EXPLANATION OF DENTAL PLAN COVERAGE AND BENEFITS* Updated: 6-10-2014 BLS

COVERAGE AND BENEFITS: Dental plans are designed to share the cost of dental care. **Most dental plans are not insurance in the traditional sense because the customer is always called upon for partial payment of the services but it is better than paying the full amount.** Some dental plans may not allow benefits for all available options even when your dentist determines that a specific treatment is in your best interest. The least expensive alternative is not always the best option. Your dental plan may not cover certain procedures or treatments regardless of their value to you. **It is the patient's responsibility to understand the coverage and benefits of your specific dental plan.** Please be aware that dental office staff cannot always answer specific questions about your dental benefits or predict the level of coverage for a particular procedure because dental plans written by the same benefits company or offered by the same employer may vary according to the contracts involved. **Your plan sponsor (often your employer) is usually in the best position to explain the individual features of your plan and answer questions about coverage and benefits.** You may also contact the insurance company regarding any questions or concerns about your dental plan. Thank you for your cooperation and understanding.

COPAYMENT: Most dental plans will only pay a percentage of the contracted fee for a covered service and the insured or patient is responsible for their percentage portion. This means that the insurance company and the customer both pay some of the charges for dental work covered by their dental plan.

DEDUCTIBLE: Amount of expenses that is paid by the insured or patient before the insurance will pay for any covered expenses. The deductible amount can range from $25 to $100 but $50 is the most common. Most dental plans will have a onetime per plan year deductible to each patient towards Basic or Major services. *Please be aware that any deductible amount is your responsibility and any amount below does not include the deductible.*

BASIC BREAKDOWN OF AN AVERAGE DENTAL PLAN:

Type 1 –100% – PREVENTATIVE CARE: Most dental plans will cover a cleaning, checkup exam, and 2 bitewing x-rays once every 6 months from the date of your last cleaning and checkup exam at 100%. Most dental plans will also cover Fluoride treatment for children every 6 months, sealants for children on back teeth and once per tooth, full set of x-rays or panoramic film once every 5 or 7 years, and periapical x-rays and limited exams as needed at 100%.

Type 2 – 80% – BASIC SERVICES: Most dental plans will cover Fillings, Deep Cleaning, Root Canal, Extractions, and to fix or repair major services at 80% (patient responsibility is 20% - deductible not included). The average patient copayment for Basic services covered at 80%: Fillings are normally from $19 to $60 each with a normal payment of around $36, Deep Cleaning is normally 2 visits and around $88 for each visit, Root Canal is normally 1 to 2 visits with a payment from $130 to $200, Simple extractions are around $28, and Surgical extractions can normally range from $50 for a simple extraction up to $100 each for fully impacted wisdom teeth.

Type 3 – 50% – MAJOR SERVICES: Most dental plans will cover a Post & Core, Crown Lengthening, Crown, Bridge, and Dentures at 50% (patient responsibility is 50% - deductible not included). The average patient copayment for Major services covered at 50%: Post & Core is normally around $150, Crown Lengthening is normally $275, Crown is normally 2 visits with a payment of around $575, a 3 unit Bridge (1 missing tooth) is normally 2 to 3 visits and normally cost around $2000, Partial Dentures are normally 2 visits with a copayment normally around $450 for resin to $650 for cast metal for each partial, and complete Dentures are normally 5 visits with a copayment normally around $600 for each denture. Some dental plans will cover Dental Implant (Implant D6010, Abutment D6056, and Implant Crown D6059) under MAJOR at 50% with a copayment of around $2500, Implant Crown at 50% ONLY which will result in a total patient payment of around $3300, or NO dental coverage for an implant which results in a total patient payment of $4000.

ELIGIBILITY: Eligible for coverage are employees, spouses, and dependent children to the end of the year in which age 21 is reached, unless a fulltime student, in which case eligibility is extended to the end of the month in which age 24 is reached for most dental plans. The insurance company does not notify this office regarding eligibility. It is the patient's responsibility to notify this office of any new dental plan, termination, or for any changes to your dental plan.

LIMITATIONS AND EXCLUSIONS: There are certain limitations and exclusions which may apply to your dental plan. For example, dentistry that is performed for cosmetic reasons (appearance only), Fluoride Treatments over age 19 and sealants over age 15 for most plans, and for any services provided or started prior to the effective date of the dental plan are not covered. A **waiting period** for 6 months to 1 year may apply to some services for a new dental plan. In most cases, a new plan will have a 6 month waiting period for Type 2 services and 1 year for Type 3 services. A **missing tooth clause** may affect coverage and/or payment toward a post & core, crown, bridge, denture, or implant if the root canal on the tooth or the extracted tooth was performed before the effective date of the plan and/or is not on file with the insurance company. Some dental plans may include an **alternative benefit** or sometimes called a **downgrade clause** that may be applied to some services. Please be aware that a downgrade clause means that the insurance will pay for the "least expensive treatment" and the patient is responsible for the difference in cost. In some cases, a dental plan will only pay for an amalgam filling (silver filling) toward the office charge of a posterior composite filling (white filling on the back teeth) and will result in a larger payment for the patient.

MAXIMUM ALLOWABLE FEE: This is a compensation arrangement in which a participating dentist agrees to accept a prescribed sum as the total fee for one or more covered services. An adjustment will be made when we receive the EOB from the insurance for any difference between our charge and the maximum allowable fee on covered services for a participating provider. **Your dental benefits plan purchaser provides the final decision on "maximum levels" of reimbursement for services through its contract with the insurance company.** *You are responsible for any unpaid claims, denied claims, and for any remaining balance on the account.* Please contact your plan sponsor or the insurance regarding any questions or concerns about payments.

INSURANCE MAXIMUM: The maximum dollar amount the insurance company will pay toward the cost of **ALL dental care** incurred by an individual in a specific period, usually in a calendar year. Some dental plans with Orthodontic coverage will have a separate lifetime maximum on average of $1500.00 with a separate deductible. **The average insurance maximum for most dental plans is $1500.00.** Please be aware that any amount that goes over the maximum is the patient's responsibility. Please contact the insurance company for the correct insurance maximum remaining on your dental plan.

PREDETERMINATION: If the cost of a service is expected to exceed $300, you can ask your dentist to submit a pre-treatment estimate in advance of treatment. It will return in **30 days** to you and the dentist indicating coverage, how much will be paid by your plan, and how much is your responsibility.

PATIENT PAYMENTS: We accept Visa, MasterCard, Discover, CareCredit, money order, cash, and check to better serve you. Any patient payment portion (patient co-payment and any deductible) is the patient's responsibility and this amount will be collected when services are rendered unless prior financial arrangements have been made. Any multi-visit service requires a 50% deposit of your patient payment portion expected at the first visit and/or equal payments at each visit for this type of service to help cover any expenses and any remaining patient payment portion will be collected at the completion visit. **We appreciate your business and thank you for providing your estimated patient payment responsibility at the time of service.**

EXPLANATION OF BENEFITS (EOB): Our estimate of your patient payment at the time of service is usually extremely accurate. In about 30 days you and the dentist will receive an EOB from the insurance usually indicating the services that are covered, any insurance payment to the provider, how much was paid by your dental plan, maximum used, and how much is your responsibility. In some cases, a difference in payment for the patient may occur due to the specific contract of your dental plan. Please contact your plan sponsor or the Insurance for questions or concerns regarding dental payments.

** This is only an explanation of dental benefits and coverage for the average dental plan at our office which may differ from our plan and is being provided for patient educational purposes only. **