Answers to 5 Common Dental Insurance Questions

By: Corporate Synergies' Benefits Experts

Aside from protecting your smile, dental care ensures good oral and overall health. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Understanding and choosing dental insurance will help protect you and your family from the high cost of dental disease and surgery.

What Is Dental Coverage?

Dental coverage is similar to regular medical insurance and is one of the voluntary benefit options commonly offered through employers. When you have dental insurance, you pay a premium and then your insurance will cover part or all of the cost for many dental services.

Like medical insurance, dental coverage is offered in several types of plans:

Dental health maintenance organization (DHMO)–Coverage is only provided when you visit dentists who are in-network with the insurance plan.

Dental preferred provider organization (DPPO)–Coverage is provided with in- or out-of-network dental care providers, but you will typically pay less with an in-network dentist.

Dental indemnity plan–Coverage is provided for any dentist you choose, with no difference in cost.

Discount dental plan–This type of plan is a common option for reducing dental costs without regular insurance coverage; with this plan, you pay for all your dental care at an agreed-upon discounted rate.

Why Should I Have Dental Insurance?

Professional dental care can diagnose or help prevent common dental problems including toothache, inflamed gums, tooth decay, bad breath and dry mouth. If conditions like these remain untreated, they can worsen into painful and expensive problems such as gum disease or even tooth loss. Regular dental exams can not only treat dental problems but can also identify other serious health concerns, including some types of cancer. Dental coverage will allow you to inexpensively receive preventive and diagnostic care.

What Dental Services Are Typically Covered?

Dental coverage focuses on preventive and diagnostic procedures in an effort to avoid more expensive services associated with dental disease and surgery. The type of service or procedure received determines the amount of coverage for each visit. Each type of service fits into a class of services according to complexity and cost. Services are generally broken up into the following classes:

Class I–Diagnostic and preventive care (cleanings, exams, X-rays)

Class II–Basic care and procedures (fillings, root canals)

Class III–Major care and procedures (crowns, bridges, dentures)

Class IV–Orthodontia (braces)

Because dental coverage typically focuses on preventive care, Class I services are covered at the highest percentage. Class II services are then covered at a slightly lower percentage, followed by Class III services, which are covered at the lowest level. For example, if a plan follows an "100-80-50" structure, Class I services are covered at 100%, Class II at 80% and Class III at 50%.

Class IV services are frequently covered under a separate lifetime maximum (instead of the annual maximum) and often limit coverage to children under the age of 19.

In addition to the class of service, coverage also depends on other factors. Several common services are limited by frequency. For example, most plans will only cover two cleanings and exams per year. For more complicated procedures or surgeries, coverage is often limited to a maximum dollar amount, such as $1,500 per year. Age is yet another factor that determines coverage. For example, fluoride treatments are typically covered for children, but not adults. Cosmetic procedures, such as teeth-whitening, are rarely covered.

How Does Dental Insurance Work?

Dental coverage works similarly to a medical insurance plan. You pay premiums, and then the insurance will cover dental costs according to the benefits listed in the plan. The routine exams and cleanings are usually covered at 100%, but other services are often subject to a deductible and copay. The deductible is the amount you must pay before your insurance will pay. After you meet your deductible, you may be responsible for a copayment or coinsurance, which is the percentage of the treatment cost that you pay. For example, if the insurance covers a filling at 80% and you have already met your deductible, you would only have to pay the other 20% of the charge. Every plan is different, so you will need to read your benefit information carefully to understand your coverage.

Some dental plans, usually individual plans, enforce a waiting period. This waiting period means you will not have coverage for certain services (usually Class III procedures) until you have had the plan for a designated amount of time, such as six months. Waiting periods prevent a person from purchasing insurance shortly before major dental surgery and then dropping coverage as soon as the policy expires.

How Has Health Care Reform Affected Dental Coverage?

Under the Affordable Care Act (ACA), dental services are an essential health benefit for children under the age of 19, although individual states can choose to extend the age limit beyond this baseline. Declaring pediatric dental care an essential health benefit means that all new medical health plans must offer dental benefits for children unless certified stand-alone coverage is available. Non-medically necessary orthodontia is not included in the essential health benefits definition.

The essential health benefit status for dental coverage does not apply to adults. In addition, unlike medical insurance, you do not have to obtain dental coverage to avoid penalties.