WHAT DOES MY INSURANCE COVER?

How to understand your dental insurance, maximize your benefits and avoid common mistakes!

1. **How does dental insurance work?**
   Dental benefits are not really insurance plans. They are agreements to help pay for some of your dental needs. The more your employer pays for coverage, the lower your out-of-pocket costs will be. However, whatever your benefits, they are a wonderful gift to have.

2. **How are plans different?**
   Most plans have co-payments, deductibles, maximums, and excluded services. Tables 1 & 2 provide easy explanations and examples of these confusing features.

3. **My plan covers 100%.**
   Perhaps for some services; but never for all. Plus the 100% may be on artificial fee, rather than what any dentist in your area charges. For example: Take an X-ray. A good plan might set coverage at $20, a middle plan at $10 and a low-priced plan may exclude it altogether. Yet all the plans may claim to cover X-rays at 100%.

4. **Can you waive my portion & accept whatever insurance pays?**
   This seems innocent and we'd like to help. However, such acts are considered falsified billing. Carriers audit records for such activity and prosecute violators aggressively.

5. **Can you change codes, or dates, to get me better coverage?**
   Insurance carriers inspect records. Your x-rays, lab slips and chart tell the true story. If fraud is committed, you and your dentist can be fined or imprisoned.

6. **I reached my maximum in no-time. Is that normal?**
   The $1000 maximum was set 40 years ago. At that time, $1000 was considered a reasonable level of dental coverage each year. Adjusting for inflation, your maximum should be your $5000 today, but employers have sought to keep costs down. Many people need care that far exceeds this artificial maximum.

7. **My insurance will pay only for a less expensive treatment. Should I get that instead?**
   Insurers commonly pay for the "least expensive alternative treatment. " Many times this is not the smartest or best choice. Tables 1 & 2 provide some examples.

8. **If I don't have coverage, it must not be necessary; right?**
   No. The limitations of your policy are totally arbitrary. They have no relation to the treatment that you need or may want. Remember, your dentist's responsibility is to advise you what treatments are available and what is best for you. Your insurance contract is designed by lawyers and financial experts to control costs.

9. **My carrier said my dentist overcharged me. What should I do?**
   Carriers often call their artificial fees "usual, customary or reasonable." However, these fees are often based more on what premium your employer paid, than what any dentist in your area charges. There are virtually no regulations as to how insurers arrive at their reimbursements; and most refuse to release such information. Fees may be out-dated, unrealistic, or based on an inappropriate geographic area.

10. **Why aren't preventive treatments or better alternatives covered? Wouldn't insurers save in the long run?**
    Employers change carriers, on average, every 2 years; so your insurer is not concerned with what happens later. Insurance corporations report profits quarterly. The incentive for them is to save now, not years later.

11. **Why can you only estimate my coverage?**
    Dentists deal 1000's of plans and 100's of types of treatments each year. Most carriers refuse to release the details of their plans. They change policies and reimbursements constantly and without notice.

12. **Why not sent written estimates?**
    Pre-authorizations are rarely required, despite contract language that is designed to suggest otherwise. The process is so long and frustrating that statistically nearly 70% of estimated work never gets done. Plus carriers rarely disclose what the actual dollar reimbursement will be anyway. Most dentists consider pre-estimates a waste of time.

13. **Coverage seems so unfair. How much is dental insurance?**
    At only about $30-50/ month for family coverage, dental benefits are a wonderful bargain. If your plan is disappointing, show your employer this pamphlet. They may not be aware of the restrictions and fine-print in the contract they purchased. Better benefits often cost only pennies more.

14. **What if my spouse has insurance?**
    Dental plans used to work together. However, many times you will get little or no coverage from a second plan anymore. Consider any extra benefit an unexpected gift.

15. **Do you take medical insurance?**
    Medical Plans do not cover dental services, except for a few situations, such as accidents and some oral surgery.

16. **How do dentists get on the list of "preferred providers"?**
    Providers are screened for malpractice and legal violations; but for the most part all they have to do is agree to accept lower reimbursements. Be aware. The more compensation is reduced, the more difficult it is to devote adequate time to you; or to offer you the latest in quality care. The shorter the list of dentists, the more compromises you may be unknowingly accepting.

17. **How do you handle my insurance?**
    We are happy to process your paperwork for you. To accept insurance, we ask to keep a credit card on file. Before treatment, we will approximate your coverage and ask for your estimated co-payment. After insurance pays, we will credit or change your card to reconcile any differences. Whatever your coverage, please remember that you are ultimately responsible for payment.

18. **Why do you collect co-payments automatically?**
    The more paperwork and administration costs we eliminate, the more savings we can pass back to you.

19. **Does dental insurance have to be so complicated?**
    No. Many companies are switching to "direct reimbursement plans". These are so clear and simple that they cut administration costs by 50% or more. Most employers do not know about them. For more information, have them call the American Dental Association at 800-621-8099 Ext 7746.

How The Fine Print Works

Table 1:
What if the roof on your home was leaking? Here's how "dental insurance" might handle the problem. The following common clauses are hidden in many dental benefit contracts:

Least Expensive Alternative:
You want better products and workmanship, but insurance pays only for the most basic job. Insurers are not saying you should not get the better work, or denying that it is superior; just that they won't pay for it.

Bundling:
The wood under your roof has rotted and replacement will entail extra costs. Insurance ignores the extra work by "bundling" it into your roof building. You must bear the additional expense.

Pre-existing condition:
Your roof was damaged before you got insurance. Coverage will be denied.

Medical Necessity:
You need a new roof, but your contract's language specifies that insurance will pay only for a "patch". You must pick up the difference.

Frequency Limitation:
You patch the roof, but it fails 2 years later. Your contract says they will pay once every 5 years. Coverage denied.

Fees and percentages:
You have 50% coverage for a new roof. You get several estimates-all in the $4000 range, yet your carrier's fabricated fee is only $3000. They will pay 50% of $3,000 ($1,500), not 50% of the actual cost.

Maximum:
Your plan has a $1,000 maximum. The most your carrier will pay is $1,000; even if that is less than 50% of their fabricated fee.

Better Plans:
Your neighbor has the identical roof and problem, but a better insurance plan. The same carrier will pay more for his job than for yours.

Need Verses Contract Language:
Your roof is unusually difficult and costs more. You protest and send a letter to your carrier for a higher reimbursement. Your request will be denied. Coverage is based solely on the legal language in your contract; not your health needs.

Dental Insurance Terms

Table 2:
Dental insurance provides wonderful benefits. However, there are several confusing provisions in the "fine print" of most contracts. Some common terms to know:

- **Deductible:** How much you have to pay before your insurance begins to kick in. (Commonly $50)
- **Maximum:** The most you can spend of your insurance company's money each year. (Usually $1000-$1,500)
- **UCR Fees:** The artificial fee your carrier assigns to each dental procedure. When your plan "says" it will pay 80% for a filling, it will pay 80% of this artificial fee, not what any dentist charges. Insurers refuse to disclose how they fabricate these fees, and there are virtually no regulations governing whether they are fair or realistic.
- **Categories:** Carriers often present percentages based on 3 "categories" of services:
    1. Diagnostic: Exams, X-rays, simple cleanings-usually covered at 80-100% of the insurer's fabricated fee.
    2. Basic: Fillings, Root canals-usually covered at 60-80% of the carrier's assigned fee.
    3. Major: Crowns, Bridges, Dentures, Gum treatment-usually covered at 0-50% of the artificial insurance fee.
- **Exclusions:** Dental treatments that are not covered. Common examples include cosmetic services, treatments for gum disease, implants and bite therapy. Over half of all the dental codes are excluded from most contracts.
- **Alternative Benefits:** If there are several ways to fix your dental problem, your carrier will pay for the least expensive option, even if you pick better care.
- **Pre-existing conditions:** Dental problems that existed before your benefits became effective. Treatment may not be covered.