

**UNDERSTANDING YOUR DENTAL BENEFITS**

*Dental benefits are a wonderful help to receiving the important care you need! While a benefit summary can aid in understanding general points of financial support, it is not an all-inclusive document. Our staff do an excellent job of providing approximations of dental coverage for services rendered; however, these are estimations–not guarantees—and* ***it is each patient’s responsibility to fully understand his or her policy and what will be covered in a policy year****. Being familiar with a few key points about dental benefits will allow you to make an informed decision based on your particular coverage.*

**Maximums:** Contrary to popular belief, a yearly dental benefit maximum is the opposite of a yearly health care benefit maximum. Rather than being the amount you are expected to pay out of pocket and having insurance cover the rest, this amount is **the most your insurance carrier will provide in benefits for the entire policy length**. **All provided services, including preventative care (cleanings and x-rays), will be deducted from the annual maximum.** For almost every policy, this amount does not roll over into the next policy year. For this reason it may be beneficial to schedule proposed treatment before the end of a policy year so these benefits are not unused. If this maximum is reached prior to the end of the policy year, all remaining costs **including preventative cleanings** will be out of pocket.

**Usual, Customary & Reasonable Fees:** Benefit summaries that show a percentage of coverage (i.e., “100% coverage on preventative services” [cleanings and x-rays]) refer to usual, customary, and reasonable (UCR) fees in your insurance carrier’s system. Across the board, insurance carriers’ fees are approximately **10-15% lower than dental practices’ fees**. This means that a cleaning will be covered at 100% of what your carrier’s fees are listed at. If a dental practice’s fee is higher than the carrier’s fee, **you will be expected to pay the difference**. When our staff estimate a patient’s portion for a particular service, they take into account your policy’s proposed percentage of coverage and collect your portion as well as the approximate 10-15% deficit for the total charge. Occasionally insurance will pay a little more than we expect, but we work hard to keep in communication with our patients once the Explanation of Benefits (EOB) is received.

**Frequency Limitations:** Most dental policies pay toward two cleanings and two exams each policy year per subscriber. Some patients make more frequent visits to our office throughout the year or alternate with a periodontal office to maintain their gum disease. If more than two cleanings or exams are performed **by any dental provider** within a policy year, this will be considered about the frequency limitation, and the amount for an additional performance(s) of these services in the same policy year will be **required out of pocke**t. Many policies also have a shared frequency limitation for emergency exams and periodic exams, and some of our patients’ most common policies no longer cover emergency exams. If you have visited our office for a cleaning and an emergency visit before your policy year is over, **a second typically covered cleaning or exam will not be covered**. Please keep this in mind when scheduling visits that require a dental cleaning or examination.

**Delayed / Denied Claims:** Our staff do their utmost to make sure claims are followed up with and paid in a timely manner. If your carrier asks for additional supporting information to continue processing your claim or denies it for reasons that can be worked out, we are more than happy to resubmit your claim. The typical processing time for claims is 14-30 days although it can take longer for mailed-in claims to be paid. If a carrier continues to deny the claim or requests above-and-beyond information for the procedure, we request that you pay the remaining balance on the claim and personally follow up with the carrier. A subscriber calling his or her carrier directly can often causes the carrier to process it faster, and at this point you would be due whatever reimbursement the carrier provides for that particular claim.

**Blue Cross Blue Shield:** If your insurance carrier is Blue Cross Blue Shield, in most cases we ask that you **pay for your services in full at your appointment**. Our staff will happily file your claim electronically with all necessary documentation, and we will ensure that any due reimbursement gets paid directly to you. The reason for this is that Blue Cross Blue Shield does not correspond with providers at all, and if a claim is delayed or denied we will not be notified of this. If you experience a delay or denial of your claim, **please call us immediately** and we will do our best to help you resolve this.

**Secondary Insurance:** Oftentimes patients have secondary or supplemental insurance. This is a wonderful addition to primary insurance; however, our office is only able to file with your primary insurance for you. If you have a secondary policy and would like to file the remainder of a claim, ask our staff for assistance and they will be happy to provide you with a detailed invoice that has the needed service codes.

*As always, we want to make your experience both with us and with your insurance provider as effortless as possible. We appreciate your understanding that processing claims is not always an easy task and appreciate your help by both being informed about the process and being willing to help when necessary.*