Insurance FAQ

Insurance can be confusing and frustrating, especially when services aren't covered at 100%. Some of your questions may be answered below. If not, please contact our office! We are always happy to help educate about your insurance plan.

Why didn't my insurance cover everything?

Employers offer dental benefits to help employees and their families pay for a *portion* of the cost of their dental care. This is great! Still, there are usually still expenses for the employee and their family to cover. The amount your plan pays is determined by the agreement negotiated by the employer with the insurer. Your plans "allowed" fees are predetermined amounts that will be covered by the plan for eligible services. Most plans pay an established percentage of the dentist's fee or their "allowed" amount, whichever is less. If your dental provider exceeds the plan's "allowed" fee, it does not mean your dental provider has overcharged the procedure.

Insurance companies do everything they can to lower their costs, including:

- **Deductibles and maximums**

The deductible is the amount you must pay out of pocket before insurance will start paying benefits, and this resets every benefit period. A maximum is the financial benefit that insurance will contribute to care annually. Once you have maximized your insurance benefit, insurance will no longer make contributions and you are responsible for additional costs incurred.

- **Frequency limitations**

This refers to the number of times a procedure will be paid for by your plan in a benefit period. For instance, a fluoride treatment for your child may be covered only 1 time per year, while the ADA's recommendation is 2 times per year.

- **Exclusions and waiting periods**

Exclusions are coverage limitations dictated by insurance providers. For example, a common exclusion is a "missing tooth clause." This means the plan will not pay for ANY procedure to replace a tooth that was missing prior to the plans effective date. Exclusions don't mean service(s) aren't needed. Waiting periods reference a time period the patient must wait until benefits will be paid. It's a good idea to become familiar with your plan exclusions as they range in severity.

310 Mountain Avenue, Berthoud CO 80513 ∞ 970.528.0900 ∞ mountainridgedentistry.com

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Insurance FAQ

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- **Downgrading**

Insurance companies often choose to pay an alternate benefit to achieve similar treatment results. For example, your dental provider may suggest a white 'tooth colored' composite filling, but your insurance will only pay for a silver amalgam filling. This is known as the "least expensive alternative treatment." It does not mean an inaccurate code was submitted as we always code exactly what we do. It is just another way your insurance company saves themselves money.

- **Bundling**

Bundling is when insurance providers count several codes towards the same benefit. For example, many insurance companies combine exam frequencies for periodic (check-up) exams and limited (emergency) exams. This may result in a loss of exam benefits towards the end of the year due to an emergency or two early in the benefit period.

Remember, insurance companies DO NOT base their coverage on the American Dental Association's recommendations for optimal health. We encourage patients not to let insurance dictate oral healthcare decisions.

Tired of dealing with insurance? You might consider switching to our in-house discount plan. The plan usually exceeds typical insurance savings, without the constraints of acceptable treatment rules they often impose. The plan also allows us to provide exact pricing, instead of estimations of how insurance will impact cost. Contact our team if you're interested in learning more.

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