

Understanding Dental Insurance: Get to Know Your Benefits



Dental insurance is one of the most valued benefits offered by employers. As a Delta Dental subscriber, you have one of the best dental benefit plans available.

The best way to take full advantage of your dental coverage is to understand its features. And the best advice is to read your benefits information booklet before you go to your dentist. To get you started, we'll cover some of the most important benefit plan highlights in this article.¹

Plan Basics

All Delta Dental plans emphasize prevention of dental diseases. Brushing and flossing every day, and visiting your dentist regularly for checkups, can help you avoid expensive dental treatments and their costs. Many Delta Dental benefit plans pay all or most of the cost for routine dental checkups, including cleanings and examinations, to promote preventive care.

As you work to understand your coverage, you'll want to know the answers to two key questions:

Which Delta Dental plan² do I have? Most Delta Dental customers have a Delta Dental PPO®, Delta Dental

PremierSM or Delta Dental PPO Plus Premier plan. For these plans you can choose any dentist you wish, though there are advantages to choosing a Delta Dental network dentist (see below). If you have a DeltaCare® USA plan, you must select a primary care dentist from our DeltaCare network.

Is my dentist in the Delta Dental network? Odds are, the answer is yes. Since Delta Dental has the nation's largest network of participating dentists – more than 142,000 dentists at more than 251,000 office locations nationwide – it's very likely that your dentist is part of our networks. Most of our plans offer access to either our PPO or Premier plan, and often both. Accessing our PPO network offers the lowest out-of-pocket fees and the richest benefits, while visiting a dentist in our Premier network also offers discounts and protection from additional billing, with the benefit of a larger selection of dentists. If you choose to visit an out-of-network dentist, you may be subjected to higher fees and required to submit claims yourself.

Please see the section at the end of this paper for more information on advantages of using a Delta Dental network dentist.

Terms You Need to Know

Annual Maximum. Most dental plans have an annual dollar maximum. This is the maximum dollar amount a dental benefit plan will pay toward the cost of dental care within a specific benefit period (usually January through December). The patient is personally responsible for paying costs above the annual maximum. Consult your plan booklet for specific information about your plan's annual maximum.

Benefit Period. Dental benefits are calculated within a "benefit period." The benefit period typically is for one year, but not always a calendar year. To learn when you might be approaching your deductible payments or plan maximums, you can check your benefits information online at www.deltadental.com.

Categories of Coverage. Many dental plans offer three classes or categories of coverage – often with different reimbursement levels for each. Each class provides specific types of treatment and those treatments are typically covered at a certain percentage. Each class also specifies limitations and exclusions (see specific section below). Procedures within a category of services can vary from plan to plan, so be sure to read your benefits information carefully.

The three levels typically work this way:

- **Class I** procedures are diagnostic and preventive. These are usually covered at the highest percentage (for example, 100 percent of the plan's approved fee). This gives patients a financial incentive to seek early or preventive care because such care can deter dental disease and the need for more expensive treatments in the future.
- **Class II** includes basic procedures – such as fillings, extractions and periodontal treatment – that are sometimes reimbursed at a slightly lower percentage (80 percent, for example).
- **Class III** is for major services and is usually reimbursed at a lower percentage (for example, 50 percent). Class III services may have a waiting period before they are covered.

Coinsurance. Many insurance plans have a coinsurance provision. That means the benefit plan pays a pre-determined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the coinsurance, and it is part of your out-of-pocket cost. It is paid even after a deductible is reached.

Coordination of Benefits (COB). If you are entitled to benefits from more than one group dental plan, the amounts paid by the combined plans will not exceed 100 percent of your dental expenses. This is known as coordination of benefits, or COB.

Deductibles. Most dental benefit plans have a deductible – a specific dollar amount you must pay before the plan begins to cover your expenses. During a benefit period, you personally will have to pay a portion of your dental bill before your benefit plan will contribute to your cost of dental treatment. Your plan information will describe how your deductible works. Plans do vary on this point. For instance, some dental plans will apply the deductible to diagnostic or preventive treatments, and others will not.

Enhanced Benefits. Many plans now offer enhanced coverage for individuals who have specific health conditions that can be positively affected by additional oral health care. These enhancements are based on scientific evidence and often include additional cleanings and/or applications of topical fluoride for at-risk individuals (for example, individuals with periodontal disease, diabetes, or heart conditions).

Limitations and Exclusions. Dental benefit plans are designed to help with part of your dental expenses; they may not always cover every dental need. The typical plan includes limitations and exclusions, meaning the plan does not cover every aspect of dental care. This can relate to the type or number of procedures, the number of visits or age limits. These limitations and exclusions are carefully detailed in the plan booklet and deserve your attention.

Pre-Treatment Estimate. If your dental care will be extensive, you may ask your dentist to complete and submit a request for a cost estimate, sometimes called a pre-treatment estimate or pre-determination of benefits. This will allow you to know in advance what procedures are covered, the amount the benefit plan will pay toward treatment and your financial responsibility.

Key Document: Explanation of Benefits Statement

One of the most important communications you will receive from Delta Dental is your Explanation of Benefits (EOB) statement. This is a document sent to you after you receive dental treatment. An EOB is *not* a bill. The EOB explains what procedures were covered under your benefits plan, as well as any procedures that might not have been covered and why they were not covered.

An EOB will tell you:

- Dental services performed (description of procedures)
- Dentist fees
- Delta Dental's payment
- Payment you may owe (such as deductibles, coinsurance and non-covered services)
- Coordination of benefits (COB) information, if applicable
- The portion of annual maximum used and the amount paid toward deductible in the current benefit year

Rollover Helps Manage Costs

Many Delta Dental PPO plans include a “rollover” feature, a valuable benefit feature that allows members to roll over part of their unused spending in a healthy year to increase their maximum benefit limit the next year, and beyond. Limitations apply, and some programs exclude this feature. Please refer to your benefits booklet or contact Delta Dental customer service for more information.

Visit a Network Dentist for Maximum Value

Most Delta Dental benefit plans give enrollees the freedom to choose any dentist they wish. To get the full advantage of your Delta Dental coverage, however, you should choose a dentist who participates in the Delta Dental network. Here's why:

1. Delta Dental network dentists agree to accept pre-determined fees for services that are often discounted from typical charges. In addition, Delta Dental network dentists agree not to “balance bill” patients for differences between approved fees and their typical charges.
2. There's no waiting for reimbursement. When you are treated by a Delta Dental network dentist, you don't have to pay the entire bill and wait for reimbursement from Delta Dental. Instead, we pay your dentist directly and send you a notice (the EOB statement) explaining your portion of the bill. You pay only the amount for which the dentist bills you.
3. Because Delta Dental network dentists handle all claim forms and other paperwork, there's less work for you.
4. All Delta Dental network dentists must meet professionally recognized quality standards. Delta Dental re-credentials providers periodically to ensure standards are maintained.

With a better understanding of the benefits included in your Delta Dental plan, you can have a key role in your oral health and wellness – and get the most value from your investment. For more information about your dental benefits, visit our website at www.deltadental.com.

¹ This paper includes content adapted from materials originally developed by Delta Dental of Michigan; Delta Dental of Illinois; and Delta Dental of California, Delta Dental Insurance Company and their affiliated companies.
² Due to the range of plans and options within those plans, your coverage details may vary from friends or neighbors who also have Delta Dental.