

# Quality Care Dental Plan (QCDP) Orthodontic Expense Prorating Worksheet

Obtain figures to complete worksheet from the Dental Pre-Authorization Form and Explanation of Benefit Statement (EOB)

This worksheet is provided for your convenience in calculating the estimated, prorated orthodontic amount and may not cover all circumstances. When deciding the amount to withhold for MCAP, **please estimate conservatively.**

- Refer to the Flexible Spending Account Booklet for claim documentation requirements.
- The plan year is July 1 through June 30. Calculate out-of-pocket expenses accordingly. It is the participant's responsibility to track the number of remaining months of treatment in a plan year.
- If you do not participate for the full 12 months (e.g., 9-month faculty), you will have to make adjustments.
- Each covered family member has a \$1200 maximum per year that includes general and specialty services. Medically necessary amounts more than the \$1200 maximum benefit are eligible for MCAP.
- If no other services have been utilized, there will be a \$50 deductible assessed each benefit year that will be applied to orthodontics.
- Changes in treatment plans may affect the amount of eligible expenses that you claim in MCAP.

Participant Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Patient: \_\_\_\_\_ Provider: \_\_\_\_\_

Total Length of Treatment: \_\_\_\_\_ (months)      Date Treatment Began: \_\_\_\_\_

- Records and Consultation Fee:      \$ \_\_\_\_\_ (Eligible within the fiscal year service is provided.)
- Initial Out-of-Pocket Banding Expense: \$ \_\_\_\_\_  
(Eligible within the fiscal year braces are placed. This is shown as "ineligible amount" on the Dental Pre-Authorization or EOB and counts as the initial month of treatment.)
- Annual Deductible: (If applicable)      \$ \_\_\_\_\_
- Monthly Out-of-Pocket Expense:      \$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
(Amount reflected on Dental Pre-Authorization or EOB statement as "ineligible amount," i.e., amount not paid by insurance.)      \*See Below      TOTAL

\*Calculate the number of month(s) of treatment per plan year minus one month for the banding fee. You are claiming the banding expense in #2 above (Initial Out-of-Pocket Banding Expense).

**TOTAL (First Year Expenses)**      \$ \_\_\_\_\_ (Add eligible amounts from 1,2,3 & 4)

To calculate consecutive years of eligible expenses, complete figures below, if applicable.

- Annual Deductible: (If applicable)      \$ \_\_\_\_\_
- Monthly Out-of-Pocket Expense:      \$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
(Amount reflected on Dental Pre-Authorization or EOB statement as "ineligible amount," i.e., amount not paid by insurance.)      (Number of months of treatment provided within fiscal year.)      TOTAL

**TOTAL (Second Year Expenses)**      \$ \_\_\_\_\_ (Add amounts from 3 & 4)

- Annual Deductible: (If applicable)      \$ \_\_\_\_\_
- Monthly Out-of-Pocket Expense:      \$ \_\_\_\_\_ X \_\_\_\_\_ = \$ \_\_\_\_\_  
(Amount reflected on Dental Pre-Authorization or EOB statement as "ineligible amount," i.e., amount not paid by insurance.)      (Number of months of treatment provided within fiscal year.)      TOTAL

**TOTAL (Third Year Expenses)**      \$ \_\_\_\_\_ (Add amounts from 3 & 4)