What is a dental preferred provider organization (PPO) plan?
A PPO plan is a regular indemnity plan combined with a network of dentists under contract to the insurance company to deliver specified services for discounted fees in accordance with provisions in the signed agreement.

Why should a dental practice be well-informed about dental plans, particularly PPO plans?
According to the National Association of Dental Plans, approximately 263 million people had a commercial or publicly funded dental program in 2019. That’s 80% of the US population with some type of dental benefit and 85% of commercial dental plans are PPOs which dominate the marketplace as PPO plans continue to be purchased by employers.

This is what a typical PPO plan design looks like.

- **100% coverage for preventive & diagnostic services**
- **$50 annual deductible except preventive & orthodontics**
- **80% coverage for basic restorative services**
- **50% coverage for major restorative services**
- **50% coverage for orthodontics - separate lifetime maximum of $1,500**
- **$1,500 annual maximum for all services except orthodontics**
  (% applied to maximum allowable fees as determined by the plan)
What is a deductible?

The deductible is the amount of dental expense for which the beneficiary (i.e., patient) is responsible before a dental plan will assume any liability for payment of benefits. The deductible may be an annual or one-time charge, and may apply to an individual or a family. $50 is still the most common deductible.

What is co-insurance and how does it impact my patients’ costs?

Coinsurance is a provision of a dental plan in which the beneficiary shares in the cost of covered services, usually on a percentage basis after the deductible is paid. For example, if a patient sees a network dentist, a plan may pay 80% of its allowed fee and the patient is responsible for the other 20% of the plan’s allowed fee. The following are typical co-insurance provisions for a PPO plan.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Preventive &amp; Diagnostic Procedures</td>
</tr>
<tr>
<td>80%</td>
<td>Basic Dental Procedures</td>
</tr>
<tr>
<td>50%</td>
<td>Major Dental Procedures</td>
</tr>
<tr>
<td>50%</td>
<td>Orthodontics</td>
</tr>
</tbody>
</table>

What is the plan’s annual maximum?

Many dental plans feature a total annual maximum – a maximum dollar amount that may be reimbursed each year, even if the patient’s dental costs exceed that limit. A common annual maximum is $1,000 or $1,500, but it is not uncommon to see plans with much higher annual maximums of $2,000 or $3,000 to match the rising costs of dental treatment. These can be based on individual or family maximums.

Can I see the dentist of my choice?

Most PPO plans allow benefits for out-of-network dentists; however, exclusive provider organization (EPO) plans only allow benefits if the patient receives treatment from a network dentist. Benefits are not paid if the patient sees an out-of-network dentist. Dental offices should always verify coverage.

Additional Resources

An on-demand webinar, Dental Insurance 101 – A Beginner’s Course for Office Staff, is available along with additional information and other valuable educational ready-to-use resources on innovative dental insurance solutions at ADA.org/dentalinsurance.