Insurance - Q&A

What is “Out-of-Pocket” cost?

This is the total dollar amount the patient is responsible to pay for their dental treatment. It’s made up of deductibles, co-insurance and co-payments (in certain cases). The "out-of pocket" cost is decided by the contract between the plan you chose and the insurance company. We give you estimates for your anticipated out-of-pocket costs to help you prepare for each visit at our office.

What is a “Deductible”?

A deductible is a set dollar amount decided by your plan and the insurance company. The patient must pay this amount before the insurance company contributes to the dental bills.

What is “Co-Insurance”?

Once the deductible is met, insurance will start paying a portion of each procedure leaving the balance to you, the patient.

What does my deductible apply to?

Deductibles and co-insurance amounts are decided by the insurance company and the employer. Depending on your plan and the benefits it provides, the deductible can be assigned to any procedure including cleanings, x-rays and checkups.

What is a “Co-Pay”?

The only time a co-pay would apply at SS would be when/if we bill the medical insurance **or** when/if our patient belongs to a 'self-funded' plan that works using co-pays.

Please check your benefit booklet and let us know if this applies in your case.

In dental, co-pays are very rare. One would normally see a co-pay with DHMO (Dental Health Management Organization), of which SS does not participate. DHMOs have set amounts that the patient pays and the insurance pays rather than doing a percentage of each service. With a DHMO a patient is assigned to a doctor and the doctor gets paid so much a month to do basic services such as cleanings, x-rays and exams whether or not the patient is seen. If the patient then has a cavity which needs to be fixed, the DHMO booklet would clearly show the patient must pay a co-pay of $xx.00 and the insurance will pay $xx.00 to equal the agreed amount of the 'in network' doctor.

What does it mean when Smile Starters says that you are “In Network”?

We have signed contracts with your insurance company, agreeing to accept their member patients at a discounted rate. For example: If we bill $120.00 for a particular procedure, our contract may require us to discount our $120.00 fee down to $100. This is called a “network discount”. Deductibles remain the same, but co-insurance is calculated from the lower 'contracted rate' thus saving you money.

Great news! Smile Starters has negotiated contracts with most major insurance companies.

What does it mean when Smile Starters says that you are “Out of Network”?

We do **not** have a contract with your insurance company, therefore we do not accept any “network discount”.

Normally when you choose an 'Out of Network' office, you become responsible not only for deductibles and co-insurances, but also for the difference between what is billed by the office and what is allowed by the Insurance Company (UCR).

Luckily, we are committed to making Dental Care accessible to all children in NC, therefore we keep our prices reasonable. Most services we provide are still within the insurance companies UCR (maximum allowable) therefore there is very little difference to you as a patient.

If my plan is not paying for necessary treatment, who should I talk to?

If you notice certain important things are not being covered, then you should speak to the sponsor of the dental benefit and request a better plan. A doctor's office has no say in how something is paid.
Employer Sponsored Plans: The HR department at work.
Self Insured Plan (Individual Plan): Speak to the insurance company. There may be a better plan for you to move into.

It seems as if the co-insurance changes ... can that be true?

Yes, it is true. Part of the employer/insurance contract specifies the insurance company portion and the employee portion for each procedure. As an employee or as a consumer, you need to read the fine print on each plan.

Why does SS not tell me exactly what I owe? Why does the amount change?

As previously stated, each plan has a different contract stating exactly what will and won't be shared by the insurance company. SS does not have access to all the benefits manuals, so the best we can do is estimate your portion of payment. The insurance makes the final decisions on payment based off either the employer contract or the individual plan contract.

Other considerations that the dental insurances use in final determination of benefits (payment), are things such as frequency of service (for example this is your first exam at SS but your 3rd exam for the year), age limitations on common procedures and prior treatment history. SS may not be aware of previous treatment if not performed at one of our offices.