Many employers now offer a **PPO** (Preferred Provider Organization) plan in lieu of or in addition to the more "traditional, indemnity" dental plans. With a PPO plan, you are offered a select list of dental providers. These providers have agreed to discount their usual fees and will accept a lower amount from the insurance carrier. The insurance **carriers and/or employers who offer a PPO plan may encourage individuals to choose a doctor from the list. Patients are able to go to a dentist on the list or a dentist of their choice.** If you elect to use a provider from the network your benefit reimbursement can be affected and therefore your "out-of-pocket" expense may be less. However, you have the flexibility to see either an "In Network" provider or an "Out of Network" provider. Patients have their Freedom of Choice with this type of plan.

OUR OFFICE ACCEPTS PPO PLANS

Your treatment costs will be similar to that of a Network provider.
If you would like to know in advance what your portion of the cost will be for the procedure, our Business Manager will be glad to give you an Itemized figure prior to your appointment.

COST OF TREATMENT VS. THE FEE PAID BY INSURANCE

Another area that affects premium costs is the "ceiling amount" the carrier will pay per procedure. The term that is commonly used by dental offices and carriers alike is "UCR" fee or "Usual, Customary, and Reasonable" fee.

Each carrier has its own "UCR" allowable reimbursement per individual dental code. This will vary from carrier to carrier and is based on the first 3 digits of the practice location. The insurance carrier will not usually disclose these fees to dental offices, patients or employers.

Typically, the insurance carrier/employer determines the reimbursement level at a fee that arises between what 70%-90% of the dentists in the area charge. For a particular procedure that most dentist charge $550, some policies may base their claims payment at $600 or higher. However, **if the employer wants to keep the costs down, one option for them is to buy a plan that reimburses at a reduced level.** In other words, instead of reimbursing at $550 or higher, it may only allow $550 or less on that same procedure.
The lower reimbursement of $500 will reduce the cost of the insurance policy. If the dentist's fees however is $550 the amount that dentists must charge, the carrier is likely to state on the (EOB) Explanation of Benefits (mailed to the patient) that the dentist's fee is above the UCR (Usual, Customary, and Reasonable) fee. This comment could naturally make the patient think their dentist's fee is higher than most other local offices. Although this can be a common misconception, the reality is that the employer chooses a plan that doesn't reimburse at the level most dentists in the area charge. In these situations the patient would then be responsible for additional "out-of-pocket" expenses since their employer reduced the ceiling amount (UCR) coverage in order to lower the overall premiums of insurance. It is also important to realize other employers with the same carrier (or even those with a different carrier) may consider the $550 a "reasonable" fee.

Dr Bowden recommends dental care for you that he determines is the best treatment for your individual needs. He considers his fees to be reasonable, considering factors such as time, skill, experience and quality of service. Should you have any questions about your treatment plan, please see our Business Manager at our front desk.

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B·A·R·R·Y BOWDEN D.D.S. DENTISTRY

Our Personalized Dentistry

An overview about DENTAL INSURANCE

Telephone: (512) 288-2823

Our Office Hours:

Monday, Tuesday and Thursday
8:30am - 5pm
Wednesday
8:30am – 3pm
Friday
No office hours

About Your Insurance

KNOW YOUR COVERAGE

We believe the more you know and understand **About Your Insurance,** the better the dentist/patient relationship can be. This brochure will answer many of the common questions patients have regarding coverage. If you are concerned about certain limitations or exclusions within your dental plan, please contact your employer's Human Resources Manager.

Your employer is the only one who can amend or change the dental policy.

OVERVIEW

When your employer buys a dental insurance policy from an insurance carrier, there are several things to consider. These include cost, availability of phone support for answering policy questions, and administrative efficiency at processing insurance claims. Much like other types of insurance, the price of the policy determines the coverage.

In today's market, most carriers sell "cafeteria style" policies, allowing each employer to choose what will and will not be covered. It is not unusual to have above average coverage on some procedures and below average coverage on other procedures, all within the same dental policy. Please keep in mind that your dental plan is not meant to pay for all needed dental treatment but rather to assist you in the cost of these expenses.

LIMITATIONS

Most plans will have an **annual deductible.** This amount is the insured's responsibility, prior to any reimbursement from the insurance carrier. This deductible may apply to the first treatment that a claim is filed on, or applicable only to certain procedures. Procedures are generally classified as either **"Preventive", "Basic" or "Major"** in nature. Each category is reimbursed at a pre-determined level of coverage. Most plans cover between 50%-80% on services that are not considered preventive in nature. What dental procedures fall under what category can vary with each carrier and/or dental policy. Additionally, your dental plan will have an **annual maximum**, limiting the amount the insurance carrier will pay each policy year for dental treatment. Unfortunately, many dental plans still have a $1000 maximum, the amount commonly available to each insured person.

When a procedure is excluded by your insurance company, it is not an indication the procedure was not "dentally necessary", but rather a restriction of your plan. This restriction may be due to an age limit for that procedure, a waiting period, or a frequency limit, etc.

If your coverage is inadequate on certain dental procedures, it is likely that coverage was reduced in this area to lower the cost of the employer's insurance premiums.
Dental coverage varies from carrier to carrier. Since not all procedures and guidelines are addressed in the policy or employee dental handbook, each carrier may vary considerably in their administrative decisions on how these matters are processed.

EXAMPLE

"Carrier A" may allow a periodontal procedure every 6 months, while "Carrier B" will typically allow that same procedure once every 2 years. "Carrier C" might have no frequency limit to the procedure when it is dentally necessary. Keep in mind, most carriers' limitations exclusions, and provisions are based on cost rather than "dental necessity".

A common limitation to dental policies is called the **"Alternate Benefit Clause".**
This is a cost containment feature that states if there is a less expensive treatment or method that can produce the same satisfactory result the plan will pay for the least expensive treatment and not necessarily the actual procedure performed. For the patient, this usually means more out-of-pocket expenses.

DMO AND PPO PLANS

Some employers may offer a **DMO** (Dental Maintenance Organization) plan in lieu of or in addition to other dental plans they provide. With a DMO plan, the dentist has agreed to accept a minimal fixed monthly fee in exchange for dental services. The amount is determined by the number of patients assigned, whether utilizing the services or not. The dentist is required to render a set number of services at no charge. The plan will provide an additional schedule amount to the practice for any additional patients seen than the required minimum. The dentist is not allowed to collect the difference between his/her usual fee and the agreed schedule amount.

The patient is locked into this type of plan, usually for a year and there is no Freedom of Choice. The insurance carrier will not pay any benefits if you see an Out of Network provider.

Dr Bowden has chosen not to participate in any DMO plans.