stDental Times

February 9, 2009

Produced in-house by Santa Teresa Dental to improve your dental health and awareness.

Recently, we ate at one of our favorite pizzerias in San Jose. There is a sign posted on the door: "*We do not participate in the economic recession. Please take your economic discussion outside.*" How funny, I thought. It would be nice NOT to participate in an economic recession, but the reality is everybody is affected one way or the other; some more than the others. The actual economic recession began in December 2007.

Nope, this is not an editorial for MONEY magazine. This is still the newsletter produced inhouse by **Santa Teresa Dental** for your dental health awareness. Now, since we are on the topic of the economy, it is the best time to discuss the *basis of dental insurance*, and *how to stretch your dollars in dental care*. We are constantly keeping up with the changes in insurance industry. Dr. Ann Lien is now certified for Dental-to-Medical-Cross-Coding by the Warschaw Learning Institute, which enables her the knowledge to assist you in preparing billing under your medical insurance for possible additional reimbursement. Ask about it at your next appointment!

Sincerely,
Dr. Andrew Huang &
Dr. Ann Lien

Dental Health Insurance: The Basics

Dental health benefit plans vary widely so let's review some dental health care "basics."

How benefits are determined

There are many ways dental benefits plans are designed. You should know how your plan is designed, since this can significantly affect the plan's coverage and your out-of-pocket expense. Although the individual features of plans might differ somewhat, the most common designs can be grouped into the following categories:

- **Direct reimbursement programs** reimburse patients a pre-determined percentage of the total dollar amount spent on dental care, regardless of treatment category. This method typically does not exclude coverage based on the type of treatment needed, allows patients to go to the dentist of their choice, and provides incentive for the patient to work with the dentist toward healthy and economically sound solutions.
- **"Usual, Customary and Reasonable" (UCR) programs** usually allow patients to go to the dentist of their choice. These plans pay a set percentage of the dentist's fee or the plan administrator's "reasonable" or "customary" fee limit, whichever is less. These limits are the result of a contract between the plan purchaser and the third-party payer. Although these limits are called "customary," they might or might not accurately reflect the fees that area dentists charge. There is wide fluctuation and lack of government regulation on how a plan determines the "customary" fee level.

Table or Schedule of Allowance programs determine a list of covered services with an assigned dollar amount. That dollar amount represents just how much the plan will pay for those services that are covered, regardless of the fee charged by the dentist.

See ***Dental Insurance***, Pg 2

How to Stretch Your Dollars in Dental Care

The following article is adapted from U.S. News. Original publication date: July 31, 2008. Original Author: Michelle Andrews.

It doesn't take a whole lot to derail people from keeping a date with their dentist. Even if you have dental insurance, it generally maxes out after just a few thousand dollars. With the economy uncertainty, it is easy to put off making time to pay someone to poke around in your mouth.

But instead of avoiding Dr. Huang entirely, do yourself a favor and keep up with your regular preventive care. As in so many things, you'll save yourself pain and expense if you prevent dental problems from occurring in the first place.

What that means: Get your teeth cleaned regularly, usually every six months, although people with gum disease may need more frequent attention.

See ***Stretch Your Dollars***, Pg 2

Dental Insurance

Continued from page 1

The difference between the allowed charge and the dentist's fee is billed to the patient.

- **Capitation programs** a.k.a. Dental Health Organizations (DMOs) pay contracted dentists a fixed amount per enrolled family or patient. In return, the dentists agree to provide specific types of treatment to the patients at no charge. The patient is assigned to a dental office, and may not choose his or her own dentist. Treatments are limited to what is "approved" by insurance, or a patient's out-of-pocket expense may be very high.

Dental plans limitations

To control dental treatment costs, most plans limit the amount of care you can receive in a given year. This is done by placing a dollar "cap" or limit on the amount of benefits you can receive, or by restricting the number or type of services that are covered. Some plans might totally exclude certain services or treatment to lower costs. You should know specifically what services your plan covers and excludes. It might be wise to choose a plan that imposes dollar or service limitations, rather than one that excludes categories of service. By doing so, you can receive the care that's best for you and actively participate with the dentist in the development of treatment plans that give the most and highest quality care.

To help you stretch each dental benefit dollar, most plans provide patients and purchasers with special administrative services. Find out if your plan provides the following mechanisms to help you budget, analyze, and dispute, if necessary, the costs of your dental care.

Predetermination of costs

Some plans encourage you or your dentist to submit a treatment proposal to the plan administrator before receiving treatment. After review, the plan administrator might determine the patient's eligibility, the eligibility period, services covered, the patient's required co-payment, and the maximum limitation. Some plans require predetermination for treatment exceeding a specified dollar amount.

See ***Dental Insurance***, Pg 3

Stretch Your Dollars

Continued from page 1

Keep up on your X-rays as well; a full set typically needs to be made only once every three to five years, so you may be able to slide for a while on that. But you should get less comprehensive "bitewing" X-rays more frequently, on whatever schedule Dr. Huang recommends.

As for that thousand-dollar crown that you need, Dr. Huang may be able to stabilize your tooth so you can delay the work temporarily. That may buy you a few months to hoard some cash or hold you over into next year so you can stash the money in a flexible spending account and pay for it on a pretax basis. But it's a stopgap measure only; you still need to get the work done.

Unfortunately, there are no stopgaps when it comes to dealing with tooth decay or infection. If you've got cavities, get them fixed now or risk injuring the nerve of the tooth. That could force you to get a root canal or an extraction down the road.

No matter how unwelcome those checkup reminder cards may be—and no matter how unwanted the bite out of your wallet—make the appointment. By the time something hurts, it's usually far more severe than it would have been had we addressed it earlier.

Dental Insurance

Continued from page 2

Annual benefits limitations
To help contain costs, your plan might limit your benefits by number of procedures and/or dollar amount in a given year. In most cases, particularly if you've been getting regular preventive care, these limitations allow for adequate coverage. By knowing in advance what and how much your plan allows, you and your dentist can plan treatment that will minimize your out-of-pocket expenses while maximizing compensation offered by your benefits plan.

Peer review for dispute resolution
Many plans provide a peer review mechanism through which disputes between third parties, patients, and dentists can be resolved, eliminating many costly court cases. Peer review is established to ensure fairness, individual case consideration, and a thorough examination of records, treatment procedures, and results. Most disputes can be resolved satisfactorily for all parties.

Premium adjustments and re-evaluations
Patients and plan purchasers should insist on regular reviews of premium levels to ensure that UCR or Table of Allowances payment schedules are equitable. This analysis can help optimize your benefit levels, ensuring that every dollar you spend is used wisely.

Coordination of benefits
If you are covered under two dental benefits plans, you might be assured full coverage where plan benefits overlap, and receive a benefit from one plan where the other plan lists an exclusion.

See ***Dental Insurance***, Pg 4

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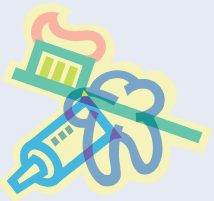

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Tax Saving Tips!

You may be able to claim a deduction on un-reimbursed medical expenses for you, your spouse, or a dependent once your total spending exceeds 7.5 percent of your gross adjusted income. IRS Publication 502.

You may be able to claim a tax credit for up to 35 percent of expenses used to pay someone to care for a child under 13, or a spouse or dependent unable to care for themselves. IRS Publication 503.

If your employer offers Flexible Spending Accounts (FSAs), you can use them to stretch your healthcare dollar. Dollars can be transferred directly from your wages into FSA, before it is taxed. Be careful, you either use it or lose it.

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Dental Insurance Basics

Continued from page 3

However, watch out for "limited coordination of benefit" or "non-duplication of benefit." For groups with a non-duplication of benefits rule in their plan, the secondary carrier pays only the difference between what the primary carrier actually paid and what the secondary carrier would have paid if it had been the primary carrier.

What key features of a dental health plan should I look for when selecting among dental plan options?

In reviewing and comparing health plans, consider the following when determining whether the coverage will satisfy your dental care needs:

- Does the plan give you the freedom to choose your own dentist or are you restricted to a panel of dentists selected by the insurance company? **Choosing from a list is not the same thing as freedom of choice**. Some patients ask, why isn't Santa Teresa Dental "on the list?" Because we strive to provide the best quality care to our patients without dental insurance contract limitation.
- Who controls treatment decisions – you and the dentist or the dental plan? Some plans might require the dentist to follow the "least expensive alternative treatment approach."
- Does the plan cover diagnostic, preventive, and emergency services? Will it cover preventive services such as sealants and fluoride treatments, which may save patients money in the future?
- What routine treatment is covered by the dental plan?
- What major dental care is covered by the plan? Does the plan cover dentures, implants or treatment for temporomandibular disorders?
- What are the plan's limitations (a limit to the benefits for a procedure or the number of times a procedure will be covered) and exclusions (denied coverage for certain procedures)?
- Will the plan allow referrals to dental specialists? Will the dentist and I be able to choose the specialist?
- Can you see the dentist when you need to and schedule appointment times convenient for you?
- Who is eligible for coverage under the plan and when does coverage go into effect? Is there a waiting period for certain procedures?

Santa Teresa Dental cannot answer specific questions about your dental benefit or predict what your level of coverage for a particular procedure will be, even though we try. Each plan and its coverage vary according to the contracts negotiated. If you have questions about coverage, contact your employer's benefits department, your dental health plan, or the third-party payer of your health plan.

Insurance Benefit Gaps

Patients often are surprised to find that their insurance benefits do not cover all the treatment their dentist recommends. Dental insurance benefits for the most part have remained at the same level for more than two decades, leaving patients to pick up any added costs out-of-pocket. Our office accepts cash, checks, and credit cards. We also partner with CareCredit, which offers you no interest payment plan options. Go to www.stDental.com/services to learn more.