looking at things differently. Would taking another look at dental insurance be the place to start?