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Understanding Your Dental 'Insurance' Benefits

Dental Insurance Programs are not underwritten in the same fashion as your Medical Insurance Plan. It is a common misconception that you may be insured against Dental ill health in any way. These plans are sold to your employer and larger member organizations as Dental Cost Assistance Plans; the level of benefit coverage available to you as subscriber is entirely dependent upon the monies your administrator or employer is willing to pay out in premiums. Dental Assistance venders become profitable by accepting the premiums paid and limiting subscriber utilization. Limiting your access to benefits is accomplished in a number of ways; each method has been carefully determined by insurance actuaries. Understanding dental insurance terminology is extremely important to understanding how the Plan is attempting to limit your benefit access. Do not, however, undervalue the asset you may have in many of these programs; used judiciously they do have some value to you.

'Insurance' Terminology:

- ANNUAL DEDUCTIBLE MONIES: money *you pay* that is deducted from your entitled benefit applied to any procedures that are not diagnostic or preventive. This is a once/year penalty that is generally $50-150 for each person using the plan.
- ANNUAL MAXIMUM UTILIZATION ALLOWANCE: the total benefit monies you are entitled to extract from the plan in any one year. This figure is generally $1,000 - $1,500; these figures have remained the most common since 1981. Each person covered under the plan will generally have their own annual maximum and annual deductible; however, I have seen some union plans with a single annual maximum to cover the entire family. *There is no accumulation of benefits from one year to the next if the plan is not used.*
- PLAN ANNUAL TURNOVER DATE: Generally January 1 of each calendar year. This is the date which after which you are eligible to a new annual maximum and lose the unused maximum from the previous year; it is also the date after which you must pay a new annual deductible upon utilization of the plan. School Systems will generally have turnover dates that are reflective of each contract year rather than calendar year. This date is also important as to when you are eligible to receive benefits for your diagnostic (exams, x-rays) and preventive (cleanings) services.
- UCR LEVELS: 'usual, reasonable, and customary' - This is a term that reflects the level of fee schedule benefit coverage your employer has selected, as determined by the premium contribution level he has negotiated to pay on your behalf.
- CO-PAYMENT SCHEDULES: 'Co-pay' is what *you pay* as a percentage of the negotiated UCR fee that will not be paid by the plan. This is variable according to which dental procedure is required (e.g. crowns are generally plan covered 40 – 60% of UCR; root canal 80%; extraction 90 – 100%; TMJ bite equilibration 0%; etc.). To receive benefit coverage you must pay balance of what the plan will not pay.
- ELIMINATION PERIOD: Some plans are written so that you may be ineligible to receive benefit coverage on some restorative procedures until you have been paying the premiums for a predetermined enrollment period. Specific procedures may also be limited to periods of eligibility (e.g. a crown may only be paid out once every five years for the same tooth regardless of need or circumstance).
- PRE-EXISTING CONDITION: You are ineligible to receive benefit coverage for a condition that exists prior to you being covered under the Plan (e.g. you may not be eligible to receive coverage on the required bridge to replace a tooth that was extracted prior to your enrollment under the Plan).
- ACCEPTABLE ALTERNATIVE TREATMENT: Your Plan administrator may choose to cover your condition at a level which is the least costly in monies paid out, regardless of diagnosis and patient health (e.g. you require two fixed bridges; your dental administrator determines he can pay out less by covering you for a removable partial denture / you require a composite white bonded filling; you are eligible to receive benefit coverage only for a

mercury/silver alloy filling – this is the extent of benefit you will receive). We see this often in lesser-funded plans.

- INELIGIBLE SERVICES: Dental plans in general cover on a percentage basis the 'nuts & bolts' procedures that were acceptable to us when we were children and young adults: dentures, extractions, root canals, mercury/silver alloy fillings, caps. Some plans have such a low contribution rate that cleanings and exams are the only services offered for coverage. Common excluded procedures include tooth whitening, veneers, bite adjustments, orthodontics, TMJ treatment, implant placement and restoration,. periodontal diagnostic and surgical procedures.
- DUAL INSURANCE: When both spouses have plans under which both are eligible to receive benefits; each will have two annual deductible payouts and two annual maximum utilization allowance figures. This is helpful for larger treatment plans. However, this can get complicated when trying to maximize your benefit coverage, especially when the turnover dates do not coincide. Your Plan is the "Primary" and must be submitted first; your spouse's Plan is your "Secondary" and can only be submitted after documentation is received from the "Primary".
- EOB: Estimation of Benefits
- PREDETERMINATION OF BENEFITS: Generally the dentist can request an exact printout of estimated benefits (EOB) for a particular procedure or treatment plan which is often helpful; those insurance plans mandating processing predetermination documentation realize great profit by delayed treatment, mishandled or lost claims, loss of patient eligibility, running the claim into a new annual deductible period, or ebbing of patient interest. Most insurance carriers are unwilling to impart this specific coverage information by telephone inquiry.
- PPO: Preferred Provider Organization, a network by which the insurance vender negotiates a preferred fee schedule or UCR with the participating member dentist on behalf of the patient. I do participate with a number of specific plans; however, I will not participate in all, as some plans cut fees to the point that I cannot deliver the level of quality materials and care that I would demand for you and for myself as a patient.
- HMO: Health Maintenance Organization. I do not participate in HMO plans, DMO plans, capitation plans, or government welfare plans. These plans have long been the subject of 'balance' between provider ethics and profitability. I will not provide the arena for these discussions with another working model.

Let me illustrate an example of how you may be affected by the above terminology in the processing of your claim:

- Root canal treatment, molar: office fee $701

UCR adjustment for root canal @650 -51 - 51

Minus Co-pay @ 20% UCR of 650 -130

Minus Annual Deductible -100

You pay $281 / your insurance pays $420

Insurance actuaries know that requiring patients to pay any contribution toward their health care will eliminate a good percentage of plan members from extracting benefits in any way!

We make every effort to maximize the benefit coverage to which you are contracted under your Plan in submitting the necessary claims and x-rays to your insurance carrier on your behalf; you are then billed the unpaid balance as Co-Payment. As a courtesy to you and our most trusted patients, I generally do not demand full payment at the time we initiate more costly prosthetic and/or surgical work. Rather, I request an initial partial payment and wait for all primary insurance claims to be processed and credited prior to any final payment demands. I do not require you to process or mail your own claims or backup correspondence with your insurance carrier *within reason*. It is required by the laws governing insurance companies that your carrier process your claim expeditiously within 30 days. Should your account remain open after sixty days due to insurance disputes, delays, or mishandling of your claim by your carrier, it will be your responsibility at that time to make full payment on your outstanding balance to this office. Should your dispute remain unresolved to your satisfaction with your carrier we will make available to you information by which you may contact the State Insurance Commission.

It is also *not* the responsibility of my position to locate, extract insurance payment or co-payments, or negotiate with estranged spouses to cover the expenses generated on behalf of you or other family members in this office. These are family dynamics that are your responsibility to control prior to contracting services in this office.

I do not underwrite or accept premium payment as Underwriter of your Plan or any other Dental 'Insurance' Plan. I do not establish Benefit Coverage, Co-payment Schedules, UCR Levels, Annual Deductible Moneys, or Yearly Maximum Utilization

Allowances for your Plan. This is a contract between you and your employer. The Plan and level of benefit coverage your employer has selected for you is determined by the premium level he has negotiated to pay on your behalf.

Your 'insurance' assistance plan can be a valuable aid in your pursuit of quality dental health care and beauty. I encourage you to understand the parameters of its benefits and limitations; we will help you. It is important that you do not let the negotiated benefits and limitations of your plan dictate the diagnostic decisions for your health care. Remember that the most expensive dental work you invest in is the dental work that has to be made twice.