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Understanding Dental Insurance

Maximize your benefits. It's free money, use it or lose it…

Dental Insurance?

The world of health care and health insurance is getting more complex every day. Be glad that your employer thinks enough of your dental health to include dental insurance in your benefit package.

DELTA DENTAL

Unlike medical insurance that takes care of your health through all hospital costs, dental insurance has a yearly maximum (usually around $1000.00) that can be applied towards your dental care. This benefit has not increased in over 20 years, so we do our best to help you maximize your coverage and to avoid additional out of pocket expenses. If you need more treatment than the plan covers, the costs are your responsibility.

So, it really isn't insurance, it really should be called a dental benefit plan.

Glenn G. Lew D.M.D.
GENERAL DENTISTRY

It's more like a gift card

When you get a gift card to Target you can use the card only up the amount that is debited on that card. If you spend more, you have to make up the difference. The same applies with dental insurance, the only difference is that your dental "gift card" has an expiration date, usually December 31st of each year. If you don't use it, you lose it. Your insurance company actually saves money that would have been spent on you. You can maximize your benefits each year by visiting us on a regular basis.

Estimating coverage

We do our best to help our patients maximize their dental benefits. We do this by documenting your treatment with photos, x-rays, and narratives. This gives the insurance adjuster the information needed to approve payment for a procedure.

MetLife

However, due to policy provisions, waiting periods and frequency limitations (see reverse for definitions), we are faced with many unknown variables that can sometimes hinder our ability to give you an exact estimate of what your plan is willing to cover. Insurance companies levels of reimbursement have no regulations, resulting in wide fluctuation from one patient to the next.

Why Doesn't My Insurance Pay For This?

Thanks boss!!

Employers offer dental benefits to help employees pay for a portion of the cost of their dental care. Dental plans are designed to share in the cost of your dental care, not to completely pay for those costs.

The contract

Almost all dental benefit plans are a result of a contract between the plan sponsor (employer/ union) and a third party payer (insurance company).

Why the plan pays what it does?

The amount your plan pays is determined by the agreement negotiated by your employer and the insurer. Your dental coverage is determined not by your dental needs-but by how much your employer contributes to the plan.

Key terms typically used to describe the features of a dental plan may include the following:

UCR (Usual, Customary and Reasonable)

Usual, customary and reasonable charges (UCR) are the maximum amounts that will be covered by the plan for eligible services. The plan pays an established percentage of a dentist's fees or pays the plan sponsor's "customary" or "reasonable" fee limit, **whichever is less**. Although these limits are called "customary", they may or may not reflect the fees that area dentists charge. **Exceeding the plan's customary fee, however, does not mean your dentist has overcharged the procedure.** Why? There are no regulations as to how insurance companies determine reimbursement levels, resulting in wide fluctuation. In addition, insurance companies are not required to disclose how they determine "usual, customary and reasonable" charges.

Annual Maximums

Most dental programs have an annual dollar maximum. This is the maximum dollar amount a dental plan will pay towards the cost of dental care within a specific benefit period, usually the plan year. **The plan purchaser / employer make the final decision on "maximum levels" of reimbursement through the contract with the insurance company.** The patient is usually responsible for paying costs above the annual maximum. Your employer may want to research plans that offer higher annual maximums when assessing how to better meet the needs of employees.

Preferred Providers (P.P.O.)

The plan may want you to choose dental care from a list of its preferred providers. This is a term that often is applied to dentists who have a contract with the dental benefit plan. **Whether or not you choose to receive dental care from this defined group can affect the level of reimbursement.**

Pre-existing Conditions

Just like medical insurance, a dental plan may not cover conditions that existed before the patient enrolled in the plan. This includes plans that have a "missing tooth" exclusion. Benefits will not be paid for replacing a tooth that was missing prior to the effective date of coverage. **Even though your plan may not cover certain conditions, treatment may still be necessary.**

Treatment Exclusions

A dental plan may not cover certain procedures or preventative treatments. This does not mean that these treatments are unnecessary. **Patients need to be aware of the exclusions and limitations in their dental plan but should not let those factors determine their treatment decisions.** Your dentist can help you decide what type of treatment is best for you.

Coordination of Benefits and Non-duplication of Benefits

Coordination of benefits (COB) is a method of integrating benefits payable for the same patient under more than one plan. Benefits from all sources should not exceed 100% of the total charges.

Non-duplication of benefits is a term used to describe one of the ways the secondary carrier may eliminate the portion of the payment if a patient is covered by two benefit plans. The secondary carrier calculates what it would have paid if it were the primary plan and subtract what the first plan paid.

Even though you may have two or more dental benefit plans in place, there is not guarantee that any of the plans will pay for your services. Please consult with your own plan for further details regarding coordination of benefits and non-duplication of benefits.

Plan Frequency Limitations

Certain procedures may simply not be covered as often as necessary for optimal oral health. A common example might be a plan that pays for tooth cleaning only twice a year even though the patient requires cleaning every three months. Limitations may vary depending on the contract purchased. Limitations in coverage are the result of the financial commitment the plan sponsor has agreed to make and the benefits the third-party payer will offer for that commitment

Not Dentally Necessary

The plan provides benefits for those services and materials that it considers to be dentally necessary and meet generally accepted standards of care. Based on the information your dentist submits, the service may not appear to meet plan criteria and no benefit may be allowed. **This does not mean that services were not necessary**. You or your dentist can appeal the benefit decision by submitting relevant information. The claim, along with the submitted information, should be reviewed by the plan's dental consultant.

Cost Control Measures

To keep the premium costs down, insurance carriers will incorporate cost control measures into the plan design incorporating cost control measures during the claims adjudication process, many times benefits are reduced or not at all. Some of the more common cost control measures.

Bundling- This is the systematic combining of distinct dental procedures by third-party payers that result in a reduced benefit for the patient/beneficiary.

Downcoding-This is the practice of third – party payer which the procedure code has been changed to a less complex and /or lower cost procedure than was reported except where delineated in contract agreements.

Least Expensive Alternative Treatment- The dental plan may only allow benefits for the least expensive treatment for a condition. As in the case of exclusions, patients should base treatment decisions on their dental needs, not on their dental benefit converges. **In many instances, the least expensive alternative is not always the best option. You should consult with your dentist on the best treatment option for you.**

Explanation of Benefits (EOB)

An EOB is a written statement to a beneficiary, from a third-party payer, after a claim has been reported, indicating the benefit/charges covered or not covered by the dental benefit plan. **In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the EOB.** Any difference between the fee charged and the benefit paid may be due to limitations in the dental plan contract. Typical information reported on an EOB includes: 1) the treatment reported on the submitted claim by ADA procedure code numbers and nomenclature; and 2) the ADA procedure code numbers and nomenclature on which the benefits were determined.