Insurance Facts

Dental practices are faced with big challenges when it comes to working with insurance companies. With so many companies and so many different policies being issued, there is no way we can keep up with what each one pays. Therefore we have established a strict policy regarding dental insurance. Please be aware of this: Your insurance policy is an agreement between you and an insurance company. They agree to pay certain amounts for your dental care—amounts which are determined by the contract purchased by your employer. The insurance company has no contractual obligation to your dental office. On the other hand, your dental bill is the result of an agreement between you and your dentist. Your dentist does work for you in exchange for a fee. You are responsible for full payment of your bill regardless of the status of your insurance claim. The purpose of this document is to inform you of some of the common problems we encounter in dealing with dental insurance plans.

Waiting Periods

There is often a misconception that once you have dental insurance you are covered for any and all expenses you incur at a dental office. But in many instances only certain things are covered, and the coverage that you do get goes into effect incrementally. An example might be a plan that covers preventive and diagnostic services immediately, restorative services after six months, then makes you wait a full year before covering crowns, bridges, or dentures. Of course, those waiting periods have nothing to do with when you need care, only when they will pay for it. You should make yourself aware of any waiting periods that apply so you don't get any financial surprises.

Annual Maximums

Dental Insurance plans have annual maximum payouts that are allowed. This is exactly the opposite of major medical insurance plans that pay *all* charges over a set amount known as your stop loss. Unfortunately, the amount that they pay out per year has not increased much over the past 20 years, while the costs of dental services have gone up substantially. If you need anything more than the normal preventive care, a filling or two, and a single crown, you'll probably exceed your annual maximum.

Just because you have exceeded the annual maximum for your plan does not mean that you should put off recommended dental care. Delays can jeopardize a patient's health, which is a bad choice. Some patients have mistakenly assumed that annual maximums are intended to gauge how much dentistry a person should have in a year. The fact is they are intended to assure the profitability of the insurance company—nothing more. If you find yourself in need of extensive dental work within a year, you will likely have to fund the care on your own.

Fee Schedules

Some dental insurance plans pay on a fixed fee schedule rather than a percentage of the cost incurred. That fee may be the entire amount charged or very little of the amount charged. Our fee is not affected by whether they pay much or little. Be aware that fee schedule plans often have low benefits to the patient, and leave you paying more out of your own pocket.

Usual, Customary, and Reasonable (UCR) Limitations

Sometimes insurance companies limit amounts they pay for dental procedures and claim that the charges exceed the usual, customary and reasonable charges for your area. But how are those amounts determined? There is no policing agency to make sure that UCR limitations are fairly calculated. There is no mandated reporting of the fees charged by area dentists, so the only way a company knows fees is by collecting data from the claims they receive. It is not scientific; it's always based on old data, and is always based on averages.

Although we strive to keep fees affordable, there may be times that your insurance company says a fee we charge is above average. They could be right, because we don't do average work here. We continually strive for excellence. It is impossible to consistently do above average work and charge average fees. But we always give excellent value by keeping fees reasonable, and using the best materials and techniques available. We stand behind our work, and use the highest possible standards when placing restorations for our patients.

Things to consider:

- When the insurance company gets the numbers from all the claims submitted, there will be a range of fees—some high, some low. They know that any given claim falls in a percentile range. What percentile do they accept to pay, and what percentile is too high? As you can imagine, a plan that pays all claims at or below the 90th percentile is a lot better than a plan that pays all claims at or below the 50th percentile.
- You will probably not be told the percentile that your plan considers acceptable.
- You will not likely be told what charges make up the fees that the insurance company uses to determine UCR. They may be from your zip code, your city, or your state. If you live in an area where costs are high, but the insurance company includes fees from areas where costs are low, your reimbursement will be decreased.

Treatment Exclusions

Some insurance plans exclude specific procedures. These exclusions may have nothing to do with whether or not the procedure is needed or appropriate. In many instances the excluded procedures are simply a matter of keeping the cost of the policy low for the employer. Insurance companies have to make the price of their policies competitive in order to sell them. Then they have to keep their payout low enough to make a

profit. Cosmetic and experimental procedures are almost always excluded, as are dental implants. Other commonly excluded services include Nitrous Oxide Sedation, Inlays and Onlays, use of our Laser, Fluoride treatments, and tooth colored fillings. Sometimes what gets excluded is the best treatment for your specific condition. That puts you, the patient, in the difficult position of choosing between the best care with no coverage and the inferior care allowed by your insurance plan with coverage.

Least Expensive Alternative

There are often a variety of ways to treat dental conditions. As you might imagine, some are far superior to others. If your insurance plan only pays for the cheapest possible treatment, you may be faced with having to pay for the better care without the benefit of insurance. There are many times that we have decided not to perform procedures we consider inferior or substandard. Although we are capable of performing the procedure, we know they are not in the patient's best interest. In that case you might have to find alternate means of financing your dental care.

Pre-Existing Conditions

There are times when insurance plans will not pay to fix any problem that existed before you were covered on that plan. It may be the replacement of a tooth that was lost prior to coverage, or treatment of a condition that was chronically building over time such as wear on your teeth. Unfortunately those long standing problems are often the ones most needing treatment. We will recommend going ahead with treatment even though insurance will not pay for the treatment.

Delay Tactics

Many times we find that insurance companies return claims—even ones that are filled out correctly with all needed information—and ask for some minor amount of extra information. In our opinion this is nothing more than an excuse to delay payment of the claim. Our office only files insurance claims as a courtesy to our patients—we have no obligation to do so. We allow our patients to pay the amount we guess that the policy will not cover. It is the responsibility of the patient to pay their entire dental bill if the insurance company fails to make payment for over 45 days, no matter what the reason. Our office is committed to providing you and the insurance company with all reasonable information in order to help them process your claim and get you the insurance benefits you deserve, but we cannot accept responsibility for the fact that some insurance companies pay slowly.

A Special Note About HMO's and PPO's

To keep our costs of dental services fair to all of our patients, we have made the decision not to enroll as providers in any dental insurance plan that requires discounting of fees or preferential treatment of any group of patients. We are not signed up as Preferred Providers for any company (including Delta Dental and Blue Cross) because we feel that it shifts the burden of higher dental fees to those who have to pay all of their dental costs out of pocket. That is an unfair treatment in our opinion.

We realize that you have a choice to make about where you get your dental care, and we work hard to assure it will be worthwhile for you to go "out of network" if you have one of these more restrictive policies. For years we have maintained this policy, and although some patients have opted to go to a participating dentist, we have been gratified by the fact that many (if not most) have returned to our office because they thought the service was superior here than at other offices.

We file normal dental insurance claims daily, and allow our patients to pay only the estimated patient portion at the time of service. This amount is only an educated guess, and should not ever be construed as the final amount due. If there is a difference in the amount we think the insurance company will pay and what they actually pay we send a refund or a bill for the appropriate amount. Our computer tracks reimbursement amounts for each insurance plan, so it is usually pretty accurate.

Patients who have dental insurance plans that will not pay "out of network" providers are expected to pay for their dental care at the time of service unless prior financial arrangements are made. And although we do not accept assignment of benefits for HMO or PPO type plans, we will be glad to print out an insurance form or submit your claims electronically to make sure you get any allowable reimbursement for your dental expenses. **Realize that reimbursements are typically substantially lower at an out of network provider than they would be if you went to an in-network provider.**

The Purpose of Dental Insurance—A Review

Dental insurance is a contract between an employer and an insurance company. It obligates the insurance company to pay you back for a percentage of the costs of any covered dental service. The terms of those contracts are widely varied, and are often dependent upon the cost of the plan. In many instances the plans pay a higher percentage on preventive care, a lower percentage on restorative care, and the lowest percentage on the things that cost the most. Therefore, dental insurance is a way to help you pay a portion of your dental costs, and it is not intended to be a pay-all. Regardless of what the insurance company pays, the patient is responsible for paying their entire dental bill.

What If I'm Dissatisfied with My Dental Coverage?

If you don't like the coverage you have, ask your employer to consider changing carriers or getting a better policy from the same carrier. If enough people express the interest in a better dental insurance plan, maybe you'll get what you request.

There is a chance that your employer is paying all they can afford for the coverage you are receiving. If that is the case, we can be grateful for the help we get, and look for other alternatives to cover expenses that are not covered by insurance. Ask us what expenses you can expect, and we can help you develop a dental savings plan.

Medical Insurance Claims

Some dental care is reimbursable by medical insurance. Examples include dental services rendered because of an automobile or other accident, or because of damage to teeth as a result of a medical condition. Although these are legitimate reasons to file dental claims under medical insurance, we have had very poor success at getting reimbursed for those services in a timely manner. Therefore we cannot accept assignment of benefit for services covered under medical insurance. We will not file medical claims for you, but we will be glad to assist you in filing your own medical claim. We will provide you with a list of all procedures for which we have charged you, the associated description of the service, and the clinical reason for the procedure. With this information and a completed form you should be able to file your claim.