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Understanding Your Dental Insurance Benefits

Understanding your dental insurance benefits can be a difficult thing. To help you better understand your plan we have put together this list of terms that are frequently used by your insurance company. Many of these terms are used to discuss the limitations of your dental insurance benefits. It is important to realize that most *dental* insurances are much different than traditional *medical* insurances. They usually cover much less and have significantly more restrictions. It is also important to know that dental insurance is designed merely as a *supplement* to help you cover the costs of your dental treatment. In many cases, your dental insurance may not cover all of your necessary treatment.

At Page Dental Arts, we do *not* recommend putting off or avoiding treatment based on what your insurance will cover. Serious complications, including infection and tooth loss, can occur with such avoidances. However, we understand that when your insurance does not cover all of your needed treatment, your out of pocket costs can seem unmanageable. We want all of our patients to know that if this occurs, we offer flexible, no-interest payment plans through Care Credit to help you manage these unexpected dental expenses. We are here to help you afford a smile that you can be proud of!

1. **Maximum Benefit**: This refers to the maximum amount your insurance will pay over a given time, usually one year. If this amount is reached during the year, your insurance will not cover any more services until the following year.
2. **Deductible**: This is a flat fee that the patient is required to pay by the insurance company before the insurance company will pay for specific services (Similar to a deductible for car insurance). The fee is applied to the cost of these services. This fee is typically required for basic and major services. Most plans waive this fee for preventative or diagnostic procedures (i.e. cleanings, exams and x-rays). Depending on your specific insurance plan, your insurance company may require a deductible to be paid yearly or just once during the lifetime of the plan.
3. **Plan Coverage**: Coverage varies with every plan. As a courtesy to you, we will research your insurance to find out how they cover the different services offered at our office.
4. **Plan Frequencies**: This refers to the number of times a procedure will be covered by your insurance company per year. For example, most insurance plans cover a cleaning twice a year. If it is recommended that your teeth be cleaned more often than twice a year, then your insurance company will not cover anything in excess of the two cleanings in that year. It would be the patient's responsibility for any additional cleanings.
5. **5 year replacement rule**: This is a rule that has been established by insurance companies that limits how often they will cover the replacement of certain services. This rule usually applies to major type services (i.e. crowns, bridges, dentures). For example, if a crown needs to be replaced, your insurance will not cover their portion of this service if the original crown was placed less than 5 years ago. Some plans may even extend this rule to 8 or 10 years.
6. **Missing tooth clause**: This is a clause that has been established by insurance companies that limits the coverage for replacement of missing teeth. It states that if the tooth to be replaced was missing before the effective date of your insurance plan, then its replacement will not be a covered benefit by your insurance company.
7. **Waiting period**: This is a specific length of time that may be established by your insurance company during which you are not eligible for coverage for certain services. For example, an insurance plan may have a six month waiting period for major services (i.e. crowns, implants, dentures). This means that major services will not be covered for the first six months that the plan has been effective.
8. **Plan History**: This refers to the services that have been completed since your insurance plan has been effective.
9. **Eligibility**: This refers to whether or not you are *currently* eligible for coverage for a specific service. Some reasons your insurance may deem you "not eligible" for a service are the following: the waiting period has not been met, frequencies for the year have been exhausted, or the maximum benefit for the year has been met. If you are not eligible for insurance coverage for a service, then payment is your responsibility. It is important to understand that if your insurance deems you "not eligible" for a service, that does not mean that you cannot have that service, or that you do not need the service. This does, however, mean that the insurance company will not pay for that service.
10. **Alternate Benefit Clause**: This is a clause established by insurance companies that states your insurance company has the right to decrease the amount they will pay for certain services if there is a cheaper alternative service. This clause is most often applied when molar teeth are restored with white fillings or porcelain crowns. For example, if you had a cavity filled with a white filling, then your insurance would only pay the benefit for a silver filling. Any difference in cost would be the patient's responsibility. Please note, due to our commitment to providing you with the best esthetic result, Page Dental Arts only offers white fillings.