

Why Doesn't My Insurance Pay for This?



ADA American Dental Association®
America's leading advocate for oral health

Key terms typically used to describe the features of a dental plan may include the following:

UCR (Usual, Customary and Reasonable)

Usual, customary and reasonable charges (UCR) are the maximum amounts that will be covered by the plan for eligible services. The plan pays an established percentage of the dentist's fee or pays the plan sponsor's "customary" or "reasonable" fee limit, whichever is less. Although these limits are called "customary," they may or may not reflect the fees that area dentists charge. **Exceeding the plan's customary fee, however, does not mean your dentist has over-charged for the procedure.** Why? There are no regulations as to how insurance companies determine reimbursement levels, resulting in wide fluctuation. In addition, insurance companies are not required to disclose how they determine "usual, customary and reasonable" charges.

Annual Maximums

Most dental programs have an annual dollar maximum. This is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period, usually the plan year. **The plan purchaser/employer makes the final decision on "maximum levels" of reimbursement through the contract with the insurance company.** The patient is usually responsible for paying costs above the annual maximum. Your employer may want to research plans that offer higher annual maximums when assessing how to better meet the needs of employees.

Preferred Providers

The plan may want you to choose dental care from a list of its preferred providers. This is a term that often is applied to dentists who have a contract with the dental benefit plan. **Whether or not you choose to receive dental care from this defined group can affect the level of reimbursement.**

Pre-existing Conditions

Just like medical insurance, a dental plan may not cover conditions that existed before the patient enrolled in the plan. This includes plans that have a "missing tooth" exclusion. Benefits will not be paid for replacing a tooth that was missing prior to the effective date of coverage. **Even though your plan may not cover certain conditions, treatment may still be necessary.**

Treatment Exclusions

A dental plan may not cover certain procedures or preventive treatments. This does not mean that these treatments are unnecessary. **Patients need to be aware of the exclusions and limitations in their dental plan but should not let those factors determine their treatment decisions.** Your dentist can help you decide what type of treatment is best for you.

Coordination of Benefits and Nonduplication of Benefits

Coordination of benefits (COB) is a method of integrating benefits payable for the same patient under more than one plan. Benefits from all sources should not exceed 100% of the total charges.

Nonduplication of benefits is a term used to describe one of the ways the secondary carrier may calculate its portion of the payment if a patient is covered by two benefit plans. The secondary carrier calculates what it would have paid if it were the primary plan and subtracts what the other plan paid.

Even though you may have two or more dental benefit plans in place, there is no guarantee that any of the plans will pay for your services. Please consult with your own plan for further details regarding coordination of benefits and nonduplication of benefits.

Plan Frequency Limitations

Certain procedures may simply not be covered as often as necessary for optimal oral health. A common example might be a plan that pays for tooth cleaning only twice a year even though the patient requires cleaning every three months. Limitations may vary depending on the contract purchased. Limitations in coverage are the result of the financial commitment the plan sponsor has agreed to make and the benefits the third-party payer will offer for that commitment.

Not Dentally Necessary

The plan provides benefits for those services and materials that it considers to be dentally necessary and meet generally accepted standards of care. Based on the information your dentist submits, the service may not appear to meet plan criteria and no benefit may be allowed. **This does not mean that the services were not necessary.** You or your dentist can appeal the benefit decision by submitting relevant information. The claim, along with the submitted information, should be reviewed by the plan's dental consultant.

Employers offer dental benefits to help employees pay for a portion of the cost of their dental care. **Dental plans are designed to share in the cost of your dental care, not to completely pay for those costs.** Almost all dental benefit plans are the result of a contract between the plan sponsor (usually an employer or a union) and the third-party payer (usually an insurance company). The amount your plan pays is determined by the agreement negotiated by your employer with the insurer. Your dental coverage is determined not by your dental needs — but by how much your employer contributes to the plan.



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