

# Understanding your dental insurance

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Lot of you may have some form of dental benefit coverage but may not be using it to it's maximum for various reasons, One of which is not understanding your plan fully. You should know how your plan is designed and use it properly as oral health plays an important role in overall health of your body.



American Dental Association recommends having oral checkup and prophylaxis at least twice a year or more depending on the overall health of your gums and teeth to prevent severe dental diseases. Two of these Hygiene visits are paid in full by most of the plans and everyone should be taking advantage of this part of the dental insurance coverage.

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 your cost savings.

Dental benefit plans are designed in many different ways, the most common designs can be grouped into the following categories:

**Direct Reimbursement** programs reimburse patients a percentage of the dollar amount spent on dental care, regardless of treatment category. This method 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 or the plan administrator's "reasonable" or "customary" fee limit, whichever is less.

**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. The patient pays the difference.

**Preferred Provider Organization (PPO)** programs are plans under which contracting dentists agree 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).

You may find your dentist recommending treatment that your plan will not pay for in some cases which does not mean the treatment is not necessary. It is common for dental plans to exclude treatment that is covered under the company's medical plan. Some plans also exclude necessary dental treatment such as sealants, pre-existing conditions, adult orthodontics, specialist referrals and other dental needs. You need to be aware of the exclusions and limitations but should not let those factors determine your treatment decisions.

Some plans will only provide the level of benefit allowed for the least expensive way to treat a dental need, regardless of the decision made by you and your dentist as to the best treatment, for example your dentist may recommend a crown for a tooth for more strength, support and prevention against fracture but your plan only allows for a large filling. You should base treatment decisions on your dental needs, not on your dental benefit plan in these cases.

If you have more questions regarding your dental benefits and need help understanding the breakdown of allowances, please feel free to call our office at 510-796-1656 or write us at [hp\\_dds@yahoo.com](mailto:hp_dds@yahoo.com) and we'll be glad to assist you to use your dental insurance at it's maximum extent.

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