on a patient's age. Typically, orthodontics, fluoride and sealants have age restrictions.

*Common age limitations are that Orthodontics is covered to age 19, or that fluoride is covered through age 15.

"Are there office visit co-pays?"

Some insurance companies are starting to make you pay a co-pay each time you go to the dentist. This co-pay is taken out after the insurance calculates its payment, and is in addition to any deductibles on the plan.

*Common co-pays are $10 to $30 each time you visit the dentist office.

"Is there a missing tooth clause?"

A missing tooth clause means that the insurance company will not cover procedures for teeth missing or extracted prior to your enrollment.

*If you are having a bridge, denture or implant, knowing if there is a missing tooth clause is vital.

"What services are covered?"

Make sure that your plan covers all services. Sometimes plans only cover "Preventive and Diagnostic" services (i.e. cleanings, exams, etc.) and not fillings or crowns.

*Some plans do not cover Periodontal cleanings even if they cover Preventive and Diagnostic services.

Compare the costs and the benefits

Look at how much money you will be spending to have insurance and compare that with how much money you would be spending on dental work without insurance. Is the difference worth it? Only you can decide if this is an affordable cost.

Final thoughts

Remember that insurance is designed to help reduce your out of pocket costs, not make them disappear. It helps to protect you from having larger out of pocket expenses. A simple way you can protect yourself from these larger expenses is to maintain a regular schedule of cleanings, exams and films, as well as take proper care of your teeth at home, including brushing and flossing.

Please feel free to ask any of our treatment coordinators for help.

Resources

Anthem
www.anthem.com
(844) 304-8777

Cigna
www.cigna.com
(855) 340-9388

Humana
www.humana.com
(888) 371-9538

United Healthcare
www.goldenrule.com
(800) 944-4699

Created by Robert P. Horosewski on 5/21/13 for Clark & Leighton, P.C.

Updated by Robert P. Horosewski on 5/11/17.

family-focused dentistry
Clark & Leighton P.C.

A Guide to Buying Dental Insurance

If you are considering buying dental insurance on your own (meaning not through an employer), you already know that it can become complicated quickly. Contained in this guide is some information that we hope will make the process of buying, or not buying, dental insurance simpler.

Things you will need to know

How much do you spend on dentistry?

When considering buying dental insurance, it is wise to compare the cost of a dental plan with your current dental expenses. For a patient who is seen only for cleanings, exams and films and has no restorative work done, the cost is approximately $400 per year. Please ask our treatment coordinators and we will be glad to tell you how much you spent in the previous year.

How much does dental insurance cost?

The cost of dental insurance varies widely based on a number of factors including maximums, deductibles, and the types of procedures covered. In general, plans start around $40 a month and go up to about $90 a month. At the end of this pamphlet are some websites for insurance companies that can give you an instant quote.

Questions to ask when purchasing

"Do I have to switch dentists?"

Some insurance companies only allow you to see dentists who are in their dental network. Keep in mind that we do not participate in any networks. This means that if the insurance company mandates you see a dentist in their network, the insurance will not pay benefits for any work done here.

*Some insurance companies allow you to see an out of network dentist, but may reduce your overall benefits in one way or another.

"What is the maximum on this plan?"

A maximum is the total amount of money the insurance company will pay out in a 12-month period. This includes money paid for routine cleanings. This maximum is renewed every 12 months.

*Common maximums are from $1,000 to $2,000.

**If you have limited or no dental work being recommended beyond routine cleanings and exams, pick a plan with a lower maximum. Do you have lots of work that needs to be done? Pick a plan with a higher maximum.

"Is there a deductible on this plan?"

A deductible refers to an amount of money that you must pay prior to the insurance company making any payments. Like maximums,

deductibles usually renew every 12 months. Diagnostic and Preventive procedures (cleanings, exams and films) are typically exempt from deductibles.

*Common deductibles are from $25 to $100.

**Some insurance companies have lifetime deductibles. This means that you pay the deductible only once while you are insured.

"How is payment for services determined?"

Ask if the insurance company determines payment by Usual, Customary and Reasonable (UCR) rates or if they use a Fee Schedule. UCR is based on charges by dentists in similar locations. Fee Schedules are meant to limit reimbursement.

*Plans that set allowances by UCR usually pay much better than those that use Fee Schedules.

"What percent is paid for services?"

No dental insurance is meant to cover all your dental expenses. Insurance companies tend to pay a smaller percent for procedures as the cost of the procedures goes up.

*Common percentages are that Diagnostic and Preventive procedures are covered at 100%, Fillings and Root Canals are covered at 80%, and Crowns and Implants are covered at 50%.

"Are there any waiting periods?"

A waiting period means that the insurance company will make no payments for services until

you have been enrolled under their plan for a certain amount of time. Waiting periods often do not apply to procedures in the Diagnostic and Preventive category.

*Common waiting periods are from six months to 24 months.

**Waiting periods may differ for different types of procedures. Crowns and Implants typically have longer waiting periods than Fillings and Extractions. Orthodontics usually has the longest waiting periods.

"What are the frequency limitations?"

Insurance companies usually only allow procedures a certain number of times per period. Procedures like this are said to have a frequency limit. Most frequency limitations apply to Diagnostic and Preventive services.

*Common frequency limits are that cleanings are covered twice a calendar year, or that bitewing films are covered once per 12 months.

** If you have a service more often than permitted by your insurance, it will not cover the expense regardless of other stipulations in your plan.

"Are there any age limitations?"

In addition to frequency limitations, some procedures may also be restricted based