What are Dental Benefit Plans?

Dental benefit plans are benefit plans provided by employers to help defray the cost of dental care. The term “dental insurance” is also used, but it is misleading because of the much more limited scope of dental benefits compared to medical insurance.

How are Dental Benefits Different From Medical Insurance Coverage?

Medical benefits protect patients from catastrophic and unpredictable loss due to illness or accident. This is accomplished with policies that require some cost sharing through annual deductibles and co-payments, but then provide coverage for the majority of costs incurred during the year after the deductible is met. There is typically an annual out-of-pocket maximum, meaning that patients are not personally responsible for any covered expenses above that amount.

Dental care is not an “insurable risk” because the average dental care cost per-person per-year is well under $1,000. This is not considered a risk of catastrophic financial loss. Because most oral disease can be prevented by personal dental hygiene and regular cleanings, dental benefit plans are designed to encourage regular check-ups. In addition, because maintenance of teeth for oral disease requires active participation of the patient, dental plans believe that if patients share the cost of expensive treatment, this will increase the likelihood of compliance in maintaining oral health.

Therefore, dental benefit plans are designed to make available a finite amount of money (the “total maximum benefit”—typically $1,000-1,500 per year) to help cover dental care. **The average benefit amount has not increased significantly in 30 years.**

The “total maximum benefit” adds a layer of complexity to claims submission and payment. For example, if a dental plan requires preauthorization for a procedure, the plan does not review the request with regard to the amount remaining in the patient’s benefit package. Likewise, verifying a patient’s eligibility before providing services does not guarantee payment from the benefit plan.

Dental benefit plans also may limit the frequency of coverage for certain services for a given year, including examinations, radiographs and root canal retreatments. Some benefit plans only pay for “least expensive alternative treatments.” The most common example of “least expensive alternative” in general dentistry is a plan that will pay for a filling but not a crown. The dental benefit companies generally do not base these decisions on any medical or dental reasons whatsoever. Often procedural codes’ coverage is dependent on which ones the employer agreed to pay for with premiums; many endodontic (as well as periodontal and implant) codes receive insufficient, little or no coverage at all.

What are the Implications for Endodontists?

Because the dental benefit is small, endodontic care is expensive, and many codes are not covered, it is rare for a patient’s dental benefit plan to cover the entire cost of the endodontic care. One endodontic procedure on a single tooth generally surpasses the total maximum benefit. By the time patients see an endodontist; they have also often used some of the benefits on care provided by the general dentist. Therefore, patients are likely to have significant out-of-pocket responsibility for endodontic services rendered making utilization of dental benefits at endodontist’ office difficult and confusing.

It is best for the patients to keep the benefits available for their general dentists’ use such as post-endodontic treatment crowns, and, instead, choose other forms of payments at the endodontist such as checks, credit/debit cards, flexible/health saving accounts (FSA/HSA), and monthly financing programs.