Frequently Asked Questions About Dental Insurance

Many patients are fortunate to receive benefit packages from their employer. Often these "perks" include dental insurance. The following information will help to learn more about your dental benefits and how they may assist you in paying for your dental treatment.

Why are my dental benefits better than my spouse's even though they are both from the same insurance company?

Whenever your employer buys a dental insurance policy from an insurance carrier there are several things to consider, most importantly cost. There are as many insurance policies as there are employers. The price of an insurance policy determines the level of coverage that you get. Insurance carriers sell "cafeteria" style policies allowing each employer to choose what will and won't be covered and how much to pay for covered procedures. In other words, "you get what you pay for".

I have already used my $1500 in dental benefits and the year is not over. Shouldn't that money provide all the dental care I need for a year?

Unlike medical plans, dental plans have a yearly maximum that your employer will pay out per year. Sadly, the average yearly maximum has been the same since before 1960. There have been no increases for inflation or the rising costs of care in over 50 years! If you have one or more teeth that need attention or it has been a little while since you have had dental care, it is unlikely that $1500 will cover all needed expenses. Your dental insurance is meant to help off-set some of the cost for your care but is not meant to cover all care even in the best of circumstances. Consider today's dental plans as a coupon for $1500 with multiple conditions for redemption and an expiration date.

I need a cleaning 4 times a year but my insurance company will only pay for 2. Shouldn't the insurance company pay since it is "clinically necessary" for me?

Another way for employers to limit their costs associated with dental benefits is to set up rules for how often procedures are to be paid. Common examples of frequency limitations include: 1 cleaning every 6 months and x-rays once a year. Dental policies are not governed with the "clinically necessary" model used in medical policies but by the framework rules (frequency, quantity, reimbursement levels) set by the employer when the policy was bought. *These money-minded restrictions are not meant to sway the patient away from needed services but to simply limit the employer's financial responsibility.*

How does my insurance company determine how much to pay on my dental claims?

When your employer bought your dental policy the price of the policy was calculated based on the "ceiling amount" the carrier would pay for each procedure. The term that insurance carriers use for this is *UCR* or Usual, Customary, and Reasonable. UCR is actually not one fee per procedure but a statistically gathered table of fees set up at percentile levels from 20-95% for each zip code in the United States. Almost all dentists set their fees at the 90-95th percentile for their given zip code. Many policies used in a given area are also set at the 90-95th percentile for the zip code for which the policy was bought which makes the 90-95th percentile what is truly Usual, Customary, and Reasonable for a zip code. However, the employer chooses the level (sometimes lower than 90th percentile) to set the dental policy just as maximums, frequencies, and covered procedures are chosen during the cafeteria style process. An employer who chooses to spend more money on a dental policy will have a more inclusive, higher percentile-paying policy resulting in less money coming from the patient's pocket.

I know all insurance policies are different but how do I know if my employer's is worth the money?

A typical policy will normally pay at the following percentages of the *Employer's Maximum Benefit Fee* (not the dentist's actual fees): 100% (exams, x-rays, cleaning, fluoride, sealants); 80% (silver fillings, root canals, deep cleanings, extractions); 50% (crowns, bridges, dentures). Currently, most policies pay about 65-70% for white fillings on back teeth due to a restriction called the *Alternate Benefit Clause* that many employers adopt to limit plan costs. Approximately half of dental policies have some coverage for implants and implant crowns. Most policies exclude coverage for tooth replacement if the tooth was missing before you went to work for your employer and for cosmetic work including front tooth crowns and veneers.

Why does my insurance not pay for all of my cleaning visit even though it says it pays at 100%?

The 100% clause in your policy relates to 100% of the charge that your employer chose when the policy was bought rather than the dentist's actual fee (which is generally set at the 90-95% percentile level explained above). The fine print in your dental policy will always read 100% of the "Maximum Allowable Charge as Outlined in the Plan Benefit Booklet". An employer can choose to lower the cost of a dental policy by choosing a lower percentile such as 70 or 80%. The difference between what the insurance will pay on the employer's behalf and the dentist's charge would be the patient's responsibility rather than the employer's thus lowering the employer's benefit plan costs.

My employer has several different dental benefit options. What is the difference between a PPO, a DMO, and an indemnity policy?

There are 3 types of employer provided insurance: PPO, DMO, and indemnity. A Preferred Provider Organization (often referred to as a PPO or PDP) is a type of insurance that gives patients a choice as to where to have dental care. A patient may chose from the PPO list to find a provider that has a contract with the insurance company or go to any dentist he or she chooses. The insurance policy rules and level of reimbursement are usually the same whether you use a network provider or not (due to Texas State law). The advantage is that the provider's fees are set by the PPO insurance contract at a lower level and therefore the patient's copays may be slightly smaller.

A DMO or Dental Maintenance Organization is not a true insurance but a system where a patient is assigned to a dental clinic near the patient's home or work. The patient is required to use that dental provider and in return receives dental care for copays or at prearranged discounts. No claims are filed. If the patient needs to see a specialist, the assigned dentist determines necessity and gives a referral to a contracted specialist. The model is very similar to the HMO model except that there are few dental providers that contract with Dental Maintenance Organizations because the fees that insurance companies set for participating dentists are lower than the actual cost of the care. Therefore a patient's access to care is often reduced resulting in frustration and loss of use of the dental policy.

An Indemnity policy is similar to a PPO policy except that there is no network with which to contract. The patient chooses a dental provider and the insurance company pays based on the rules set up for the policy.

I am self-employed. Is there any good dental insurance for me?

Unfortunately, since dental insurance is an employer benefit that is funded by the employer, insurance companies do not offer those types of policies to individuals. The insurance company is in business to make money. In order for an individual policy to be "money-making" to the insurance company, it must be paid more from the policy holder than it pays out in benefits. Therefore individual insurance plans are usually "money-losing" for the patient. However, the government has recently passed some laws to help the self-employed. A health savings account (HSA) is an account with tax advantages in which you may set aside money for health and dental expenses. Contact your accountant or benefit agent for information. Morgan Dental also offers a 5% cash discount for those without dental insurance that pay with cash or check.