TENNESSEE FAMILY DENTAL

PATIENT RESOURCES

Dental Benefits (Insurance) Guide

A General Guide To Help You Understand
The Basics Of Your Dental Insurance.

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MANY PEOPLE ARE UNAWARE of the benefits their dental or medical plans provide them annually, and despite paying their premiums in full, they lose out on the covered care that is available under their plan! We don't want that to happen to you!

We have put together a general guide to help you understand your dental insurance. While every dental benefit plan is different, this general guide will help you understand the basics.

HOW DO I USE MY BENEFITS?

Whether you have benefits through your current employer, or if you are self-insured, dental plans vary widely. Dental benefit plans are also full of terms that people outside of the insurance industry often have a hard time understanding. This page is meant to be a broad resource for helping you to interpret basic terms and coverage types in dental benefits — however, this page is not definitive to your specific plan. Please feel free to call us and ask our business coordinator to help you understand what is covered under your specific plan.

WHAT ARE THE MAIN TYPES OF COVERAGE?

Preventative/Diagnostic (100%): This is typically covered at or near 100 percent by most dental benefit providers. It includes a certain number of professional cleanings and preventative exams per year, as well one set of 4 bitewing x-rays for adults and 2 bitewing x-rays for children, and a panoramic x-ray once every few years (typically every 3 – 5 years). Fluoride treatments and sealants may also be covered for minors less than 14 years old. (*Keeping up with your annual preventative exams and cleanings is the most cost-effective dental care you can give yourself in the long run.*)

Basic (80%): This is typically covered at or near 80 percent and may be subject to meeting your annual deductible. Your deductible varies according to your plan, but the majority fall between $25 and $100 per person per year. *Basic* coverage includes routine procedures such as fillings, root canal therapy and minor oral surgeries (such as an extraction).

Major (50%): This is typically covered at or near 50 percent and usually requires meeting a deductible. Typically, procedures that are grouped under this coverage consist of: dentures, bridges, crowns, and implants.

HOW DOES MY DEDUCTIBLE WORK?

For the majority of benefit plans, procedures and services that are grouped as *Preventative/Diagnostic* are covered at 100 percent with *no deductible requirement*. Insurance companies know that preventative measures such as annual exams and cleanings will catch problems early, before they get too large (or expensive!) and become issues that must be treated under the *Major* coverage grouping. Therefore, it's in their best interest to completely cover *Preventative/Diagnostic* dentistry. By covering your twice per year cleanings and x-rays, the insurance companies know that you are statistically less likely to require more expensive treatment later on down the road. This is also why benefit plans typically covers less and less as the treatment costs rise from the *Basic* to *Major* categories, and also why the patient is typically required to meet a deductible before coverage kicks in for these categories.

EXAMPLE: Consider these ballooning costs, for example:

1. Cleaning and Exam – $300 (not an actual fee)
2. Root Canal – $800 (not an actual fee)
3. Crown – $1200 (not an actual fee)

If your insurance plan is similar to what we've described above, then they will likely cover 100 percent of the cleaning and exam, and the root canal would be covered at 80 percent once you pay your $50 deductible. So the total cost to you for the root canal would be the $50 deductible, plus the $150 that your benefit plan did not cover which is $200 TOTAL, as calculated below:

1. Subtract the deductible ($50) from the full cost ($800) before the percentage of coverage is calculated: $800 – $50 deductible = $750.
2. Apply the percentage of coverage (80%) to the remaining amount ($750) to determine the benefit portion: 80% of $750 = $600
3. Subtract the benefit portion ($600) from the remaining full amount ($750) after the deductible: $750 - $600 = $150 your portion.
4. Determine total amount: $50 deductible + $150 your portion = $200.

The deductible is always subtracted from the full cost *before* the percentage of coverage is calculated.

The deductible is also a *one-time, once per year* fee. This means that you if you needed two root canals, for example, you would pay the $50 deductible once, plus $150 for the first root canal. Your second root canal would be covered at 80 percent (80% of $800 = $640), so your portion of the second root canal would be $160 ($800 – $640 insurance portion = $160 your portion). The total cost to you of both root canals would be $360 ($200 + $160). (Similarly if you needed one

root canal and one crown, the deductible would only be paid once per calendar year, and then you calculate the percentage your insurance covers.)

ANNUAL MAXIMUM

An annual maximum is just what it sounds like: an annual maximum, or cap, that an insurance company will spend on a plan member (that's you) per year.

Yearly maximums may range from $1,000 to $3,000 (again, your plan may vary), and they are set as an agreement between you, or your employer, and the benefit provider. You'll need to check you policy to see if it renews on January 1st of each year, or if it is set to renew on the date you were hired at your place of employment, or date of purchase of your policy.

If you have an unused portion of your maximum remaining at the end of the year, the unused portion *will not* roll over or carry over to the next year. (For example, if you used $500 of your $2000 maximum, when your policy resets the next year, you'll still have a $2000 maximum, not $3500.) This is why the year's end tends to be a busy time for dentists who accept insurance.

We always recommend that you accept treatment upon diagnosis and take steps to have the treatment completed in a reasonable amount of time. **This is because disease states that are diagnosed will only worsen over time, and when they worsen, the expense to correct them increases**. However, if you need a lot of work and can't afford to do it all at once, then we'll work with you to figure out how to maximize your benefits without jeopardizing your oral health. For example, if you need more than two crowns but your benefit plan annual maximum will only cover two crowns per year, then you can opt to have two done in the current year, and two done immediately when your benefit plan resets the following year.

REASONABLE AND CUSTOMARY RATES

Insurance companies will tell you that your benefit coverage amounts are based on reasonable and customary rates. What this means is that your benefit plan carrier has a schedule of fees for every kind of dental procedure covered under your plan. The fee schedule means that they will pay for benefits based on the methods we've outlined above, but cap the total price of a procedure for which they are willing to pay.

For example, let's say your benefit plan states it covers cleanings at 100 percent and your dentist charges $90 for a cleaning, but you receive a bill for $20 (again, these are not actual fees). This means that your insurance capped the price they are willing to pay for a cleaning at $70, and that your dentist has billed you for the difference.

Many insurance plans cap their prices at slightly less than what most dentists charge in their office fees. Fee caps vary widely among different benefit plans. (Less expensive plans typically have the lowest fee caps, while the most expensive plans will typically have the highest fee caps. This means that a patient with inexpensive benefit plan premiums will be billed a larger difference than a patient with more expensive benefit plan premiums.)

The fee caps for your plan are a function of the amount of money you, or your employer, pays toward your dental health benefits. You can call your dental benefit provider and ask for them to send you their fee schedule so you can see what the exact covered costs are, and anticipate any difference you may be billed for. (To the insurance company, a fee schedule is a calculation of how much they can pay for procedures before they lose profit based on the amount of money your employer pays them.)

FILING YOUR INSURANCE CLAIM

As a courtesy to all patients, we will electronically file your insurance claim for you. However, some smaller dental benefit companies still process their claims by paper and we must submit these by mail. Please understand that mailing a claim takes much longer.

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Thank you for reading!

We hope this has been helpful for you.

Tennessee Family Dental is in-network with most major insurance companies. Please contact us to ask us any insurance-related question, and we'll get back to you ASAP!

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4 Convenient Locations across the Nashville Area

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