

It's Important to Put Your Money Where Your Mouth Is

When most people think about health insurance, they think first about covering costs of treatment for serious medical conditions or accidents. That's a natural thing to do. But there's another type of insurance that's equally important to your well being—dental insurance. Because dental disease is so common, being protected by dental insurance and using it wisely are essential safeguards for you and your family.

There's a World of Difference Between Medical and Dental Disease...

Unlike medical disease, which can be both unpredictable and catastrophic, most dental ailments are preventable. Preventive care, including regular checkups and cleanings, is the key to maintaining your oral health. With regular visits to the dentist, problems can be diagnosed early and treated without extensive testing or elaborate and expensive procedures. That keeps the costs of dental care much lower than those of medical care. In fact, total spending for dental care is decreasing. In 1970, it made up 6.3 percent of total health care expenditures. But in 1991, dental care's share of health care spending was only 4.9 percent.

...And Between Medical and Dental Benefits

Medical insurance is designed primarily to cover the costs of diagnosing, treating and curing serious illnesses. This process may involve a primary care physician and multiple specialists, a variety of tests performed by doctors and laboratories, multiple procedures and masses of medications. Depending on the health, age and attitudes of people in the medical coverage group, costs can fluctuate widely.

Dental insurance works differently. Most dental coverage is designed to ensure that the patient receives regular preventive care. High quality dental care rarely requires the complex, multiple resources often required by medical care. A thorough examination by the dentist and a set of x-rays are all it usually takes to diagnose a problem. By and large, dental care is provided by a general practitioner, although some cases may require the services of a dental specialist. Because most dental disease is preventable, dental benefits plans are structured to encourage patients to get the regular, routine care so vital to preventing and diagnosing the onset of serious disease.

In fact, most dental benefits plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. By placing an emphasis on prevention, and by covering regular teeth cleaning and check-ups, Americans saved nearly \$100 billion in dental care costs during the 1980s.

Dental Insurance is Helping Keep America Healthy

The availability of dental insurance is the single greatest factor in helping you get the dental care you need. More than 48 percent of all Americans—113 million of us—are covered by privately financed dental insurance plans. This compares with just 12 million people who had such coverage in 1970. As a result of increased access to regular care and the widespread use of preventive measures, the incidence of dental decay has dropped sharply. Half of today's school children never have had a cavity.

Different Plans for Different Needs—Know the Differences

Consumers can choose from an assortment of dental benefits plans that accommodate a variety of needs and expectations. The following factors differentiate one plan from another:

1. the type of third party responsible for funding and administration of the plan;
2. the alternatives offered for selecting a dentist;
3. the structure used to compensate the dentist for services provided; and
4. the method by which benefits and payments are calculated.

Understanding these differences is essential to making an informed decision when selecting a plan and using the benefits.

1. Third Parties

Regardless of the dental benefits plan, there are usually three parties involved: you, the patient; the dentist providing care; and a third party with whom you or your employer contracts for coverage. If your options include a plan funded by your employer, you may have an administrator responsible for processing and payment of claims. The primary responsibility of the third party is to provide the financial foundation for your dental benefits plan. There are three types of third parties.

Dental Service Corporations. These not-for-profit organizations negotiate and administer contracts for dental care to individuals or specific groups of patients. Delta Dental Plan and Blue Cross/Blue Shield Plans are examples of this third party type.

Insurance Carriers. These for-profit companies underwrite the financial risk of, and process payment claims for, dental services. Carriers contract with individuals or patient groups to offer a variety of dental benefits packages, often including both fee-for-service and managed care plans.

Self-Funded Insurers. These companies use their own funds to underwrite the expense of providing dental care to their employees. The company pays for the dental costs of its employees, usually with limitations on services and fixed-dollar allocations.



2. Choosing a Dentist

Dental benefits plans can be categorized by the options offered for selecting a dentist. Some plans allow you the freedom to choose your own dentist, while others, in exchange for lower rates, limit your choice. These two alternatives are called open and closed panel plans.

Open Panel. This type of dental benefits plan allows covered patients to receive care from any dentist and allows any dentist to participate. Any dentist may accept or refuse to treat patients enrolled in the plan. Open panel plans often are described as freedom of choice plans.

Closed Panel. This type of plan allows covered patients to receive care only from dentists who have signed a contract of participation with the third party. The third party contracts with a certain percentage of dentists within a particular geographic area. There are two types of closed panel plans.

- **Preferred Provider Organization (PPO)** - This plan allows a particular group of patients to receive dental care from a defined panel of dentists. The participating dentist agrees to charge less than usual fees to this specific patient base, providing savings for the plan purchaser. If the patient chooses to see a dentist who is not designated as a "preferred provider," that patient may be required to pay a greater share of the fee-for-service.
- **Exclusive Provider Organization (EPO)** - This closed panel plan allows a particular group of patients to receive dental care only from participating dentists. Although there may be some exceptions for emergency and out-of-area care, if a patient decides to see a dentist which is not listed on the EPO panel, charges for service will not be covered by the plan. Because participating dentists are required to offer substantial fee reductions, many dentists elect not to participate in EPO-type plans. Under some benefits plans, participating dentists may be salaried employees of the EPO. An EPO contracts with a limited number of practitioners within a geographic area. Access to necessary specialized care can be restricted. The EPO also may limit the amount of services that a patient can receive in a given calendar year.

3. Paying the Dentist

When choosing a benefits plan, it is important to know who pays what to whom. Dental plans can be categorized into three types based on the compensation and treatment provided.

Indemnity Plans. This type of plan pays the dentist on a traditional fee-for-service basis. A monthly premium is paid by the patient and/or the employer to an insurance carrier, which directly reimburses the dentist for the services provided. Insurance companies usually pay between 50 percent and 80 percent of the dentist's fee for covered services; the remaining 20 percent to 50 percent is paid by the patient. These

plans often have a pre-determined deductible, a dollar amount which varies from plan to plan, that the patient must pay before the insurance carrier will begin paying for care. Indemnity plans also can limit the amount of services covered within a given year and pay the dentist based on a variety of fee schedules.

Capitation Plans. This type of plan provides comprehensive dental care to enrolled patients through designated provider dentists. A Dental Health Maintenance Organization (DHMO) is a common example of a capitation plan. The dentist is paid on a per capita (per head) basis rather than for actual treatment provided. Participating dentists receive a fixed monthly fee based on the number of patients assigned to the office. In addition to premiums, patient co-payments may be required for each visit.

Direct Reimbursement Plans. Under this self-funded plan, an employer or company sponsor pays for dental care with its own funds, rather than paying premiums to an insurance carrier or third party. The patient pays the dentist directly and, once furnished with a receipt showing payment and services received, the employer reimburses the employee a fixed percentage of the dental care costs. The plan may limit the amount of dollars an employee can spend on dental care within a given year, but often places no limit on services provided. Patients can select a dentist of their choice and, in conjunction with the dentists, can play an active role in planning the treatment most appropriate and affordable to ensure optimum oral health.

4. Calculating Payments

A clear understanding of the methods used to calculate benefits and payments will allow you to compare and evaluate the purchasing power of different plans. The following are four common payment schedules.

Capitation (per capita). This fee schedule is used by plans structured to provide a predefined level of benefits. Because dental care needs vary by individual, it is critical to have a thorough understanding of the level or range of services "defined" or covered by the plan. Under this fee schedule, the patient is responsible to pay for treatment not covered within the scope of the plan. In some cases, the allocated payment a dentist receives from the benefits plan, including patient co-payments, is less than the actual cost of providing care. Patients often settle for less-than-optimal treatment alternatives or postpone necessary services when their co-payments do not cover all possible options.

Table of Schedule of Allowances. Plans using this form of benefits calculation establish a maximum dollar limit for each covered procedure, regardless of the fee charged by the dentist. If you select a plan that uses this type of table or schedule, ask how often the table is adjusted for inflation or for changes in accepted dental procedures. In these plans, the difference between the allowed charge and the dentist's fee is paid directly by the patient.



Patients should understand that contracted fee reductions listed in some plan allowance schedules can significantly diminish the level and quality of care delivered. Contracted rates are based on the size of the patient population and projections of the amount and type of treatment performed within a given time frame. Since cost control drives this payment approach, your ability to choose your dentist or see a specialist may be limited.

Direct Reimbursement. In this self-funded plan, the patient pays the doctor for services. The employer or plan sponsor reimburses the employee for a predetermined percentage of all costs. Under this fee schedule, the employee has an incentive to work with the dentist to plan healthy and economical solutions.

Usual, Customary & Reasonable (UCR). Most indemnity (traditional fee-for-service) plans use this payment schedule. It allows patients to select their own dentist. The UCR schedule pays benefits based on a fixed percentage of the lesser of the dentist's fee or the fee determined by the insurance carrier to be "usual," "customary" or "reasonable" for the service in the community in which the service was delivered. Wide fluctuations in UCR fees between communities have made this payment system highly controversial. Because many insurance carriers set the UCR percentage too low in comparison to the area's usual professional fees, patients may wind up paying more out-of-pocket. Most payments are made directly to the dentist, but in some instances they are made to the beneficiary.

Dental Plans do Have Their Limitations

Today's health insurance, including your dental plan, is designed to help you get the care you need at a reasonable cost. Because each person's oral health is different, costs can vary widely. To control dental treatment costs, most plans will limit the amount of care you can receive in a given year. This is done by placing a dollar "cap" or limit on the amount of benefits you can receive, or by restricting the number or type of services that are covered. Some plans may totally exclude certain services or treatment to lower costs. Know specifically what services your plan covers and excludes.

There are, however, certain limitations and exclusions in most dental benefits plans that are designed to keep dentistry's costs from going up without penalizing the patient. All plans exclude experimental procedures and services not performed by or under the supervision of a dentist, but there may be some less obvious exclusions. Sometimes dental coverage and health insurance may overlap. Read and understand the conditions of your dental plan. Exclusions in your dental plan may be covered by your medical insurance.

The California Dental Association encourages consumers to choose plans that impose dollar or service limitations, rather than those that exclude categories of service. By doing so, you can receive the care

that's best for you and actively participate with the dentist in the development of treatment plans that give the most and highest quality care.

To help you stretch each dental benefit dollar, most plans provide patients and purchasers with special administrative services. Find out if your plan provides the following mechanisms to help you budget, analyze and dispute, if necessary, the costs of your dental care.

Predetermination of Costs. Some plans encourage you or your dentist to submit a treatment proposal to the plan administrator before receiving treatment. After review, the plan administrator may determine: the patient's eligibility; the eligibility period; services covered; the patient's required co-payment; and the maximum limitation. Some plans require predetermination for treatment exceeding a specified dollar amount. This process is also known as preauthorization, precertification, pretreatment review or prior authorization.

Although your dental benefits plan may not be bound to predetermined costs, this mechanism can help you and your dentist plan and budget a treatment plan appropriate to your oral health needs.

Annual Benefits Limitations. To help contain costs, your plan may limit your benefits by number of procedures and/or dollar amount in a given year. In most cases, particularly if you've been getting regular preventive care, these limitations allow for adequate coverage. By knowing in advance what and how much your plan allows, you and your dentist can plan treatment that will minimize your out-of-pocket expenses while maximizing compensation offered by your benefits plan.

Peer Review for Dispute Resolution. Many plans provide a peer review mechanism through which disputes between third parties, patients and dentists can be resolved, eliminating many costly court cases. Peer review is established to ensure fairness, individual case consideration and a thorough examination of records, treatment procedures and results. Most disputes can be resolved satisfactorily for all parties.

Premium Adjustments and Reevaluations. Patients and plan purchasers should insist on regular reviews of premium levels to ensure that UCR or Table of Allowances payment schedules are equitable. This analysis can help optimize your benefit levels, ensuring that every dollar you spend is used wisely.

Coordination of Benefits. If you are covered under two dental benefits plans, notify the administrator or carrier of your primary plan about your dual coverage status. Plan benefits coordination can help protect your rights and maximize your entitled benefits. In some cases you may be assured full coverage where plan benefits overlap, and receive a benefit from one plan where the other plan lists an exclusion.

Eight Things to Consider When Choosing Your Dental Plan

What looks like a bargain today may not be a good buy in the long run. While your out-of-pocket costs are, of course, an important part of your decision-making process when choosing a dental plan, they are not the only criteria to use when evaluating your options. Your primary focus should be to determine whether the coverage will satisfy your dental care needs. Consider the following:

- 1. Does the plan give you the freedom to choose your own dentist or are you restricted to a panel of dentists selected by the insurance company?** If you have a family dentist with whom you are satisfied, consider the effects changing dentists will have on the quality or quantity of care you receive. Because regular visits to the dentist reduce the likelihood of developing serious dental disease, it's best to have and maintain an established relationship with a dentist you trust.
- 2. Who controls treatment decisions—you and your dentist or the dental plan?** Many plans require dentists to follow treatment plans that rely on a Least Expensive Alternative Treatment (LEAT) approach. If there are multiple treatment options for a specific condition, the plan will pay for the less expensive treatment option. If you choose a treatment option that may better suit your individual needs and your long-term oral health, you will be responsible for paying the difference in costs. It's important to know who makes the treatment decisions under your plan. These cost control measures may have an impact on the quality of care you'll receive.
- 3. Does the plan cover diagnostic, preventive and emergency services? If so, to what extent?** Most dental plans provide coverage for selected diagnostic services, preventive care and emergency treatment that are basic for maintaining good oral health. But the extent or frequency of the services covered by some plans may be limited. Depending upon your individual oral health needs, you may be required to pay the dentist directly for a portion of this basic care. Find out how much treatment is allowed in any given year without cost to you, and how much you will have to pay for yourself.

Every dental care plan is different. It's your responsibility to be informed about what your specific plan will cover. As a basis of comparison, the following services should be covered in full, with no deductible or patient co-payment:

- Initial Oral Examination—once per dentist
- Recall Examinations—twice per year
- Complete x-ray survey—once every three years
- Cavity-detecting bite-wing x-rays—once per year

- Prophylaxis or teeth cleaning—twice per year
- Topical Fluoride treatment—twice per year
- Sealants—for those under age 18

- 4. What routine corrective treatment is covered by the dental plan? What share of the costs will be yours?** While preventive care lessens the risk of serious dental disease, additional treatment may be required to ensure optimal health. A broad range of treatment can be defined as routine. Most plans cover 70 percent to 80 percent of such treatment. Patients are responsible for the remaining costs. Examples of routine care include:
 - Restorative care - amalgam and composite resin fillings and stainless steel crowns on primary teeth
 - Endodontics - treatment of root canals and removal of tooth nerves
 - Oral Surgery - tooth removal (not including bony impaction) and minor surgical procedures such as tissue biopsy and drainage of minor oral infections.
 - Periodontics - treatment of uncomplicated periodontal disease including scaling, root planning and management of acute infections or lesions
 - Prosthodontics—repair and/or relining or reseating of existing dentures and bridges.

Understand what routine dental care is covered by the plan, and what percentage of the costs will come out of your pocket.

- 5. What major dental care is covered by the plan? What percentage of these costs will you be required to pay?** Since dental benefits encourage you to get preventive care, which often eliminates the need for major dental work, most plans are not generous when it comes to paying for major dental work, most plans cover less than 50 percent of the cost of major treatment. Most plans limit the benefits—both in number of procedures and dollar amount—that are covered in a given year. Be aware of these restrictions when choosing your plan and as you and your dentist develop treatment best suited for you. Major dental care includes:
 - Restorative care—gold restorations and individual crowns
 - Oral Surgery—removal of impacted teeth and complex oral surgery procedures.
 - Periodontics—treatment of complicated periodontal disease requiring surgery involving bones, underlying tissues or bone grafts.
 - Orthodontics—treatment including retainers, braces and/or diagnostic materials.
 - Dental Implants—either surgical placement or restoration
 - Prosthodontics—fixed bridges, partial dentures and removable or fixed dentures.

6. **Will the plan allow referrals to specialists? Will my dentist and I be able to choose the specialist?** Some plans limit referrals to specialists. Your dentist may be required to refer you to a limited selection of specialists who have contracted with the plan's third party. You also may be required to get permission from the plan administrator before being referred to a specialist. If you choose a plan with these limitations, make sure qualified specialists are available in your area. Look for a plan with a broad selection of different types of specialists. If you have children, you may prefer a plan that allows a pediatric dentist to be your child's primary care dentist. Since specialized treatment is generally more costly than routine care, some plans discourage the use of specialists. While many general practitioners are qualified to perform some specialized services, complex procedures often require the skills of a dentist with special training. Discuss the options with your dentist before deciding who is best qualified to deliver treatment.
7. **Can you see the dentist when you need to, and schedule appointment times convenient for you?** Dentists participating in closed panel or capitation plans may have select hours to see plan patients. They may schedule appointments for these patients on given days, or at specified hours of the day, restricting your access. Some dentist's fees for seeing you on weekends or during emergencies are high than those the plan allows. You may be required to pay additional costs yourself. If you select these types of plans, have a clear understanding of your dentist's policies as well as the plan's dentist-to-patient ratio. It's the best way to ensure your access to care is not unduly restricted and that you are not surprised by higher fees the plan does not cover.
8. **Will the plan provide benefits to patients who may also be covered by another dental plan?** It is not unusual to be eligible for dual benefits. You may be covered under your company's plan as well as under that of your spouse's employer. In analyzing your options, make sure to look for a plan that allows coordination of benefits.

You should be entitled to either 100 percent coverage or some form of premium credit. By coordinating benefits, you can eliminate being penalized or denied coverage when the two plans have conflicting exclusions.

Getting the Best and Most From Your Plan

To take full advantage of your dental benefits plan, visit the dentist regularly and get the preventive care that will keep your mouth healthy. Follow the treatment plan you and your dentist have developed. Do your dental homework—brush and floss regularly and maintain a regular schedule of oral examinations and teeth cleanings.

Should you need treatment for particular conditions, follow the procedure for predetermination required by your plan. Find out what your insurance will cover. Feel free to discuss a payment plan with your dentist for your portion of the treatment costs.

Making an Informed Choice

The law mandates that consumers with dental coverage receive a fully detailed patient information handbook—a *Description of Benefits*—that clearly outlines coverage, limitations and exclusions. Before selecting a plan that best suits your needs, ask your carrier or company benefits coordinator for a copy of the benefits handbook.

If you have questions about coverage, exclusions, calculation of benefits or payment of benefits, ask before making your plan selection. Find out which plans your dentist participates in and why. That's the best way for you to get care from the dentist of your choice, and still take advantage of the costs savings due to you.

Selecting an insurance program wisely isn't simple. But having the facts to make an informed decision can make a difference. No plan is perfect; each has its advantages and limitations. Read the fine print. And by all means ask questions. The more you know about dental benefits, the better equipped you will be to select the best coverage for your dental health.

The California Dental Association (CDA) presents this information in the public interest. The information provided should not be construed as either an endorsement or recommendation by CDA. While this brochure attempts to be comprehensive, there may be questions that it has not answered fully. Consult your insurance carrier, insurance broker or company benefits coordinator for complete information.