Understanding non-network benefits and costs

When selecting a dentist, whether or not he or she is a contracted dentist can change the overall out-of-pocket cost. When choosing to visit a non-network dentist, there are typically two ways costs are determined in a dental PPO (DPPO):

- **Reasonable and customary (R&C)** - "R&C" is a predetermined limit sometimes called a "reasonable and customary (R&C) allowance" to which your non-network Cigna Healthcare℠ benefits are applied. The R&C allowance is described as a percentile, meaning that Cigna Healthcare reimburses treatment costs up to the amount charged by that percentile of the dentists in the area.
- **Maximum allowable charge (MAC)** - This means that the Cigna Healthcare plan calculates the non-network payment based on the coinsurance coverage and the contracted fees we would pay a network dentist in that same area.

With both plan types, a non-network dentist can balance bill the customer for the difference between what the carrier pays them and their usual charge for the service they performed.

How is R&C computed?

Let's say these are 10 dentists in a given geographic area, and their regular fees for a given dental procedure range from $495 to $550 as follows.

DENTIST 1	DENTIST 2	DENTIST 3	DENTIST 4	DENTIST 5	DENTIST 6	DENTIST 7	DENTIST 8	DENTIST 9	DENTIST 10
$495	$500	$505	$509	$511	$529	$531	$533	$540	$550

If the R&C in your area is the 90th percentile (as shown by the arrow above), any charges in excess of this amount, such as those charged by Dentist 10 above, will not be reimbursed under the plan. For in-network treatment, however, these area charges are averaged ($520 for this example) and then discounted to determine total charges for procedures performed.

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R&C example

EXAMPLE A	EXAMPLE B
Customer chooses a **Cigna Healthcare–network dentist**. Since the in-network discount in the area is 35%, the DPPO-allowed amount is $338. Since 50% of $338 is covered under the plan, this customer's out-of-pocket cost is $169.	Customer chooses Dentist 10 above, who does not participate in our DPPO network. That dentist charges $550 for this procedure. Fifty percent of the $540 R&C allowance ($270) is covered under the customer's plan; however, the dentist bill is based on the full $550, $10 in excess of the R&C allowance. This customer's out-of-pocket cost is $280.

By going in-network, the customer in Example A would save **$111**.

How is MAC computed?

Payment is based on PPO contracted fees, which can be significantly lower than the typical 80th or 90th percentile of R&C charges. Customers pay more out of pocket because they're billed for the difference between the insurance carrier's reimbursement and the dentist's usual charge. Since the insurance carrier's reimbursement is less with a MAC plan, the cost is shifted to the customer through balance billing.

DENTIST 1	DENTIST 2	DENTIST 3	DENTIST 4	DENTIST 5	DENTIST 6	DENTIST 7	DENTIST 8	DENTIST 9	DENTIST 10
$495	$500	$505	$509	$511	$529	$531	$533	$540	$550

MAC example: An employer's dental plan allows out-of-network reimbursement based on the MAC percentile of R&C charges and 50% reimbursement for the procedure priced above, whether performed by an in-network or out-of-network dentist. On the surface, the benefits appear identical. But are they?

EXAMPLE A	EXAMPLE B
Customer chooses a **Cigna Healthcare–network dentist.** Since the in-network discount in the area is 35%, the DPPO-allowed amount is $338. Because 50% of $338 is covered under the plan, this customer's out-of-pocket cost is $169.	Customer chooses Dentist 4 above, who does not participate in our DPPO network. That dentist charges $509 for this procedure. Fifty percent of the $200 MAC allowance ($100) is covered under the plan; however, the dentist bill is based on the full $509. This customer's out-of-pocket cost is $409.

By going in-network, the customer in Example A would save **$240.**

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These are examples for illustrative purposes only. Actual costs may be different. Please check your plan documents for details.