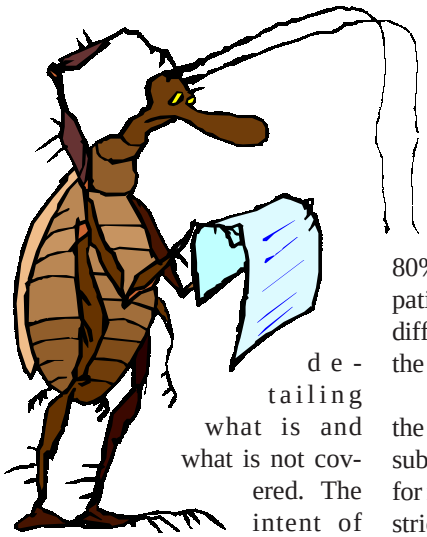
AAP PATIENT PAGE

UNDERSTANDING DENTAL INSURANCE

Feeling "antsy" about your dental plan?

Sorting through the complexities of insurance plans can be difficult. However, ultimately, patients are responsible for knowing what their coverage is. Plan sponsors (usually the employer) are required to provide booklets detailing what is and what is not covered. The intent of all dental insurance is the same: to help pay a *portion* of the cost of dental care. Virtually all plans limit the yearly dollar amount that will be paid.



Basically, three types of dental benefit plans exist: traditional, direct reimbursement and managed care.

Traditional or "fee-for-service" plans allow patients to seek care from the general dentist or specialist of their choice. Traditional plans provide benefits based upon either a fee schedule or a percentage of what the insurer determines to be usual, customary and reasonable (UCR) fees. Typically, most periodontal services are reimbursed at 80% of the UCR fee. In addition, patients may be responsible for the difference between the UCR fee and the dental office's regular fee.

In a direct reimbursement plan, the patient pays the dental bill and submits the receipt to the employer for reimbursement. There are no restrictions other than the limitation on the total dollar amount that will be paid.

Managed care plans restrict your choice of dentists. They will only pay maximum benefits if the services are provided by a dentist in their plan. Like traditional plans, they limit the type and frequency of care and require the patient to pay the difference between the covered amount and the dentist's fee.

With all types of plans, it is important to evaluate other plan components, such as deductibles (the amount you pay personally before the dental insurance plan kicks in); copayments (your share of the financial responsibility for a specific dental service); limitations (such as waiting periods before coverage begins); exclusions (treatments not covered such as implants or preexisting conditions); and annual or lifetime maximum benefit (dollar limit of the insurer's financial responsibility).

If a plan doesn't cover a procedure that is recommended by your dentist, this does not mean the treatment isn't needed. It just means the plan doesn't cover it. Periodontal disease is a chronic disease that must be monitored closely. Talk with your dentist and periodontist about the treatment you need and ask about financing options. If you value oral health and keeping your teeth, the fact that your plan does not cover your treatment should not stop you from going ahead with that treatment. ✓

Common questions answered

What should I do if I have a concern or complaint about my dental plan? Dental benefit plans are the result of a contract between your employer and the insurance company. Limitations in coverage are the result of the financial commitment your employer has agreed to make and the benefits the insurance company will offer in exchange for that commitment. Your dentist often cannot answer specific questions about your dental benefit or predict what your level of coverage will be because plans vary according to these contracts. Therefore, your concerns should be directed to your employer (usually the human resource department or benefits manager).

Can I refer myself to a periodontist? Under traditional plans, you can see the dental specialist of your choice. Managed care plans are based on a "gatekeeper" model so you may need to be referred by your general dentist in order to receive coverage for specialty treatment. In some plans, there are economic drawbacks for the general dentist to refer patients to specialists. Check to see if your access to specialty care will be restricted when evaluating plans.

What happens if my periodontist is not listed under my managed care plan? Check to see if the plan has a "freedom of choice" or "point-of-service" option. These enable you to seek care from a practitioner of your choice. Under most plans, you will not receive full benefits if you select a practitioner not associated with the plan. Of course, you can always go to the dentist of your choice if you are willing to pay yourself. ✓

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