INSURANCE INFORMATIONAL FORM AND OFFICE POLICIES

Please educate yourself of the following insurance info and office policies at Michael Dental Care, llc – (MDC).

MDC as a no-charge courtesy to patients, prepares and submits insurance claims to most insurers - in-network or not. MDC provides treatment codes and our fees in advance of treatment for full transparency to patients. MDC may provide insurer estimates payments - which are exactly that – estimates only – not payment guarantees or promises. MDC is provided co-percentage coverage estimates from insurers and very often these estimates are incorrect. Typically, insurers do not disclose dollar amount payments to MDC; however, the patient can directly contact the insurer for that information should they require it. MDC, like many other dental offices, does not regularly contact insurers in advance of treatment for exact payment for each procedure performed, nor check for procedure eligibility.

MDC as a no-charge courtesy to patients follows up outstanding claims, providing insurers information they need to make timely payments on behalf of their subscribers. When insurers have paid claims to MDC, the claim is either closed, or a bill for the remainder is sent to the patient for uncovered portions per the patient's insurance plan stipulations. MDC does not become involved in disputes between insurers and subscribers, and bills are sent to the listed responsible party. Patients are billed monthly and consecutively, and it is the patient's responsibility to pay unpaid claim portions per their contract with their insurer. As such, unpaid claims over 90 days are considered delinquent and may be sent to collections. We do not resend closed claims.

Dental insurance is a contract between the insurer and subscriber alone. It is the subscribers' (patients) responsibility to know and understand their policy – including eligibility, provider network status, tracking maximums and benefits, understanding co-percentage payments, deductibles, limitations and loophole exclusions. There are hundreds of insurers and many dental plans offered. These plan benefits change constantly as employer-sponsored plans evolve – sometimes even under the same policy. It is the patient responsibility to understand and track their plans and update information with MDC as it occurs.

Contracted Provider: MDC directly participates as a contracted provider with certain Delta Dental and Anthem plans – it is the patient's responsibility to ensure if the office is in network or not. MDC does not participate with DMO plans. MDC does not check the subscriber insurance network participation status. This information can be ascertained by checking with your insurer and is the subscribers' responsibility.

Insurance Usage and Maximums: Often, insurers will have a maximum dollar amount they will pay on the subscribers' behalf over the course of one year. Typically, the yearly amount ranges from $1000 - $2500. Some insurers may have a once-in-a-lifetime orthodontic benefit. These maximums have not increased since the 1970's. MDC does NOT track subscriber usage – regardless of where benefits may be paid – i.e., MDC or specialists offices. It is the patient's responsibility to track and monitor insurance payouts on their behalf. If a maximum is met and the subscriber has run out of benefits, treatment will be paid in full to MDC or other specialist offices.

Deductibles: A dental insurance deductible is the annual dollar amount the patient pays directly to the dentist for covered services before the dental plan insurance begins to pay. Deductibles are agreed upon between the insurer and subscriber and must be paid BEFORE the dental plan pays on the subscriber behalf. Deductible amounts are set for 12-month periods and get reset when a new coverage period begins. Most dental plan providers set their benefit periods to follow the calendar year or non-calendar basis. Deductibles may not apply to every service based upon the insurance plan features.

Downgrades / Exclusions / Waiting Periods / Missing Tooth Clause: Please be aware some insurers may "downgrade" codes and pay for a lesser treatment. For example, they may cover only silver fillings (not tooth colored composite) and pay for the lesser service resulting in a copay. Exclusions vary by plan and exclude coverage for certain services. For example, some plans pay copercentage only for preventative care and do not cover crowns or prosthetic treatments. Waiting periods can last 90 days to a year for certain services to be covered even though your insurer may state you are "eligible" for treatment during that time- the treatment fee may not be covered. The missing tooth clause in a dental insurance plan typically states that the insurer will not cover any dental treatment that replaces a tooth that was extracted or missing prior to the date the insurance coverage started. It may also include a waiting period of over a year. It is the patient's responsibility to read the fine print on their insurance plan. Due to the vast number of plans and their various intricacies, MDC does not ascertain this information for patients.

Coordination of Benefits (COB): Coordination of Benefits takes place when a patient is entitled to benefits from more than one dental plan. The plans will coordinate the benefits to eliminate over insurance or duplication of benefits. When both plans have COB provisions, the plan in which the patient is enrolled as an employee or as the main policyholder is primary. The plan in which the patient is enrolled as a dependent would be secondary. Traditional coordination of benefits allows the beneficiary to receive up to 100 percent of expenses from a combination of the primary and secondary plans. In the case of non-duplication COB, if the primary carrier paid the same or more than what the secondary carrier would have paid if they had been primary, then the secondary carrier is not responsible for any payment at all. Under Maintenance of benefits (MOB) reduces covered charges by the amount the primary plan has paid, and then applies the plan deductible and co-insurance criteria. Consequently, the plan pays less than it would under a traditional COB arrangement, and subscriber is typically left with some cost sharing. Carve out is a coordination method which first calculates the normal plan benefits that would be paid, then reduces this amount by the amount paid by the primary plan. Please be aware, there are many intricacies and exclusions with COB and if a subscriber has multiple dental insurance plans, this means more coverage which means less out-of-pocket costs, right? - Not necessarily. It is the responsibility of the subscriber to read the fine print in their insurance policy regarding their specific COB stipulations.

Insurance co-percentage payment / UCF: Insurers typically payout a co-percentage of what they consider an allowable fee or usual and customary fee (ucf). This fee varies greatly between insurers and procedures, and usually lags current office fee schedules by 15-20% less of actual fees. So, while the insurer often claims a procedure is covered at 100%, the insurance subscriber may find they owe co-pays despite being covered at "100%". Other insurers may only pay up to a certain maximum of their fee schedule – also resulting in a copayment after "100%" coverage. It is the responsibility of the subscriber to read the fine print in their insurance policy regarding co-percentage payments, fee schedules and ucf.

Non- Covered Services: Connecticut law (Sec. 38a-472h) prohibits most insurance providers from dictating the rates that dentists can charge to their patients for any services or procedures that are not covered under their dental plans. Many insurers will have a list of services they do not cover frequently including cosmetic dental work, full mouth rehabilitation, implant services, more frequent cleanings, whitening and others. These non-covered services vary greatly between insurers and insurance plans. Dental insurance does not provide coverage (or payment) for all dental services the subscriber might receive. If the subscriber receives services or procedures that are not covered benefits under their dental insurance plan or policy, the services or procedures might not be offered at a discounted rate with a contracted provider. It is the responsibility of the subscriber to read the fine print in their insurance policy regarding contracted fees and non-covered services.

Effective To Date Insurance: It is the patient responsibility to provide our office with their current active dental policy when service is rendered. MDC does not bill to medical insurance for dental procedures. Failing to provide accurate dental insurance information within 30 days of service may result in non-payment from the insurer and the subscriber owing the full treatment amount. Accounts past due 90 days are delinquent.

Insurance Estimates: MDC does not request pre-determination of benefits or insurer estimates due to constantly changing benefits and coverage amounts. These amounts are subject to change at any time by the insurer – even if a predetermination has been approved. The subscriber may contact their insurer to review any treatment codes eligible for payment. Additionally, MDC is typically provided percentage amount of co-insurance payments the patient may be responsible for. These percentages often do not reflect actual insurer payment resulting in further copays - different than estimated. MDC provides treatment codes and our fees in advance for full transparency to patients. Please directly contact your insurer with these codes to receive detailed fee payment information should you require it.

By signing below I acknowledge I have read and understand the office policies and will be bound by the policies terms.

- Print Name _____ Date _____
- Signature _____