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How does dental insurance work?

Dental insurance works very similarly to medical insurance. For a specific monthly rate you are entitled to particular dental benefits, usually including regular checkups, cleanings, x-rays, and certain services to promote general dental health. Your insurance plan dictates which services are covered, unfortunately, not always covering what is best for your dental health. Therefore some plans will require a greater financial contribution on your part when services are rendered based on the terms of your specific coverage.

What is the difference between a deductible and a copay?

A **deductible** is an annual amount that you must pay before your insurance starts covering your dental expenses. Often this amount does not apply for preventative services, but it varies by plan.

A **copay** is an amount specified by your insurance company, as agreed upon by your employer, that you must pay toward your dental visits. Since these tend to be percentage approximations, you will be required to pay your *estimated* copay at the time of your visit and once the insurance has paid their portion you will be billed for any leftover amount.

What is a Dental PPO?

Dental PPO (Preferred Provider Organization) plans are the most common type of managed care dental insurance plans. As a member of a Dental PPO plan, you may choose to see a dentist in-network or out-of-network and regardless of your choice, you will be reimbursed based on the UCR (usual, customary, and reasonable) amount that your specific insurance company has determined. The rest of the total charges for services rendered will be considered the patient's responsibility.

What is the difference between and in-network and an out-of-network dentist?

An **in-network** dentist is one contracted with the dental insurance company to provide services to plan members for specific pre-negotiated rates. An **out-of-network** dentist is not contracted with the insurance company but allows you to see the dentist of your choice. Often, if you see a dentist who is out-of-network, the amount you will be responsible for paying is similar to the amount you would pay for seeing an in-network dentist. Sometimes the amount is slightly different like the example below but you get the exceptional/personalized care of a private dental office rather than the standard/average care of a clinic or generic/mainstream office. *For example:*

IN-NETWORK		OUT-OF-NETWORK	
Annual Maximum	$1,000	**Annual Maximum**	**$1,000**
Annual Deductible	$50	**Annual Deductible**	**$50**
Preventative Coverage	100%	**Preventative Coverage**	**95-100%**
Restorative Coverage	80%	**Restorative Coverage**	**75-80%**
Major Coverage	50%	**Major Coverage**	**45-50%**

What is an HSA?

"HSA" stands for Health Savings Account. HSAs allow consumers to pay for qualified medical expenses with pre-tax dollars, meaning income-tax free, and save for retirement on a tax-deferred basis.

What is an FSA?

"FSA" stands for Flexible Spending Account. FSAs are available only with job-based health plans allowing both consumers and employers to make contributions to your FSA for qualified medical expenses. You do not pay taxes on this money but at the end of each year or grace period, you lose any money left in your account. It is important to plan carefully each year for any dental expenses that may be necessary.