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This publishing is designed to save patients: Time & Money. Please review this tutorial regarding understanding how you can maximize the most of your insurance policy.

Q: Would you take a \$1,000.00 loan with a fixed APR of 67.11 %?

If you are familiar with loans, finance and APR's the answer is No.

However, if you are not familiar with the terms and conditions of the loan, your answer could very easily sway to a "yes, I'll take the loan".

This analogy is being used because so many people have insurance policies with out understanding the terms and conditions of their policy.

The majority of times, NOT having a firm knowledge base of your insurance policy will cause more problems than solutions when dealing with Dental offices, insurance companies as well as your financial obligations due to your doctor and or insurance company.

UNDERSTANDING THE DIFFERENCE BETWEEN:

NETWORK AND Out Of NETWORK (DENTAL OFFICES)

The #1 rule of thumb is to know if your doctor or dentist is within your insurance "NETWORK" or not.

If a doctor or dentist is participating with your insurance company, they are willing to make adjustments to their set fees because they have agreed to be a member of a particular insurance company.

For example, a dental office can be a **provider** of dental services to as many insurance 'networks' as the office prefers just as long as they sign the networking contracts that specify that the office will make financial adjustments when a patient comes for a visit.

Again, remember that if you come in for to have your teeth polished and the regular price for the procedure is \$100 then the price with an insurance network could be \$80 or \$70 or less. This is more beneficial to YOU, the patient because it allows you to actually have a discount on fixed pricing a dental office has for their procedures.

An example of a network would "Met Life" or "Blue Cross Blue Shield".

Each insurance company that categorizes different dental providers such as HMO, PPO, PDP to patients who have specific types of insurance policy plans.

If you have a PPO insurance policy you will then find a dental office that is a PPO dental provider.

May Valley Dentistry is a PPO office only. PPO stands for Preferred Provider Organization.

Focusing on our practice, if May Valley Dentistry signs a contract with Met Life to become a network provider THEN, May Valley Dentistry can only charge patients a price that is set by Met Life for dental procedures.

Understanding Insurance Discounting:

Let's assume a random patient, Joe Montana, walks into May Valley Dentistry and does not have any insurance. Joe's bill would add up to the following:

1. Initial Oral Exam - \$50.00
2. ICS - \$11.00
3. Panorex X-Ray \$75.00

Total - \$136.00.

If Joe was a Met Life policy holder or **subscriber** to Met Life Dental Insurance and Joe holds a Met Life HMO insurance card, then Joe would have to still pay an out of pocket fee of \$136.00 because May Valley Dentistry is a PPO provider not a HMO provider.

Let's assume the same example with Joe Montana but this time Joe has PPO Met Life insurance card now what happens?

Joe might have to pay a small fee for his visit.

May Valley Dentistry will submit an insurance claim for \$136.00 to Met Life.

Met Life will then mail the patient (Joe Montana) and doctor a form called "Eligibility of Claims" this form will specify:

1. How much money the insurance company will pay for Joe's procedures.
2. How much money needs to be adjusted by the dental office.
3. **How much money the patient needs to pay out of pocket.**

Final Exam Question:

Finally, what would happen if Joe Montana has PPO Cigna Insurance and has an emergency and visits May Valley Dentistry who is a PPO provider but does not have a contract with Cigna?

1. PPO is the key here because even if May Valley Dentistry does not have a direct contact with Cigna, May Valley Dentistry is within the PPO network.
2. Cigna is an Out of Network Insurance Provider which means that Joe would have to pay \$136, however, May Valley Dentistry would provide Joe with an insurance claim and a receipt where Joe would simply mail the 2 documents to Cigna insurance and he would be reimbursed 'xyz' amount of money back by Cigna.

#1 LESSON: Double check to make certain that you are always going to a dentist that is within your network of your insurance policy.

Dentists will often drop contracts with insurance companies and insurance companies might not always be able to update all of their information they provide to their policy holders.



There are hundreds of thousands of patients who have insurance who do not believe they owe 1 cent for dental procedures because they believe that once they pay their deductible, that their insurance company will begin to pay the remainder of their dental needs.

This is absolutely not true, and dental insurance is a completely separate animal from medical insurance.

Also, several patients often skim their policies without reading every page within the policy and while they skim the terms and conditions within their policies they read the following text somewhere within their policies "**100% Covered**".

Dental insurance is segmented into 3 categories: Preventative, Basic, and Major that are all based on procedures.

For example: An insurance company could limit (3) *Oral Exams* per year as a preventative procedure. However, if a patient goes for a 4th visit to a dentist and has another *Oral Exam* (counted as the 4th *Oral Exam* in 1 year) the insurance will not pay for this procedure.

Instead, the subscriber has to pay. You have to know all of the guidelines of your policy in order to be in control and maximize your dental benefits for yourself, and your family.

A **tooth extraction** could fall under a **Major** procedure where a **filling** could fall under a **Basic** procedure.

There are several insurance companies that offer the following coverage breakdowns:

100% - Preventative
80% - Basic
50% - Major

However, all policies vary.

You should clearly understand (at this point) that -

INSURANCE DOES NOT COVER 100% OF DENTAL PROCEDURES.

If we use the above breakdown, the patient must pay 20% of the costs if Basic procedures were performed on a patient and 50% of the costs if Major procedures were performed on a patient.

INSURANCE EQUATION

Within our experience, insurance companies do not make an effort to educate their subscribers to better understand how their policies work.

At May Valley Dentistry it is very important for you to understand how your policy works because if YOU do not, you will (in essence) expect one of our staff to pull your chart, contact your insurance company, and define your parameters to you, which is NOT our responsibility. Your insurance policy is between you and your insurance company.

Dental offices are NOT insurance brokers, and if every person who walks through the door asks a dental staff to define insurance policies for every subscriber who is a patient within the dental office, productivity suffers.

However, out of professional courtesy we will assist our patients to make certain they can stay on top of their insurance plans and billing statements.

#1 Rule of thumb is to remember the following 2 simple equations:

Network Insurance Provider (Dental Office)

$$\text{DOS} = A + B + C$$

Let DOS = **Date of Service** or the day you walked into the office for a dental visit.

Let A = **Insurance Check** the doctor receives from your insurance company.

Let B = **Patient's Responsibility of Out of Pocket Expense.**

Let C = **Insurance Adjustment.**

Let's refer back to Joe Montana's case where Joe visits our office, and where we are a Met Life **Network Provider** and where we submit the claim of \$136 to Met Life.

- Initial Oral Exam - \$50.00
- ICS - \$11.00
- Panorex X-Ray \$75.00

Total - \$136.00.

When the doctor receives the check in the mail, the amount is for \$75.

Met Life agrees to pay:

- \$25.00 for the Initial Oral Exam
- \$50.00 for the X Ray
- Will not pay for ICS, which is not covered and is the patient's responsibility.

Let DOS = **Date of Service** or the day you walked into the office for a dental visit.

Let A = **Insurance Check** the doctor receives from your insurance company.

Let B = **Patient's Responsibility of Out of Pocket Expense.**

Let C = **Insurance Adjustment.**

$$\text{DOS} = A + B + C$$

$$136 = 75.00 + 11.00 + C?$$

C = Insurance Adjustment

The dental office must make an adjustment because the office is a Network Provider where Joe is a Network Subscriber.

The amount of the Adjustment is: $C = 136 - [75 + 11] = \$50.00$

Joe owes \$11.00.

Bottom line is that Joe owes \$11.00 i.e. even if Joe sees a network provider dental office, he stills owes the doctor money.



What happens if May Valley Dentistry is NOT a network provider of Met Life i.e. Met Life and May Valley Dentistry have not signed a contract with each other?

Because Joe has PPO insurance he can still visit May Valley Dentistry but he is being seen as a Out Of NETWORK patient vs a NETWORK patient.

The equation changes here and is even more simplified than using the equation above.

When a patient sees a dentist as a Out Of Network patient, a claim is sent to the patient's insurance company and what ever the difference is between the amount submitted and the amount paid will be the patient's responsibility.

To clarify: $\text{DOS} = A + B$. **There is no adjustment to be made by the dental office.**

Using Joe's example again, however, this time Joe is visiting a dental office as a Out Of Network patient.

Joe pays \$136 at the dentist's office and will file his own insurance claim.

Joe receives a check 4 weeks later from his insurance company for only \$75. Why?

Let DOS = **Date of Service** or the day you walked into the office for a dental visit.

Let A = **Insurance Check** Patient (Joe) receives from his insurance company.

Let B = **Patient's Responsibility of Out of Pocket Expense**.

Let C = **Insurance Adjustment**.

DOS = A + B = Out Of Network EOB (Eligibility of Benefits Equation)

So, $\$136 = \$75 + B$.

$B = ?$

$B = \$61$

B is really Joe's out of pocket expense he has to pay because perhaps the procedures that Joe has received are not covered by his insurance company or perhaps his insurance company is only paying a percentage of Joe's procedures.

Regardless, there will be some value where Joe will have to be responsible to pay the doctor (from his own pocket) in addition to compensation paid to the doctor by the insurance company.

In this case, Joe paid the doctor up front because he had to since he was an Out Of Network patient. Joe did NOT receive any discounted pricing because Joe was an Out Of Network patient.

#2 LESSON Make sure you are seeing a dentist that is within your network which will provide you with the maximum value of benefits with your insurance policy and plan.

#3 LESSON Make sure you actually have insurance and not a discount plan. Very important you know the differences between insurance cards and discount plan cards!

This tutorial will serve to clarify and clear the air concerning your account.

Understanding your insurance policy and how it works will be mutually beneficial to both our office and your peace of mind.

All of our patients will be provided with a chronological history when they are billed. If you apply the A + B + C equation you will find that is the means by which your **EOB, Eligibility Of Benefits** breakdown is sent to you per each Date Of Service (DOS).

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