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Insurance Jargon...What does it all mean?

At the end of every year, my office staff is inundated with questions about which insurance plan to choose for the following year. There are multiple insurance carriers and many different types of plans. If you receive insurance through an employer, each particular plan is customized to meet the budget of the company, so “I have Delta Dental PPO” can mean something very different for a patient on one company’s plan than for someone on another’s. When choosing an insurance plan you must consider the types of plans, UCR rates, plan restrictions, and yearly maximums.

Dental Benefit plans vary, but in general there are two basic types: managed care and fee-for-service. Managed care plans (PPOs and DHMOs) typically have lower premiums but have many restrictions on the types of treatment you can receive, and some pay only for treatment done by contracted dentists who have agreed to accept the insurance company’s reimbursement amounts. DHMO (Dental Health Maintenance Organization) plans and some PPO (Preferred Provider Organization) plans require patients to choose a dentist from a limited list of dentists and do not pay for work done by a dentist not on the list, so freedom of choice is inhibited. There are some PPO plans that do allow patients to receive treatment from a non-participating dentist. Those plans typically have higher deductibles and co-payments. Such a plan may pay, for example, 80% on a procedure done by a “participating” dentist but only 60% of the fee charged by a “non-participating” dentist. Fee-for-service, or “Direct Reimbursement,” plans typically have higher premiums but reimburse patients according to dollars spent on dental treatment and allow the patient to choose any dentist without strict guidelines on types of treatment that are covered.

Often you will hear the term “usual, customary, and reasonable” or “UCR” used by an insurance company to determine the portion of a fee they will cover. UCR reimbursement amounts are determined by different methods by the dental plan administrators – they are setting their own price on each dental procedure that they cover. These are often low compared to the average fees charged by dentists in that area, so if your bill happens to be higher than the reimbursement levels of UCR, this does not mean that your dentist overcharged you. For example, if your dentist charges \$150 for a filling, but the insurance plan’s UCR for that treatment is \$100, you may pay not only your contracted percentage, but also any dollar amount over the UCR.

Many insurance plans have restrictions on treatment covered such as “pre-existing conditions,” “alternative minimum treatments,” and “waiting periods.” If you are missing a tooth before you purchase the insurance policy, a missing tooth clause will state that the insurance company will not pay for replacement of that tooth. If you are in need of a crown, an insurance company may require you wait 6 -12 months after purchasing the plan before they will pay for that service. Some plans may pay for what they consider to be the least expensive alternative treatment which may not be the most