

Glossary of Dental Insurance Terms

A

Accepted Fee: Fee accepted as full payment under dentists' contract. Payment can be from insurance or you.

Alternate Benefit: A dental plan provision basing payment for a particular dental service on the least expensive treatment or supplies that are effective. The provision does not limit treatment options. Sometimes referred to as LEAT or Least Expensive Alternate Treatment.

Allowable Amount: Highest amount payable for covered services. It may not be the amount paid to the dentist or you. This may also be called "maximum allowable amount."

Allowed Charge: The maximum amount an insurer will pay for a dental service. This includes any amount you will pay. For in-network providers, the allowed charge is based on the provider contract. For out-of-network providers, the allowed charges may be:

- the same as for in-network providers,
- based on a percentage of the amount that Medicare would pay for the same services, or
- Usual, Customary and Reasonable (UCR) charges, i.e. the amount that your dental plan determines is reasonable for that service in your local area.

Annual Maximum: The most a dental plan or dental policy will pay toward the cost of your dental services in a year. After the plan pays this amount, you must pay the total cost of your dental services that may be at the discounted cost if your dentist is in-network. Only 3% to 5% of people with dental policies reach the **annual maximum each year**.

Appeal: A formal request for insurer's review of denied or unpaid claims. Claims can be for services or supplies. You or your dentist can file an appeal. Appeals are an attempt to receive payment from third party (usually an insurance company). Appeal rights are limited. It is important to gather and submit all important documents, so appeal rights are not unnecessarily exhausted.

Assignment of Benefits: Authorizing benefit payments to go directly to the dentist.

B

Balance Billing: When providers bill you for the difference between their charge and the allowed amount. This occurs when a provider is not in-network.

Basic Services: A category of dental services. Usually includes fillings, extractions, root canals, and root planning. Also called Class II, Group II, Type B or Type II services.

Beneficiary: A person covered on your dental benefits contract. They are eligible for benefits. *See enrollee*.

Benefit: The amount your insurer owes on cost of covered services.

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Benefit Highlight: *See Benefit Summary.*

Benefit Summary: An outline of your dental plan. It may include coinsurance percentages, deductibles, maximums and non-covered services. Also referred to as benefit highlights.

Benefit Year: 12-month period used for deductibles, maximums and other plan provisions. Also called a plan year.

Billed Charge: The amount billed by your provider for services.

C

Claim: A request for payment under a dental benefit plan. Statement listing services rendered, the dates of services, and itemization of costs. The completed request serves as the basis for payment of benefits.

Class I Services: *See Diagnostic and Preventive services.*

Class II Services: *See Basic Services.*

Class III Services: *See Major Services.*

Closed Network Plan/Closed Panel Plan: Plans that require you to use an in-network dentist to get benefits. A DHMO plan is an example of a closed panel plan.

Co-insurance: Your share of dental service costs. It is calculated as a percentage of the charged amount. It usually applies after you pay your deductible.

Co-payment or Co-pay: A form of dental cost sharing in a dental insurance plan that requires you to pay a fixed dollar amount for each visit to a dentist or for a specific service. This fee is pre-set; it will be specified in your dental insurance policy. It also may be listed on your dental insurance card.

Consultation: When you and your dentist discuss care. Your dentist offers diagnostic services. He proposes treatment. Consultation can be requested by you, another dentist, physician, parent or legal guardian.

Contracted Rates: The rates insurance companies pay their network providers for services. These rates are negotiated. They are established in the insurers' contracts with in-network providers.

Coordination of Benefits: Matching up payments when you have more than one insurance policy, so payments do not exceed allowed charges. For example, if a child is on both parents' dental plans, one plan is considered the primary. The primary insurer pays first. The second plan pays after the first plan pays. The second plan's payment, if any, often covers that balance due for dental services. But, the second plan generally never pays more than they would have paid had it been primary; however, state mandates differ on this subject. Check with your plan.

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Cost-sharing: The portion of the dental costs you pay. This can be a deductible, co-payments, or co-insurance (See separate definitions of these terms).

Covered Services: The dental services, procedures, and prescription drugs your plan covers. Not all care is covered. Even if a service is covered, you may still need to pay a deductible, co-payment or co-insurance. Policies often contain a detailed list of what is and is not covered.

D

Deductible: The amount you pay for covered dental care services before your plan begins to pay. In most cases, you must pay the deductible amount each calendar/plan year. A dental plan covering several family members may have both an individual and family deductible. The family deductible is the overall limit on what a family will pay before the dental plan pays.

Dental Assessment: A limited clinical exam. Used to find possible signs of disease. Also looks for malformation or injury. Also used to refer you to another dentist for diagnosis and treatment.

Dental Care Professional: A dentist, dental hygienist, dental assistant, or any other individual who is licensed or certified as required by a state and is performing dental services within the scope of that license or certification.

Dental Exclusive Provider Organization (DEPO): A type of dental plan. It is similar to both DHMOs and DPPOs. Like a DHMO, you must use an in-network dentist. Care from out-of-network dentists is not covered except for emergencies. Like a DPPO, you can see a specialist without a referral. These specialist visits are covered as long as the dentists are in-network.

Dental Health Maintenance Organization (DHMO): A type of dental plan. DHMOs provide comprehensive dental benefits at fixed dollar co-payments. You must go to a dentist in the DHMO network for dental services. Dentists in the DHMO network are paid a monthly fee for each person that signs up and selects that dentist. Claims are not filed for each service provided by a DHMO network dentist.

Dental Indemnity Plan: A non-network dental plan. It often has a deductible. After the deductible, it pays a certain percentage of charges for services rendered. Payments can go to you or the dentist. Plans typically have no restrictions on which dentist you visit. Also referred to as **fee-for-service** plans.

Dental Plan or Dental Insurance Policy: A contract in which the dental insurer agrees to pay for some or all of your covered dental care costs. You or your employer pay premiums for the plan or policy. You may also have to pay deductibles, co-pays, or co-insurance as part of the contract. Common types of dental plans are DHMOs, DPPOs, DEPOs, and Dental Indemnity Plans.

Dental Preferred Provider Organization (DPPO): A type of dental insurance plan. DPPOs contract with dentists for a discount from usual fees. Enrollees usually pay less when dental services are done by a dentist in the DPPO network. Enrollees may go outside the DPPO network but will usually pay more for those services. Dentists are

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paid on a fee-for-service basis after each dental care service is done. Dentists are paid at the agreed discount if they are in the DPPO network or at a rate set by the plan if they are not in the network. When using a dentist in the network individuals are not billed for the difference between the negotiated or discounted fee and the actual fee that the dentist charges.

Dental Prepayment: A method of financing the cost of dental services prior to receiving them.

Dependents: Your spouse and children covered on your policy. Generally defined by terms of the dental benefit contract.

Diagnostic and Preventive Services: A category of dental services that are often paid by the dental plan without deductibles or co-payments. Usually includes exams, cleanings, x-rays, fluoride treatment, sealants and space maintainers. Also called Class I, Group I or Type A or Type I services.

Direct Reimbursement: A self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided and allows you to seek treatment from the dentist of their choice.

Discount Dental Plan or Dental Saving Plan: A type of dental plan that is not insurance. A network of dentists agrees to perform services at specified discounted prices, or discount off their usual charge. No payment is made by the Discount Dental Plan to the dentists. You pay the dentists the full discounted fee for the services you receive.

Dual Choice Program: A benefit package. You may choose to enroll in either an alternative dental benefit program or a traditional dental benefit program.

E

Effective Date: See *Eligibility Date*.

Eligibility Date: The date you and your dependents are eligible for benefits under your plan. Often referred to as effective date.

Emergency Services: Dental services that are unexpected and require treatment right away. Services can be to relieve pain, swelling or bleeding, or to avoid putting your health at risk.

Enrollee: Individual covered by a benefit plan. See *beneficiary*.

Expiration date: The date your dental plan expires; the date you are no longer eligible for benefits.

Explanation of Benefits (EOB): Detailed summary from your dental plan on payments made for your dental services. Your dental plan sends an EOB after a claim is submitted. It also shows how to appeal decisions.

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Extension of Benefits: Extension of eligibility for benefits for covered services. Designed to ensure completion of treatment begun before expiration date. Duration is generally expressed in terms of days.

F

Family Deductible: A deductible satisfied by combined expenses of all your covered family members. For example, a program with \$25 deductible may limit its application to a maximum of three deductibles, or \$75 for your family, regardless of the number of family members.

Flexible Spending Account: Your employee repayment account. Primarily funded with your designated salary reductions. Funds are paid to you for health care. Funds can be used for you or your dependents' dental care or legal expenses. Funds are considered a nontaxable benefit.

G

General Dentist: A dentist that provides a full range of dental services. They do not specialize in a one area, such as oral surgery.

Group 1 Services: *See Diagnostic and Preventive services*

Group II Services: *See Basic Services.*

Group III Services: *See Major Services.*

H

Health Maintenance Organization (HMO): *See Dental Health Maintenance Organization.*

Health Savings Account (HSA): A tax-advantaged savings account. You can open HSAs to pay for qualified medical and other health expenses. You and your employer can put money in HSAs. The money belongs to you. You can withdraw funds tax-free if they are used for qualified medical and other health care expenses like dental care. The HSA goes with you if you change jobs.

I

Indemnity Dental Plan: *See Dental Indemnity Plans*

Indemnity Plans: *See Dental Indemnity Plans*

In-Network: Dentists and other licensed dental care providers who contract to deliver dental services on your dental plan. This includes dentists and dental clinics. Usually, you will pay less out of your own pocket when you receive care from in-network providers.

Insured: Person covered by the program (you).

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Insurer: Usually the insurance company. The party promising to pay a benefit if a specified loss occurs in an insurance contract.

L

Least Expensive Alternate Treatment (LEAT): See *Alternate Benefit*.

Limitations: Restrictive conditions stated in a dental benefit contract. Examples: age, length of time covered, and waiting periods. These affect your coverage. Your plan may also exclude certain benefits or services. It may limit the extent or conditions under which certain services are provided.

M

Major Services: A category of dental services. Usually includes crowns, dentures, implants and oral surgery. Co-payments or coinsurance is typically higher for these services. Also called Class III, Group III or Type C or Type III services.

Managed Care: A contractual arrangement. Payment or use are controlled by a third party. Refers to a cost containment system that directs the utilization of health benefits. It does this by:

- restricting the type, level and frequency of treatment;
- limiting the access to care; and
- controlling the level of reimbursement for services.

Maximum Allowable Amount: See Allowable Amount.

Maximum Plan Benefit: The reimbursement level for a procedure. Determined by the dental plan administrator. This may vary widely by geographic region or by benefit plans within a region.

Medically Necessary Care: The reasonable and appropriate diagnosis, treatment, and follow-up care. Includes supplies, appliances and devices. Prescribed by dentist. For treatment of any condition, illness, disease, injury, or birth developmental malformations. Care is medically necessary for the purpose of:

- controlling or eliminating infection,
- pain, and disease;
- restoring facial configuration
- function necessary for speech, swallowing or chewing

Medicare: Federal insurance program. For people age 65 and older. Also, for people with end-stage renal disease. May cover people with certain disabilities. Medicare **does not cover dental procedures**. Some insurance plans offer dental coverage under Medicare Advantage plans.

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Member: An individual enrolled in a dental benefit program (you).

N

Non-covered charges: Costs for dental care your insurer does not cover. In some cases, the service is a covered service, but the insurer is not responsible for the entire charge. In these cases, you will be responsible for any charge not covered by your dental plan. You may wish to call your insurer, consult your dental plan or dental policy to determine whether certain services are included in your plan before you receive those services from your dentist.

Non-Covered Services: Dental services not listed as a benefit. If you receive non-covered services, your dental plan will not pay for them. Your provider will bill you. You will be responsible for the full cost. Usually payments count towards deductible. Check with your insurer. Make sure you know what services are covered before you see your dentist.

Nonduplication of Benefits: Occurs when you have two insurance plans. It's how your second insurance carrier calculates its payment. The secondary carrier calculates what it would have paid if it were your primary plan. Then it subtracts what the other plan paid. Examples: Your primary carrier paid 80 percent. Your secondary carrier normally covers 80 percent. Your secondary carrier would not make any additional payment. If the primary carrier paid 50 percent. The secondary carrier would pay up to 30 percent.

O

Open Enrollment/Open Enrollment Period: Time of year when an eligible person may add, change or terminate a dental plan or dental policy for the next contract year.

Open Panel: Allows you to receive care from any dentist. It allows any dentist to participate. Any dentist may accept or refuse to treat patients enrolled in the plan. Open panel plans often are described as freedom of choice plans.

Out-of-Network: Care from providers *not* on your plan. This includes dentists and clinics. Usually, you will pay more out of your own pocket when you receive dental care from out-of-network providers.

Out-of-network benefits: Coverage for services from providers who are not under a contract with your dental plan.

Out-of-pocket cost: The amount you must pay for care. Includes the difference between the amount charged by a provider and what a health plan pays for such services.

Out-of-Pocket Maximum: The most a dental plan requires you to pay in a year. Deductibles, co-payments and co-insurance count toward the out-of-pocket maximum. The only dental benefits that have out-of-pocket maximums are child benefits purchased through public exchanges or purchased as an individual or through a small group. The out-of-pocket maximum for one child is \$350 and for more than one child is \$700 in all states.

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After reaching an out-of-pocket maximum, the plan pays 100% of the cost of pediatric dental services. This only applies to covered services. You are still responsible for services that are not covered by the plan. You also continue to pay monthly premiums.

Overbilling: Stating fees as higher than actual charges. Example: when you are charged one fee and an insurance company is billed a higher fee. This is done to use your co-payment. It also done to increase your fees solely because you are covered under a dental benefits plan.

P

Participating Provider: Dentists and other licensed dental providers on your plan. They have a contract with your plan. The contract includes set service fees.

Payer: Party responsible for paying your claims. It can be a self-insured employer, insurance company or governmental agency.

Plan Year: *See Benefit Year.*

Point of Service (POS) Plan: A dental plan that allows you to choose at the time of dental service whether you will go to a provider within your dental plan's network or get dental care from a provider outside the network.

Personal Protective Equipment: Commonly referred to as "PPE," is equipment worn to minimize exposure to a variety of hazards. Examples include gloves and face masks. Source: OSHA.gov.

Pre-authorization: A process that your dental plan or insurer uses to decide that particular dental services are covered. Your plan may require preauthorization for certain services, such as crowns, before you receive them. Preauthorization requirements are generally waived if you need emergency care. Sometimes called prior authorization.

Pre-determination: A process where a dentist submits a treatment plan to the payer before treatment begins. The payer reviews the treatment plan. The payer notifies you and your dentist about one or more of the following: your eligibility, covered services, amounts payable, co-payment and deductibles and plan maximums. *See pre-authorization.*

Pre-existing condition: A dental condition that exists for a set time prior to enrollment in a dental plan, regardless of whether the condition has been formally diagnosed. The only pre-existing condition that is common for dental plans or policies is a missing tooth.

Pre-treatment Estimate: *See predetermination. ***

Preferred Provider Organization (PPO): *See DPPO.*

Pre-paid dental plan: A method of funding dental care costs in advance of services. For a defined population.

Premium: The amount you pay to a dental insurance company for dental coverage. The dental insurance company generally recalculates the premium each policy year. This amount is usually paid in monthly

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installments. When you receive dental insurance through an employer, the employer may pay a portion of the premium and you pay the rest, often through payroll deductions.

Preventive Services: *See Diagnostic and Preventive services.*

Primary payer: The third-party payer with first responsibility in a benefit determination.

Provider: A dentist or other dental care professional, or clinic that is accredited, licensed or certified to provide dental services in their state, and is providing services within the scope of that accreditation, license or certification.

Provider network: Dentists and other dental care professionals who agree to provide dental care to members of a dental plan, under the terms of a contract.

Purchaser: Organization or entity. Often employer or union. It contracts with the dental benefit organization to provide dental benefits to an enrolled population.

Q

Qualified Dental Expenses: Qualified dental expenses are defined under Section 213 of the Internal Revenue Code. (See the Internal Revenue Service's Publication 502 which includes medical and dental expenses.) Qualified dental expenses are permitted to be paid for from health savings accounts (HSAs).

A dental expense is not a qualified expense if it is paid for by your dental plan or policy. If your expense is paid for or reimbursed by an HSA account, that expense cannot be included for purposes of determining itemized tax deductions.

R

Reimbursement: The amount your DPPO or Dental Indemnity Plan pays for a specific dental service. For instance, your DPPO's reimbursement rate for a dentist visit may be up to \$80. If your provider charges \$100, you would be responsible for the remaining \$20 if your plan covers that service at 100% of their maximum reimbursement rate.

S

Schedule of benefits: A list of dental services and the maximum benefit amounts an insurer will pay for each. Specificity will vary by benefit plan.

Self-funded plan: A benefit plan. Plan sponsor bears the entire risk of utilization. Plan sponsors are usually employers or unions. Some plans may be partially self-funded. The partially self-funded plan sponsor may use

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stop-loss insurance to protect against the risk of unanticipated higher utilization. Third party administrators may process claims and provide other administrative services. They do not bear any of the risk of utilization of the plan.

Self-Insured: If you work for a large employer or group of employers, your plan may be self-insured. Self-insured means that your employer pays dental claims from their bank account and establishes the plan design. The benefits may be administered from a third-party administrator (TPA) or a Dental Plan. Self-insured plans are not subject to state insurance regulation.

T

Type A Services: *See Diagnostic and Preventive services*

Type B Services: *See Basic Services.*

Type C Services: *See Major Services.*

Teledentistry: Teledentistry provides the means for a patient to receive services when the patient is in one physical location and the dentist or other oral health or general health care practitioner overseeing the delivery of those services is in another location. This mode of patient care makes use of telecommunication technologies to convey health information and facilitate the delivery of dental services without the physical constraints of a brick and mortar dental office. *Source:* American Dental Association. **minor edits to maintain 9th grade reading level.

U

Usual, Customary and Reasonable (UCR): A term for the average cost that insurers use to calculate reimbursement for a particular dental service. In-network dentists may be paid a fee up to 80% of UCR. This rate of reimbursement may also be used for the fees paid to out-of-network dentists. However, when you get dental services from an out of network dentist, you will be responsible for the difference between 80% and 100% of the dentists' fee as well as your coinsurance.

Usual and Customary: The base amount that is treated as the standard or most common charge for a particular dental service.