

Understanding Dental Insurance

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

Three types of dental benefit plans currently exist:

- **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 between 50 - 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.

Regardless of the type of plan you have, there are a number of terms you should familiarize yourself with, including:

- **Deductible** - the amount you pay personally before the dental insurance plan kicks in
- **Copayment** - 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
- **Annual or lifetime maximum benefit** - dollar limit of the insurer’s financial responsibility

It’s also a good idea to check 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. Otherwise, you can always go to the dentist of your choice if you are willing to pay yourself.

If a plan doesn’t cover a procedure that is recommended by your dentist, this doesn’t mean that the treatment isn’t needed; it only means that the procedure falls outside of the scope of coverage included in your plan. Limitations in coverage are the result of the financial commitment your plan sponsor or employer has agreed to make and the benefits the insurance company will offer in exchange for that commitment.

Periodontal disease must be monitored closely and may involve several treatments to manage your condition, so be sure to talk with your dental professional about the costs specific to your treatment plan. If using a dental insurance plan is not an option for you, many dental professionals offer financing options to help you receive the care you need.



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. 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) or plan sponsor.

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