

Patient Acknowledgement

Services Not Covered By Your Dental Plan

Occasionally, patients in our office here at Your Family Dentist have procedures that are not covered by their dental plan. We want our patients to understand the financial implications.

For example, we may place a porcelain crown or tooth colored filling but their dental plan only covers a metal crown or filling. The insurance company will calculate the benefit to you on the Explanation of Benefits (EOB) sheet, based upon a similar procedure covered by the plan, often referred as an "alternate benefit." However, you received a procedure that was not covered by your dental plan. Therefore, we are allowed to bill you the difference between the benefit calculated on the EOB and our office fee for that procedure.

In 2012, the Legislature modified *Prohibited Acts for Fees charged for dental services* § 44-7,105, prohibiting an insurance company for attempting to limit the fee a dental office could charge a patient even though the dental plan did not cover a particular procedure sought by the patient.

You are not covered for any services that otherwise would qualify as Covered Service, but which your dental benefit plan does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, alternate benefits and frequency limitations.

When you receive a procedure that is not covered by your plan, we will need to bill you for the difference between your plan benefit and our office fee.

We appreciate your understanding and acknowledgement of this situation.

Patient /Responsible Party (for family)

Date

LB 810 LB 810

LEGISLATIVE BILL 810

Approved by the Governor April 5, 2012

Introduced by Gloor, 35; Lautenbaugh, 18.

FOR AN ACT relating to insurance; to prohibit certain policy provisions relating to fees for dental services.

Be it enacted by the people of the State of Nebraska,

Section 1. Notwithstanding section 44-3,131, (1) an individual

or group sickness or accident policy, certificate, or subscriber contract

delivered, issued for delivery, or renewed in this state and a hospital,

medical, or surgical expense -incurred policy, (2) a self -funded employee

benefit plan to the extent not preempted by federal law, and (3) a

certificate, agreement, or contract to provide limited health services issued

by a prepaid limited health service organization as defined in section 44-4702

shall not include a provision, stipulation, or agreement establishing or

limiting any fees charged for dental services that are not covered by the

policy, certificate, contract, agreement, or plan.