



Dental health insurance plans vary widely. It is your responsibility to know the benefits included with your plan, because this can affect your out-of-pocket expenses.

Some dental insurance plans encourage dentists to submit a treatment plan before doing treatment. After review, the insurance determines: patient eligibility, eligibility period, services covered, required co-payment and the benefit maximum.

Some plans require a **predetermination** or **prior authorization** to decide if treatment is to be covered. Once this is submitted, you should get an estimate of benefits within 4 weeks. If you aren't sent an estimate, please contact your insurance provider.

Your dental insurance plan may limit the number of procedures that are covered and/or the dollar amount you can spend in a year. By knowing in advance what, and how much, your plan allows, you and your dentist can plan treatment that will make out-of-pocket expenses as low as possible while getting the most out of the benefits offered by your plan.

What insurance do you accept?

The Department of Dentistry is in network with some Delta Dental Plans (PPO Premiere and EPO), Blue Cross Blue Shield (Massachusetts), Cigna PPO and MassHealth (state funded plan). We accept all out of network insurances, too, but some insurance plans do not allow a visit at an out-of-network office. Please call your insurance plan if you have questions about your coverage.

When is payment due?

Payment is required on the day of service. We are happy to work with you to make sure that you are comfortable with the planned treatment and the cost. If you have questions about the cost of treatment, please call our Finance Coordinator at 857-218-4622.

What is an Explanation of Benefits (EOB)?

An EOB is not a bill or guarantee of payment by your insurance company.

The EOB is a paper or electronic statement that your dental insurance company sends you after your dentist visit. It lists any dental treatments or services you have had and outlines your costs. This includes treatment that is covered under your dental plan and treatment that is not covered with the reason(s) why.

What should I ask my insurance company?

Some important questions that you can ask your insurance company are:

- What is my total benefit amount per year?
- What is a copay and why do I have one?
- What is my deductible?
- Are recall visits (checkups and cleanings) covered once every 6 months or twice in a calendar year?

- Is specialty care, such as orthodontics (braces), endodontics (root canal), periodontics (gum treatment) or prosthodontics (permanent crowns) covered?
- Are consults covered?
- Is a follow-up visit covered?
- Is restorative treatment (fillings, primary teeth crowns) covered in my plan? If yes, at what percentage?

Dental insurance terms

Accepted fee: The total dollar amount that the provider has agreed to accept as payment in full from insurance.

Annual maximum: The total dollar amount that a plan will pay for dental care given to an individual person or family (under a family plan) in a benefit period (usually a calendar year).

Approved amount: The total dollar amount that the insurance provider approved for the service that was done.

Benefits: The amounts that your insurance company pays for dental services covered under your contract.

Copayment (or copay): A set dollar amount that some dental plans require you to pay at the time you have the service.

Deductible: A dollar amount that each person on the insurance plan (or a family for family coverage) must pay for some services before insurance begins paying benefits. The deductible is **waived (not required)** for preventive care in most dental insurance plans.

In-network: Services provided in a plan by a contracted dentist. In-network dentists have agreed to work with an insurance company's plan and to provide treatment according to set guidelines and to take their contracted fees as payment in full.

Out of network: Services provided by an insurance plan that are done by a non-contracted dentist. The out-of-pocket expense may be different from the amount allowed for an in-network dentist. Each plan has its own policies.

Out of pocket costs: The fees that you are responsible to pay. Includes deductibles, copayments and/or costs higher than the annual **maximum** (the most you have to pay).

Pre-treatment estimate: A treatment plan is sent by a dentist for review by the insurance company to give a pre-treatment **estimate** (best guess) of benefits before treatment starts. This is not a guarantee of payment. It can help you budget for dental work and decide how to go ahead with treatment.

Do you have questions?

Call our finance coordinator: (857) 218-4622