

Okay... brutally tough topic but I'll try and explain it. Bear in mind that I live and work in Canada. We don't have HMO's, PPO's or capitation here so I know little of them and won't try to explain what I don't understand. What I will describe is dental insurance as it works in BC, Canada. This topic is a HUGE headache and is a CONSTANT source of aggravation so bear with me here.

First things first - and this is critical to avoid any misunderstandings between yourself and your dental provider. You, and you alone, are responsible for knowing what your insurance covers and what it does not. What are its benefits and limitations - when it is effective and who is covered by it - how much of it you've used up. Your dentist does not have any direct links to any insurance provider and does not know anything about your plan that they haven't had to specifically look up on your behalf. In many instances we can contact your insurance provider to find out the details for you but you must first give us all the particulars about your plan and specifically ask us to do so. NEVER assume that because your dental office has recommended specific treatment for you that it is covered by your plan. If you are concerned about whether it's covered or not - ask your dental office to pre-authorize the treatment with your insurance company before the treatment is performed. You may have to wait several weeks to a month for the preauthorization to come back but you will then know with certainty what your financial responsibility will be.

Some insurers will not discuss your coverage with a dental office - they will only tell us that the insured must contact their employer for any information. We do not know if your benefits increase or are cancelled - we have no idea if your provider changes. By and large when you work for a company that provides dental coverage they will give you a booklet outlining all the different benefits that are provided. Please bring this book along with you to your first dental visit - it contains information such as your group number, your ID number, and often it contains plan particulars such as percentage coverages and frequency/dollar amount limits. Your dentist has no way of knowing this information other than you providing it. If anything about your plan changes then your employer will tell you and you must tell your dental office.

Next.... dental insurance is a misnomer - no matter what you have or what it's called it's prepaid dentistry. A carrier has agreed to provide dental coverage to a group for a certain price. As long as the carrier gets in as much or more money than it pays out then everything is fine with them. If they pay out more than they get in then your rates will go up. Whether you pay for it out of your own pocket or an employer picks it up for you the fees paid by your group will cover all of the group's dental costs.

So... let's get into it.

What is a dental plan?

A dental plan is an arrangement made on your behalf, generally by your employer, though you can arrange your own, whereby you are provided with certain dental 'benefits' possibly subject to some limitations and deductibles.

Deductibles, if present, can be per-person, or per-family and are usually either \$25 per person or \$50 per family. What they mean is that on a per-person basis, you are responsible for the first \$??? of your treatment each year. If you have a \$25 per person deductible plan then each member of your family who uses the plan will have to pay the first \$25 of their dental bill. If you have a \$25 per person, \$50 per FAMILY deductible, then the first 2 people will pay the first \$25

of their first visit after which the \$50 per family deductible will be satisfied and any other family members will not have to pay this portion.

Limitations can be either service limitations, frequency limitations, or dollar amount limitations.

Service limitations mean that only certain services are provided. You may be covered eg. for examinations but not for cleanings or for fillings but not for crowns.

Frequency limitations mean that a service can only be provided at a certain frequency. For example, 9 month recalls is becoming common - this means that your insurance plan will only pay for a recall (checkup) exam once every 9 months. If you have a checkup exam at 6 months your insurance will not pay for it.

Dollar amount limitations limit how much your plan will pay on your behalf - usually in a calendar year. If you have a \$1000 per year limitation then anything up to \$1000 per year in dental treatment will be covered - after that you're on your own till the plan resets - probably January 1st of the new year. The limitation is a limitation on the amount the carrier will pay - not the total amount:

EXAMPLE

You have a plan with a limit of \$1000 per year. Your crown and bridge coverage is 50%. You have a crown done that costs \$700. Your insurance carrier will pay 50% of that, or \$350. You still have \$650 of insurance coverage left for the year.

So how much will my visit cost me?

Tough question. That depends on many factors.

EXAMPLE

If a basic procedure, such as a checkup, is done - AND you have basic coverage - AND you haven't exceeded the frequency limit - AND you haven't exceeded your plan's dollar limit - THEN you'll be covered at the percentage your plan dictates for that group of procedures - IF the plan pays at the same fee guide the dental office bills at AND if any deductible has been satisfied. (see 'what is a benefit' below).

Are you starting to see why some dental offices don't like to deal with dental plans? The number of variables is staggering.

Some plans pay for checkups but not cleanings - some pay for cleanings but not on the same day as checkups (don't ask me why). Some pay for everything but on a non-current feeguide - or the feeguide for a different province (the dental feeguides vary from province to province to reflect local economic conditions).

You have to read the plan booklet you got very carefully, then ask the dental office you attend to look at it and explain what may not be apparent to you.

What's a feeguide?

Every year, in every province, representatives from the local dental associations meet with representatives from the major dental-insurance carriers and determine fees for each different dental service.

Each service has a unique procedure code. For example - a checkup exam is code 01202. All dental insurance carriers and all dental offices in Canada recognize the same procedure codes. The codes are lumped together in numerical groupings that denote that they are similar procedures eg. all codes that start with 3xxxx are root canal related - 4xxxx are periodontal procedures - 7xxxx are surgical.

The fee that is determined is the fee that dental insurers accept as the amount that they will pay for any given procedure. Remember that dental insurers are there to provide you with a certain basic level of care. Their goal is not to provide you with what is best - only with what will work.

There is nothing that binds any dentist to bill according to any fee guide and, indeed, many bill whatever they feel is fair. Your dentist may feel he or she provides a superior service than what the feeguide would indicate and therefore should be paid more. Your dental plan will only reimburse to what the feeguide which they accept indicates. This is important to realize because anything over the feeguide amount billed is entirely the patient's responsibility.

EXAMPLE

All these examples presuppose that you haven't exceeded any limits on your plan and that your coverage is in force and any deductibles have been satisfied.

You are seeing a dentist in BC and are insured with a company that follows the current (2001) BC feeguide. Your plan covers fillings at 80%. You see a dentist who charges the current feeguide of \$100 - your insurance would pay 80% of \$100 or \$80 - you would personally pay \$20.

Same scenario - your dentist charges over the current feeguide - say \$120. Your plan will still cover 80% of the \$100 and you will now have to personally pay \$40.

Same scenario - your dentist charges the current feeguide (\$100)- your plan pays on the 1995 feeguide which was \$80. Your plan will pay 80% of its feeguide (\$80) for a total of \$64 - you would be personally responsible for the \$36 difference.

Complicated, huh? It gets better when you add in deductibles, limits, and the fact that if you and your spouse BOTH have dental plans then you can often 'coinsure'.

Does my insurance carrier pay, or do I?

That depends entirely on the individual dental office. The technical term for this is assignment of benefits. It means that you can sign on a dental 'claim form' (a bill submitted to the insurance company) allowing them to pay directly to the dental office.

Some offices (like ours) accept assignment of benefits. You would directly pay us the portion of your treatment not covered by your plan and we would bill your plan for the rest. This is entirely a courtesy to you and is a major pain in the butt for us. We take it upon ourselves to fill out the forms, submit them to your insurance company, wait sometimes several months for payment, provide additional information about your claim at their request and our expense, resubmit if it doesn't get paid or gets paid in error and so on and so on. This is a full time job for a staff member and is possibly the most frustrating part of our job.

Many offices do not accept assignment of benefits. You are expected to pay your bill at the time treatment is rendered. The dental office will provide you with a claim for which you submit to your insurance carrier yourself. They then reimburse you and you look after tracking it yourself.

Just as dental offices can choose whether or not they accept assignment of benefits, some dental insurance companies do not allow assignment. These companies will not pay directly to a dental office and require the patient to pay for their treatment. The patient or their dentist then submits a claim form, and the patient is reimbursed directly by the insurer. This is quite inconvenient for the patient - and that is entirely the intention. The insurer feels that if the patient is forced to pay and then get reimbursed that they are less likely to utilize the plan - good for the insurance - bad for the patient.

Be sure to ask about this if it's important to you. And if you know that your plan does not allow assignment please let the dental office know - it's hard enough to track things when we know everything without little surprises like that.

Can self-employed people have dental plans?

Generally not. Plans only work because there are a lot of people sharing the cost. When there are few people 'covered' by the plan the cost of the plan is generally more than the amount of dentistry covered by it. This is because dental 'insurance' carriers add an administrative fee that is part of the dental plan cost for processing paperwork and payments.

How much does a dental plan cost?

Dental plans cost as much as they provide. Plans that have no limitations on service and many benefits cost a lot. Those that provide few benefits with many limitations cost little. Some large companies pay for the entire plan for their employees as part of their benefits package. Other companies pay for part of it or let their employees choose what benefits they want in their packages. The variations on the theme are endless.

I've heard of personal dental plans - what's that?

There are some 'personal' dental plans available. By personal, it means that your employer does not provide them for you. You may be retired, self-employed - whatever. You apply for these on your own and pay for them on your own. They generally have fairly serious limitations to them and it's wise to consider how much you will be paying for them versus how much you'll be getting.

You keep mentioning benefits.. what are those?

Benefits, as referred to by dental plans, are the kinds of services that are provided. Generally benefits are separated into:

Group A - basic diagnostic, preventive and restorative eg. exams, cleanings, fillings. The most commonly utilized procedures.

Group B - Dentures, partial dentures, repairs to dentures and partial dentures

Group C - Crown and Bridge - 'major' restorative - this is the 'cadillac' area as these services are generally more expensive.

Ortho - covers orthodontic treatment. This usually has a lifetime maximum dollar amount that the insurance company will pay per person covered on the plan.

Who's covered by my plan?

Again, that depends on the arrangement that your employer has made with the insurer. Obviously if you're the employed one with the plan then you would be the one covered. It's quite common, though, for spouses and dependent children to also be covered - though you should confirm this with the employer's benefits administrator to be sure.

Children are usually covered till age 18 at which time they are off unless the parent provides proof to the insurer that the child is still in school in which case the insurance can be extended. The extension is generally to age 21 but can be till the child is no longer in school.

My spouse has a plan too - can we use both?

This is called coinsurance - meaning that you are covered by your spouses plan and your spouse is covered by yours. When this happens you can usually use both at once. I say usually because a few insurers do not permit coinsurance. This one you really have to check into first.

When it is allowed - and it usually is - you can use your insurance to pay up to the maximum they will pay and then your spouse's insurance to pay the remainder. This is usually very advantageous to people who need extensive treatment.

When you use coinsurance the claim process is a little different. You **MUST** claim to your insurance first. They will reimburse as much as they intend to. You then take a copy of the reimbursement statement, attach it to a second claim form and send it to your spouse's insurance. They will then look at the amount claimed initially, how much they would pay towards it, deduct what the other insurance paid, and pay what's left up to either a) the maximum they would pay without your secondary insurance or b) the total amount claimed - whichever is less. They will never pay **MORE** than the amount claimed.

Not letting the secondary insurance know about the primary would result in them paying more than they should and is a criminal act of fraud so be sure you let them know.