Understanding Dental Insurance Coverage

The best way to take full advantage of your dental insurance coverage is to understand its features. Our best advice is to read your benefits information before you go to your dentist.

Plan Basics
Most insurance companies offer a variety of benefit plans with different features. The variance is generally related to the premium level chosen by the employer. It is not uncommon for employees within the same company to have different benefit levels with coverage that may differ.

Your dentist may not "participate" in the network for your dental plan. If your dentist does, he or she will submit your claim. If not, you may be responsible for paying your dentist and submitting your claim to the insurance carrier.

If you are entitled to benefits from more than one group dental plan, the amounts paid by the combined plans will not exceed 100 percent of your dental expenses. Benefits for dependents vary from plan to plan. Pay particular attention to special clauses and to language about dependents.

Dental benefits are calculated within a "benefit period", which is typically for one year but not always a calendar year. Check your benefits information so that you know when you might be approaching your deductible payments or plan maximums.

Key Concepts
- Maximums
- Deductibles
- Coinsurance
- Reimbursement Levels
- Pre-treatment Estimates
- Limitations and Exclusions

Maximums
Most dental plans have an annual dollar maximum. This is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period (usually January through December). The patient is personally responsible for paying costs above the annual maximum. Consult your plan booklet for specific information about your plan.

Deductibles
Most dental plans have a specific dollar deductible. It works like your car insurance. During a benefit period, you personally will have to satisfy a portion of your dental bill before your benefit plan will contribute to your cost of dental treatment. Your plan information will describe how your deductible works. Plans do vary on this point. For instance, some dental plans will apply the deductible to diagnostic or preventive treatments, and others will not.

**Coinsurance**
Many insurance plans have a coinsurance provision. That means the benefit plan pays a predetermined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the coinsurance, and it is part of your out-of-pocket cost. It is paid even after a deductible is reached.

**Reimbursement Levels**
Many dental plans offer three classes or categories of coverage. Each class provides specific types of treatment and typically covers those treatments at a certain percentage. Each class also specifies limitations and exclusions (see headings on these elsewhere in this section). Reimbursement levels vary from plan to plan, so be sure to read your benefits information carefully.

Here is the way the three levels typically work:

**Class I** procedures are diagnostic and preventive and typically are covered at the highest percentage (for example 80 percent to 100 percent of the plan's maximum plan allowance). This is to give patients a financial incentive to seek early or preventive care, because such care can prevent more extensive dental disease or even dental disease itself.

**Class II** includes basic procedures — such as fillings, extractions and periodontal treatment — that are sometimes reimbursed at a slightly lower percentage (for example, 70 percent to 100 percent).

**Class III** is for major services and is usually reimbursed at a lower percentage (for example, 50 percent). Class III may have a waiting period before services are covered.

**Pre-Treatment Estimate**
If your dental care will be extensive, you may ask your dentist to complete and submit a request for a cost estimate, sometimes called a pre-treatment estimate, a preauthorization or prior authorization. This will allow you to know in advance what procedures are covered, the amount the benefit plan will pay toward treatment and your financial responsibility. A pre-treatment estimate is not a guarantee of payment. When the services are complete and a claim is received for payment, Delta Dental will
calculate payment based on your current eligibility, amount remaining in your annual maximum and any deductible requirements.

**Limitations and Exclusions**
Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical plan includes limitations and exclusions, meaning the plan does not cover every aspect of dental care. This can relate to the type or number of procedures, the number of visits or age limits. These limitations and exclusions are carefully detailed in the plan booklet and warrant your attention. This booklet can help you develop realistic expectations of how your dental plan can work for you.

Allowances for some procedures covered under your benefits may be subject to limitation or denial based upon clinical criteria applied by the insurance company's licensed dentist consultant staff. Insurance companies generally maintain written guidelines for the use of clinical criteria in making benefit determinations. You may obtain a copy of such guidelines from the insurance company by sending a request in writing for the specific benefit category or dental procedure range.

The materials provided to you by the insurance company are guidelines used to authorize, modify or deny coverage for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

**Why Choose an Network Dentist?**
There are advantages to choosing a network dentist – quality, convenience and cost savings. And with approximately four out of five dentists represented in our network, you'll likely find a network dentist conveniently located near your home or work. Here are a few reasons why visiting a network dentist is recommended:

**Save Money**
Network dentists are under contract and agree to never balance bill you more than their contracted fee. For example, if you are a PPO enrollee responsible for a 20% coinsurance amount, you pay 20% of your dentist's contracted fee. Out of network dentists can charge you their full fee for their services, however, the insurance company will only reimburse at the contracted fee level. In most cases, the balance difference become patient responsibility.

**Pay Less Up Front**
Network dentists will accept assignment of benefits which means that they will wait for the insurance company to pay for the covered costs up the annual maximum. The insurance company sends you a notice explaining your portion of the bill. You pay the dentist only your portion of the services.
No Expensive and Unnecessary Unbundling
The insurance company ensures that you are never charged extra for services that should be included in the cost of treatment. For example, when you undergo a surgical procedure, the periodontists cannot charge additional fees for prescriptions, the suture removal appointment and any emergency follow-up visits.

Quality You Can Count On
Network dentists are properly licensed and meet accepted standards for cleanliness and safety procedures. The insurance company credentialing and review process is rigorous and detailed in order to maintain a high standard.

Treatment Options and Costs
When planning your treatment, it's important to know the costs, available treatment options and your plan’s benefits. Don’t be reluctant to ask your dentist about the cost of treatment before having work done. Your dental office will probably welcome the opportunity to discuss this with you. Ask about your treatment options as well as what your dentist charges for each treatment and what your share would be. In some cases, there may be several alternatives from which to choose and a less expensive alternative may be available.

A simple way to determine your expected cost is to ask your dentist to request a free pre-treatment estimate from your insurance company. A pre-treatment estimate is particularly useful for more costly procedures such as crowns, wisdom tooth extractions, implants, bridges, dentures and/or periodontal surgery. The insurance company reviews your x-rays, diagnosis, proposed treatment plan and coverage, and sends a statement back to you and your dentist estimating what your insurance plan will pay and what your costs will be. Some dental work may be limited or excluded by your plan, and a pre-treatment estimate will help you understand which services are covered before you proceed with treatment. A pre-treatment estimate is not a guarantee of payment. When the services are complete and a claim is received for payment, the insurance company will calculate its payment based on your current eligibility, your plan benefits, the amount remaining in your annual maximum and any deductible requirements.

Review Your Coverage Information
The insurance company payment for treatment will vary, depending on your plan and the dentist you visit. Some plans may offer a higher level of coverage if you select an in-network dentist. Others offer a higher level of coverage if you regularly visit the dentist. Many plans require that you select an in-network primary care dentist from whom you receive treatment in order to receive benefits.
Under some insurance plans, you are covered for a certain percentage of the cost, and the actual dollar amount paid for covered procedures may fluctuate depending on the dentist's fees. Other insurance plans cover a certain dollar amount for each procedure using a table of plan allowances. You may be asked to pay the difference between the table amount and your dentist’s accepted fee if the dentist is not in the network. Some insurance plans specify the copayment amount you pay for each service.

The best way to understand your plan benefits is to review your Insurance Coverage and Benefits Manual or online at the insurance company website. The first time you check benefits online, you may need to set up an account and then log into a secure system. With many insurance companies, you'll be able to check your eligibility and benefits, including your dentist network, maximums and deductibles, and coinsurance percentage or copayment amount for standard and orthodontic coverage. By reviewing your plan information and talking to your dentist, you'll be able to get the information you need to make the best decisions about your dental treatment.