Dental Insurance Basics

This is our explanation and policy regarding dental insurance. Please read it and we will be happy to answer any questions you may have. If you would like a copy, you will be provided with one. The Consent Form and Financial Policy you sign states that this information has been provided to you.

Dental insurance isn't really insurance (a payment to cover a loss) at all. It is actually a money benefit typically provided by an employer to help their employees pay for routine dental treatment. It is very different from other types of insurance like medical, auto, life, and disability insurance.

Dental insurance is a contract between you or your employer and the insurance company. We will bill the insurance company on your behalf as a courtesy. We estimate patient deductibles and copays as best we can based upon the information provided to us by you and your insurance company. We give estimates of what the insurance company may pay based upon what·we are able to verity. Estimated copays and deductibles are due at the time of service. Any remaining balance due after the insurance company pays will be the patient's responsibility and is due within 30 days of invoice. We will do our best to submit and collect payment in a timely manner. However, outstanding insurance claims over 60 days will become your direct financial responsibility. We will do our best to help you get reimbursement from your insurance carrier.

We will do everything possible to give you the very closest estimate of your "out-of-pocket" costs before treatment is rendered. We understand that no one likes additional surprise costs. However, it is impossible to always give perfect estimates of covered benefits because contracts between different employers or individuals and the same or different insurance companies can have different payment percentages, deductibles, exclusions, downgrades, alternative benefits, and unknown clauses that can alter these estimates. Every written and verbal communication you or our office has with every insurance company will include "there is no guarantee of payment".

The fee and payment estimates are for treatment decisions that are recommended by Dr Swain, and agreed upon by you before any treatment is began. You will be given multiple treatment options that will address your dental needs and that are offered in our office. The fees presented on your treatment plan are for the treatment options that you choose. If our best payment estimates are not sufficient, we are happy to collect payment in full up front and we will submit the claim with the assignment of benefits (payment) made to you or you can file the claim yourself. We can also submit a pre-authorization to the insurance company that may give more specific payment details, but this can delay your treatment. You can also call your insurance company directly to verify benefits and request additional information

We do not accept assignment of benefits or auto insurance or worker's comp cases. These treatment costs must be paid up front and directly by you, the patient. We will try to aid you in submitting a claim for reimbursement.

Many patients are fortunate to receive benefit packages from their employer. Often these "perks" include dental insurance. The following information will help you to learn more about your dental benefits and how they may assist you in paying for your dental treatment.

Why are my dental benefits better than my spouse's even though they are both from the same insurance company?

Whenever your employer buys a dental insurance policy from an insurance company there are several things to consider, most importantly cost. There are as many insurance policies as there are employers. The price of an insurance policy determines the level of coverage you get. Insurance carriers sell "cafeteria" style policies allowing each employer to choose what will and won't be covered and how much to pay for covered procedures. In other words you get what you pay for.

I have already used my $1500.00 in dental benefits and the year is not over. Shouldn't that money provide all the dental care I need for a year?

Unlike medical plans, dental plans have a yearly maximum that your employer will pay out per year. Sadly, the average yearly maximum has been the same since before 1960. There have been no increases for inflation or the rising costs of care in over 50 years! If you have one or more teeth that need attention or it has been a little while since you have had dental care, it is unlikely that $1500.00 will cover all needed expenses. Your dental insurance is meant to help off-set some of the cost of your care but is not meant to cover all care even in the best of circumstances. Consider today's dental plans as a coupon for $1500.00 with multiple conditions for redemption and an expiration date.

I need a cleaning 4 times a year but my insurance company will only pay for 2. Shouldn't the insurance company pay since it is ''clinically necessary" for me?

Another way for employers to limit their costs associated with dental benefits is to set up rules for how often procedures are to be paid. Common examples of frequency limitations are 1 cleaning every 6 months and x rays 1 time per year. Dental policies are not governed with the "clinically necessary" model used in medical policies but by the framework rules (frequency, quantity, reimbursement levels) set by the employer when the policy was bought. These money-minded restrictions are not meant to sway the patient away from needed services but to simply limit the employer's financial responsibility. Even if it is a procedure medically or dentally necessary, it may be excluded from the contract.

How does my insurance company determine how much to pay on my dental claims?

When your employer bought your dental policy the price of the policy was calculated based on the “ceiling amount" the carrier would pay for each procedure. The term the insurance carrier uses for this is UCR or Usual, Customary and Reasonable. An employer who chooses to spend more money on a dental plan will have a more inclusive, higher percentile-paying policy resulting in less money coming from the patient's pocket. It's easiest to think of UCR as negotiated payments for all covered procedures in your dental plan that is tied to the cost of the premiums and your zip code.

I know all insurance policies are different but how do I know if my employers is worth the money?

A typical policy will normally pay at the following percentages of the Employer's Maximum Benefit Fee (not the dentist's actual fees): 100% (exams, x-rays, cleanings fluoride, sealants); 80 %(fillings, root canals, deep cleanings, extractions); 50% (crowns, bridges, dentures). Currently, most policies pay about 65-70% for white fillings on back teeth due to a restriction called the Alternative Benefit Clause that many employers adopt to limit plan costs. Approximately half of dental policies have some coverage for implants and implant crowns. Most policies exclude coverage for tooth replacement if the tooth was missing before you went to work for your employer and for cosmetic work including front tooth crowns and veneers.

Why does my insurance not pay for my entire cleaning visit even though it says it pays at 100%?

The 100% clause in your policy relates to 1OO% of the charge that your employer chose when the policy was bought rather than the dentist's actual fee. The fine print in your dental policy will always read 100% of the "Maximum Allowable Charge as Outlined in the Plan Benefit Booklet". An employer can choose to lower the cost of a dental policy by choosing a lower percentile such as 70 or 80%. The difference between what the insurance will pay on the employers’ behalf and the dentist's charge would be the patient's responsibility rather than the employer's, thus lowering the employer's benefit plan costs.

My employer has several different dental benefit options. What is the difference between a PPO, DMO or an Indemnity policy?

There are 3 types of employer provided insurance: PPO, DMO or Indemnity. A Preferred Provider Organization (PPO) is a type of insurance that gives patients a choice as to where to have dental care. A patient may choose from the PPO list to find a provider that has a contract with the insurance company or go to any dentist he or she chooses. The insurance policy rules and levels of reimbursement are usually the same whether you use a network provider or not. The advantage is that the provider's fees are set by the PPO insurance contract at a lower level and therefore the patient's co-pays may be slightly smaller.

A DMO or Dental Maintenance Organization is not a true insurance but a system where a patient is assigned to a dental office near the patient's home or work. The patient is required to use that dental provider and in return receives dental care for co-pays or at prearranged discounts. No claims are filed. If a patient needs to see a specialist, the assigned dentist determines necessity and gives a referral to a contracted specialist. The model is very similar to the HMO model except that there are few dental providers that contract with Dental Maintenance Organizations because the fees that insurance companies set for participating dentists are lower than the actual cost of care. Therefore a patient's access to care is often reduced resulting in frustration and loss of use of the dental policy.

An Indemnity policy is similar to a PPO policy except that there is no network with which to contract. The patient chooses a dental provider and the insurance company pays based on the rules set up for the policy.

I am self employed. Is there any good dental insurance for me?

Unfortunately, since dental insurance is an employee benefit that is funded by the employer, insurance companies do not offer those types of policies to individuals. The insurance company is in business to make money. In order for an individual policy to be "money making" to the insurance company, it must be paid more from the policy holder than it pays out in benefits. Therefore individual insurance plans are usually "money-losing" for the patient. However, the government has recently passed some laws to help the self employed. A health savings account (HSA) is an account with tax advantages in which you may set aside money for health and dental expenses. Gilbert Smiles offers a 10% cash discount for those without dental insurance that pay with cash or check.

Why does my benefit plan only pay toward the least expensive alternative treatment?

To save money, many dental plans allow a benefit only for the least expensive method of treatment. For example your dentist may recommend a crown with your insurance only offering benefit towards a filling. Dr. Swain will diagnose your treatment needs and recommend options to best treat those needs. Our goal is to maintain or regain your best oral and overall health. We do not diagnose based on cost alone. Dr. Swain will recommend the best treatment options for every patient like they are a family member or close friend. Insurance companies pay as little as possible to make money.

What should I do if my insurance doesn't pay for treatment I think should be covered?

Because your insurance coverage is between you, your employer and the insurance carrier your dentist does not have the power to make your plan pay. If your insurance doesn't pay you are responsible for the total cost of treatment. Sometimes a plan may pay if patients send in their own claim. The Employee Benefits Coordinator at your place of business may help or you can appeal the decision with your insurance company.