How Dental Insurance Works

Dental benefit plans are not designed to cover all dental procedures. Plans usually cover some, but not all, of your dental costs and needs.

You should know what your dental plan covers and what it doesn't. This can help you understand why your dental benefit plan may not pay for all or even a portion of your recommended treatment. **Ultimately, your treatment should be determined by you and your dentist-not by your level of dental coverage.**

Your dental coverage is not determined by your dentist:

Your dentist's primary goal is to help you maintain good dental health, but not every procedure your dentist recommends will be covered. To avoid surprises on your bill, it's important to understand what and how much your plan will pay.

Your employer and the plan provider agree on the amount your plan pays and what procedures are covered. Your dentist is not involved in deciding your level of coverage.

Your dental coverage is not based on what you need or what your dentist recommends. It's based on how much your employer pays into the plan. Sometimes, you may have a dental care need that is not covered by your plan. Employers generally choose to cover some, but not all, of employees' dental costs.

Dental plans share treatment costs with you-There are certain cost-control measures that dental benefit plans use to determine how they share treatment cost with you.

Here are some key terms that are used to describe these measures:

Deductible – A deductible is the amount of money that you must pay before your benefit plan will pay for any service. It can take more than one service or visit to meet your deductible. Most plans don't require a deductible for preventive services like cleanings and exams or for diagnostic services.

Coinsurance-In most cases, after you meet your deductible you will be expected to pay a percentage of the allowed benefit amount of a covered dental service.

Annual Maximums-This is the maximum dollar amount a dental plan will pay during the year. Your employer decides the maximum levels of payment in its contract with the dental benefit provider. You would pay for anything over that set dollar amount.

If the annual maximum of your plan is too low to meet your specific needs, you may want to ask your employer to consider a higher annual maximum. If your plan also covers braces, there is usually a separate lifetime maximum limit.

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Pre-Exiting Conditions-Your dental plan may not cover conditions you had before enrolling even though treatment may still be necessary. You would be responsible for paying these costs. For example: If you had a missing tooth before the effective date of your coverage, then benefits may not be paid for replacing the tooth. Even though your plan may not cover certain conditions, you may still need treatment to keep your mouth healthy.

Coordination of Benefits (COB) or Nonduplication of benefits-These terms apply to patients covered by more than one dental plan. The benefit payments from all plans should not add up to more than the total charges. Even though you may have two or more dental benefit plans, there is no guarantee that all the plans will pay for your services. Sometimes, none of the plans will pay for the services you need. Each dental plan handles COB in its own way. Please check your plans for details.

Plan Frequency Limitations-A dental plan may limit the number of times it will pay for a certain treatment. But you may need a treatment more often to maintain good oral health. Make treatment decisions based on what's best for your health, not just what is covered by your plan. For example: your plan might pay for prophy (cleaning) only twice a year, but you need a prophy 4 times a year, so you would pay out of pocket for the extra 2 prophy's.

Not Dentally Necessary- Many dental plans state that only procedures that are medically or dentally necessary will be covered. It the claim is denied, it does not mean that the services were not necessary. Treatment decisions should be made by you and your dentist.

If your plan rejects a claim because a service was "not dentally necessary", you can appeal. Work with your benefits manager and the plan's customer service department or your dental office to appeal the decision in writing.

Other Cost Control Measures-Claims bundling- 2 different dental procedures are combined by the dental plan into one procedure. This may reduce your benefit. Down-coding-when a dental plan changes the procedure code to a less than complex or lower cost procedure than was reported by the dental office. Least Expensive Alternative Treatment (LEAT): if there is more than one way to treat a condition, the plan will only pay for the least expensive treatment. However, the least expensive option is not always the best option. For example: your dentist may recommend an implant for you, but the plan may only cover less costly dentures. You should talk with your dentist about the best treatment option for you.

Make Your Dental Health the Top Priority-Although you may be tempted to make decisions about your dental care based on what your dental plan will pay, remember that your health is the most important thing. Talk with your dentist to make sure you are getting the treatment that will restore your dental health.

By my Signature below, I assign directly to Northern Lights Dental, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all the charges, whether paid by the insurance or not. I herby authorize Northern Lights Dental to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Guardian _____ Date_____