Dental Insurance FAQ's

Employers sponsor dental plans for a variety of reasons, including the promotion of good health, keeping their workforce healthy and fit, and attracting and retaining top-notch employees.
Your employer will provide you with details of your plan that are easy to understand. It will give you a brief overview of the services that are covered, limitations and exclusions, and the fee guide used to calculate benefits. Keep in mind that this page offers a brief summary and the actual specifics of the plan will be spelled out in a contract between the employer and the dental plan administrator.

The employer enters into a dental plan contract with a third party that will act as the plan administrator. Dental plan contracts are lengthy, complex documents that define what services are covered and under what circumstances those services are eligible for reimbursement.

Some limitations such as frequency limitations — for example, "This service is covered once every three years" — are easily understood, while others are more complex, such as, "This service is covered only when there is evidence of recurrent decay or fracture". Dental plan administrators are contractually obligated to reimburse patients based upon the terms of the dental plan contract. This means that in some instances, necessary treatment may not be covered.

The Patient's Responsibilities
There are more than 30,000 dental plan contracts in Ontario, and each one is a little different from the next. As a smart consumer, you should make it your job to understand the details of your dental plan, and to supply your dental plan administrator with necessary information such as pre-treatment forms, claim forms or any supplementary information. You are also responsible for making arrangements for payment to your dentist for the dental care received.

The Dentist's Responsibilities
Your dentist, in accordance with the Regulated Health Professions Act and applicable regulations, will give you information on available treatment options appropriate to address your dental care needs, regardless of the nature and extent of your dental plan coverage. In addition, the dentist will assist you by supplying information required to enable you to receive benefits to which you may be entitled under your dental plan.

How Your Dentist Helps You With Your Dental Plan
Your dentist will be happy to supply you with claim and pre-treatment forms, which you will need to receive benefits through your dental plan.

Sometimes additional information may be requested by your plan administrator in order to ensure that the treatment is covered by your plan. In such cases the plan administrator will write to you and ask you to obtain the information from your dentist. Your dentist will supply any information you request, but it is your responsibility to provide it to your dental plan administrator. This ensures that your health record remains confidential and your privacy is protected.
Dental plans are designed to help patients pay for their dental treatment. However, not all dental treatments are eligible or fully reimbursable. If your dental treatment is only partially covered, you will have to share in the cost of your dental care.

Remember, you are a partner in your oral health. All treatment and care decisions should be made by you and your dentist based upon your actual needs, aside from your dental plan coverage. Your dental plan is not necessarily a treatment plan!

Dental Fees vs. Dental Plans
There may be a difference between the price your dentist may charge you and the amount covered by your dental plan. Here are three reasons why:

I. The Factors Considered When Calculating the Cost
The amount your dentist may charge you and the amount your dental plan may reimburse you for might be different because these two prices are not derived in the same way.
When your employer and insurance carrier determine the amount of money your dental plan will pay for services covered under the plan, they take into account the specific circumstances of your company and its employees. They consider such factors as company funds available for employee benefits, the nature and extent of use of the dental plan by the employees, and which version of the *ODA Suggested Fee Guide for General Practitioners* is used by the insurance carrier.

The ODA Fee Guide is a reference of suggested fees for dental services that is updated annually by the Ontario Dental Association. Some employers may use a current issue of the guide, while others may use past issues of the guide.

II. The Plan Design
For some dental services, payment may be based on a cost-sharing arrangement between the employer and employee. In these cases, the patient pays for a portion of the cost, while the plan pays for the remainder.
After you receive a service, you are responsible for the bill. This means you are also responsible to pay for the portion of the bill not covered by your plan — the portion known as the co-payment. It is illegal for the dentist to waive or ignore the co-payment and a dentist who does this could lose his or her licence.

Commercial Lab Charges Explained
There are many dental services that require additional "commercial laboratory procedures." As your dentist can explain, dental procedures that involve the services of a commercial laboratory may include:

- inlays or onlays — small and large restorations, respectively
- veneers
- crowns
- bridges
- posts and cores for crown and bridge restorations
- dentures
- implant procedures
- night guards, sports guards, sleep apnea appliances, orthodontic appliances, and
- repairs to any of the above restorations or appliances.

Laboratory Fees Are Not Dental Fees
The fees charged for laboratory services are in addition to the dentist's professional fee for the service or treatment provided. In most cases, the laboratory services are performed by companies and not your dentist. Your dentist will arrange for a commercial laboratory to do the work to precise specifications that meet your treatment needs.
While the lab fee is passed on to patients, it is not the dentist's fee. The lab charges passed on to you by the dentist will be the exact amount that the laboratory has charged your dentist to provide the service.
When completing your claim form, the fee for the service performed by the dentist, such as a crown or bridge, will be listed as a professional fee. The laboratory charges reported on the form, using procedure code 99111, will be the fee charged by the commercial laboratory. Again, this is not the dentist's fee.

Lab Fees and Your Dental Plan Coverage
Laboratory charges must be completed in conjunction with other services. The amount payable by your dental plan will be limited to the reimbursement percentage of the services that required the lab work. This percentage is determined by the employer or plan sponsor and there are a variety of ways in which reimbursement is handled by the plan administrator.

To find out the level of reimbursement that can be expected from your dental plan, you should request that your dentist prepare an estimate of the professional services and the estimated laboratory charges, which should then be submitted to your plan administrator.
The predetermination of benefits you receive back from your plan administrator will explain how your benefits for these services are calculated so that you are aware of what your costs will be, before you receive the treatment.

Assignment of Benefits-The "assignment of benefits" is when a dental patient instructs an insurance carrier to make a payment of allowable benefits directly to the dentist. This has obvious appeal to a dental patient because the patient often does not have to pay the dentist up front, and then go through the process of filing a claim with their insurance carrier and wait to get reimbursed.

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