



## **Your Dental Insurance: *What you should know***

Dental benefit plans are designed to share in your costs. Your plan may not cover the total cost of your bill. Most plans potentially cover between 50 and 80 percent of the cost of dental services. If you don't understand a reimbursement level on your bill, you are not alone. Here are some commonly misunderstood features.

### **Usual, Customary and Reasonable**

“Usual, customary and reasonable,” or UCR, may be one of the most misunderstood terms used when describing dental benefit plans. UCR plans pay an established percentage of the dentist's fee, or may pay what the plan sponsor considers a “customary” or “reasonable” fee limit, whichever is less. Although these limits are called “customary”, they may or may not reflect the actual fees that dentists in your area charge.

Your explanation of benefits or EOB, may note that the fee your dentist has charged you is higher than the UCR reimbursement levels that the plan offers. This does not mean that you have been overcharged. For example, the insurance company may not have taken into account up to date data in determining a reimbursement level. Keep in mind that there is no regulation as to how insurance companies determine reimbursement levels, and insurance companies are not required to disclose how they determine these levels. This results in wide fluctuations.

### **Annual Maximum**

Your dental benefits plan purchaser (for example, your employer) makes the final decision on “maximum levels” of reimbursement through the contract with the insurance company. The annual maximum is often based on the amount the employer wishes to pay for the dental benefit. Even though the cost of dental care has increased significantly over the years, the maximum levels of insurance reimbursement have remained the same since the late 1960's. Some plans may offer higher maximums that are comparable to rising dental care costs.

In a preferred provider arrangement, you may be asked to choose your dental care from a list of the plan's preferred providers. This is a term that is applied to dentists who have a contract with the dental benefit plan. Whether or not you choose your care from this defined group can affect your level of reimbursement.

### **Least Expensive Alternative Treatment Provisions**

Your dental plan may not allow benefits for all treatment options, even when your dentist determines that another treatment will be in your best interest. For example, your dentist may recommend a crown, but your insurance may offer reimbursement only for a large filling. As with other choices in life, such as purchasing medical or automobile insurance, or buying a home, the least expensive alternative is not always the best option.

### **Pre-Existing Conditions**

Just like medical insurance, your dental plan may not cover conditions that existed before you enrolled in the plan. Even though your plan may not cover certain conditions, treatment may still be necessary. Your dental plan may not cover certain procedures or preventative treatments regardless of their value to you. This does not mean these treatments are unnecessary. Sealants, for example, can save you money later. Your dentist can help you decide which type of treatment is best for you.

### **Conclusion**

Dental office staff cannot always answer specific questions about your dental benefits or predict the level of coverage for a particular procedure, because plans written by the same third party payer (insurance company) or offered by the same employer may vary according to the contracts involved. Your plan sponsor (often your employer) is usually in the best position to explain the individual design features of your plan and answer specific questions about coverage.