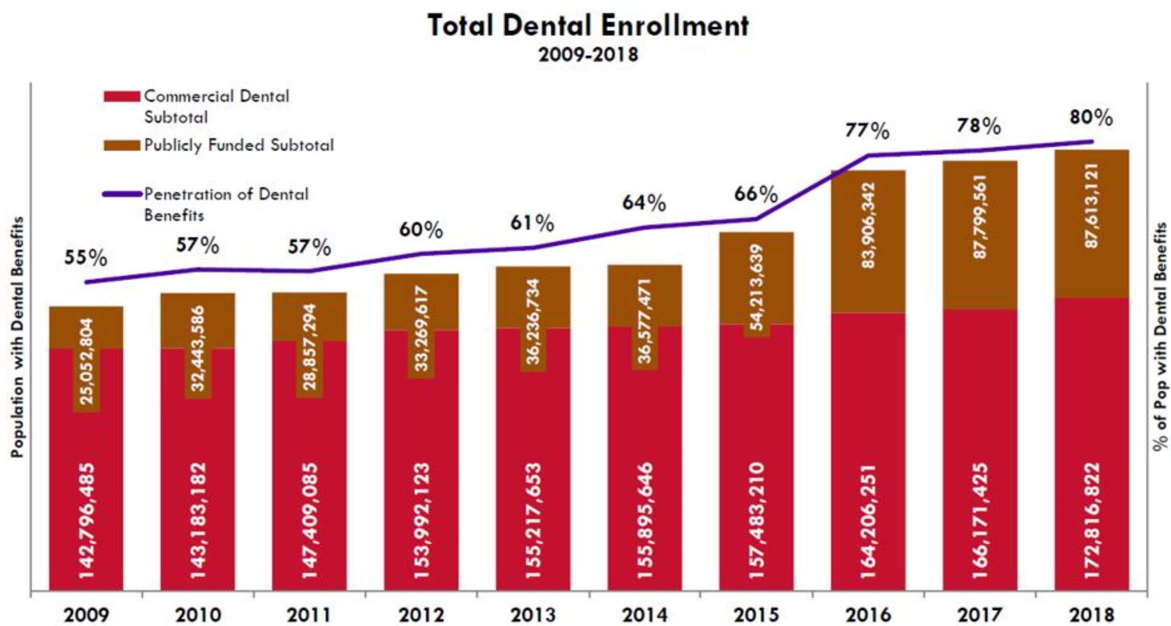
Dental Insurance 101 (PPO Plan Basics)

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.



NOTE: Due to the availability of complete federal data on Medicaid and CHIP enrollment for 2017, the total for 2016 uses a different methodology than prior years. In 2017, NADP analysis of Medicare Landscape files resulted in an increase of about 5 million Medicare lives for this report.

2019 NADP Dental Benefits Report: Enrollment   November 2019, Rev. 01/10/2020

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)

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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.

100% - Preventive & Diagnostic Procedures

80% - Basic Dental Procedures

50% - Major Dental Procedures

50% - Orthodontics

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.

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