"MANAGED" DENTAL CARE"

Information YOU Need to Know

• The following information represents the current methods for patients needing or desiring oral care to pay for those services.
• Some methods provide total freedom related to the type of diagnosis, preventive care, treatment and selection of practitioners, while others limit the type of diagnosis, preventive care and treatment, as well as the practitioner who provides the services.
• The methods are listed from the most freedom of choice to the least.

1. Fee for Service Dentists and Dental Specialists

This type of payment for services was the only type of payment for all types of medical/dental care in the past. The patient requests services from the health practitioner, the practitioner provides the service, and the patient is charged for and pays for the service. With true fee for service payment, each individual service has a specific fee associated with it. There is total freedom in type of payment, since third party payers are not involved. The patient pays for the individual services and procedures delivered. It has been estimated that only about 5 percent of US dentists are "fee for service" dentists

2. Direct Reimbursement Dental Plans

Employers can design the plan any way they want. Your employer retains control. The employees have freedom of choice for treatment modes within the financial limitations of the patient's individual budget, since they must pay the doctor directly and be reimbursed by their employer. Benefits paid by the employer are based on a percentage of a specified dollar amount up to an annual maximum. Usually there are no exclusions or limitations. Usually there are no predetermination exams or claim forms for the doctor's office to submit, because the patient's paid receipt acts as the "charging document" or proof of loss. Direct reimbursement has a complete network of dentists because it includes all dentists. The patient pays the doctor, and the patient is reimbursed by their employer. For the doctor, the administrative overhead for such plans is usually much lower than for the following categories of plans, and the savings are sometimes passed on to patients. Currently, this is the only type of third party payment plan that allows you freedom of choice of practitioners. Unfortunately, patients are resistant to this type of plan design because they are required to pay the doctor's total fee at the time of service in order to get a paid receipt and seek reimbursement from their employer. This type of benefit plan design works less for small employer groups at the upper ends of the professional scale such as legal, accounting and specialty engineering firms.

3. Indemnity Dental Plans

An indemnity plan reimburses you for your oral care expenses, regardless of who provides the service because there are no network providers in the patient's selection process. In some situations, the types of coverage you choose will determine the amount of financial reimbursement you receive. The type of coverage may be somewhat limited related to the variety of covered services. Different plans use different methods for determining how much

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You will be reimbursed for your oral care expenses due to the amount of money you and your employer contribute to the plan. Your oral care alternatives are somewhat limited in indemnity plans in that the doctor is charging full fee without consideration of any network referral discounts. The reimbursement

amount is limited by the plans. Your freedom to select practitioners is not limited, but your personal selection may influence how much you pay for the services.

5. Preferred Provider Organizations (PPOs)

A preferred provider organization is an oral care plan that has contracts with a network of "preferred" providers from which you can choose. If you receive your care from a dentist in the preferred network you will be responsible for your annual deductible (a feature of some PPOs) and an out of pocket copayment for your visit. The total amount you pay for your dental treatment will be somewhat less if you receive care from a "participating network doctor." If you receive services from a dentist who is not in the preferred network (known as going "out-of network") you will pay a higher amount, and, you usually will need to pay the dentist directly, and you will be reimbursed by your plan. In these plans, you may find that you have significant and often objectionable limitations on the amount of care you can receive, the practitioners you can elect to see, and the overall potential quality of the less than comprehensive care you receive. Dentists are usually reimbursed by the PPOs at a lower amount than the doctor's full fee due to a negotiated discount.

6. Health Maintenance Organizations (HMOs)

If you are enrolled in a health maintenance organization you will need to receive most or all of your oral care from a network provider. If you need care from a dentist specialist in the network or a diagnostic service such as a lab test or x-ray, your HMO company will have to provide you with a referral. If you do not have a referral or you choose to go to a dentist outside of your HMO's network, you will most likely have to pay all or most of the cost for that care. An HMO covers only care rendered by those dentists and other professionals who have agreed to treat patients in accordance with the HMO's fee guidelines and restrictions in exchange for a steady stream of clients. These plans usually provide benefits for only diagnostic and very basic oral care services delivered by your doctor. All other services are paid by the patient directly to the doctor at a greatly discounted rate. These plan types limit the extent of reimbursement for individual procedures in that the doctor is paid primarily based upon time rather than fee for service.