Insurance Terms

Accepted fee

The dollar amount that the contracting dentist has agreed to accept as payment in full from the insurance carrier and the patient.

Amalgam

A common material used in fillings to repair cavities in teeth; also known as “silver fillings.” Dental amalgam is a mixture of silver, mercury and other materials.

Annual maximum

The total dollar amount that a plan will pay for dental care incurred by an individual enrollee or family (under a family plan) in a specified benefit period, typically a calendar year.

Balance billing

When a dentist bills an enrollee for amounts above the insurance carrier’s payment and the enrollee's coinsurance. Non-contracted dentists are under no obligation to limit the amount of their fees.

Basic services/basic benefits

A category of dental services in an open network dental benefits contract that usually includes restorations (fillings), oral surgery (extractions), endodontics (root canals), periodontal treatment (root planing) and sealants. (This may vary by contract.) Typically, the same coinsurance percentage applies to all services grouped as basic services.

Benefits

The amounts that the insurance carrier pays for dental services covered under an enrollee’s contract.

Cafeteria plan

A benefit program in which an employer gives employees several benefit plans to choose from (i.e., a “menu” of benefit plans).

Capitation

Compensation paid to general dentists in closed network dental benefit plans (such as a DHMO) for providing covered services to enrollees assigned to their office. Most insurance carriers capitation-based plans require enrollees to select the network dentist from whom they are to receive all or most treatment, and the enrollee is required to pay a predefined amount (“copayment”) for each procedure at the time of treatment.

Claim/claim form

A standard form that provides an itemized statement submitted by an enrollee or a dentist requesting payment of benefits for dental services provided. The dentist always file claim forms on behalf of enrollees and accept payment directly from the insurance carrier so that patients are not required to pay up front and wait for reimbursement. Claim forms are also used to request a pre-treatment estimate.

Closed network plan

A type of dental plan where enrollees must visit a pre-selected or assigned network dentist in order to receive benefits.

Coinsurance

The enrollee’s share, expressed as a fixed percentage, of the contract allowance. For example, a benefit that is paid at 80% by the plan creates a 20% coinsurance obligation for the enrollee. Coinsurance applies after the enrollee meets a required deductible.

Contract benefit level

The percentage of the maximum contract allowance that insurance carrier pays after the deductible has been satisfied.

Contracted dentist

A dentist who has a contract with the insurance carrier to participate in their network. The dentist agrees to accept the insurance carriers determination of fees as payment in full for services rendered to an enrollee of a the insurance carrier plan. (Also may be referred to as participating dentist, network dentist or contracting dentist.)

Contracted fee

The fee for each single procedure that a contracted dentist has agreed to accept as payment in full for covered services provided to an enrollee.

Coordination of benefits (COB)

A process that carriers use to determine the order of payment and amount each carrier will pay when a person receives dental services that are covered by more than one benefit plan (dual coverage). COB ensures that no more than 100% of the charges for services are paid when an enrollee has coverage under two or more benefits plans — for example, a child who is covered by both parents' plans.

Copayment

A fixed dollar amount that an enrollee under certain dental plans (such as a DHMO-type plan) is required to pay at the time the service is rendered.

Deductible

A dollar amount that each enrollee (or, cumulatively, a family for family coverage) must pay for certain covered services before the insurance carrier begins paying benefits.

Diagnostic and preventive services

A category of dental services in an open network dental benefits contract that usually includes oral evaluations, routine cleanings, x-rays and fluoride treatments. (This may vary by contract.) Typically, the same coinsurance percentage applies to all services grouped under diagnostic and preventive services.

Dual choice

A program that allows enrollees to select one of two or more dental plans. (Also may be referred to as “dual option.”)

Dual coverage

When dental treatment for an enrollee is covered by more than one dental benefits plan, such as when dental services are provided to a child who is covered by both parents’ benefit plans.

Effective date

The date a dental benefits contract begins; may also be the date that benefits begin for a plan enrollee.

Eligible enrollee

An enrollee who has met the eligibility requirements under an insurance carrier plan.

Eligibility

The circumstances or conditions that define who and when a person may qualify to enroll in a plan and/or a specific category of covered services. These circumstances or conditions may include length of employment, job status, length of time an enrollee has been covered under the plan, dependency, child and student age limits, etc.

Fee-for-service

Compensation paid to dentists based on an amount per service. A fee-for-service plan generally permits enrollees to freely select a network or non-contracted dentist to provide the service.

Freedom of choice

A plan feature that permits an enrollee to visit any licensed dentist and receive benefits for covered services.

Health maintenance organization

An entity that is authorized to issue a benefit plan in which enrollees receive all or most treatment through a pre-selected or pre-assigned dental office. The dentist receives a monthly capitation payment for each patient that selects or is assigned to that office no matter how many services that patient receives. (See “Capitation”)

In-network/Out-of-network

Services provided in a plan either by a contracted or non-contracted dentist. In-network dentists have agreed to participate in a plan and to provide treatment according to certain administrative guidelines and to accept their contracted fees as payment in full. Different plans are served by distinct dentist networks.

Indemnity/indemnity plan

(See “Fee-for-service”)

Lifetime maximum

The cumulative dollar amount that a plan will pay for dental care incurred by an individual enrollee or family (under a family plan) for the life of the enrollee or the plan. Lifetime maximums usually apply to specific services such as orthodontic treatment.

Limitations and exclusions

Dental plans typically do not cover every dental procedure. Each plan contains a list of conditions or circumstances that limit or exclude services from coverage. Limitations may be related to time or frequency (the number of procedures permitted during a stated period) — for example, no more than two cleanings in 12 months or one cleaning every six months. Exclusions are dental services that are not covered by the plan.

Major services

A category of dental services in an open network dental benefits contract that usually includes crowns, dentures, implants and oral surgery. (This may vary by

contract.) Typically, the same coinsurance percentage applies to all services grouped under major services.

Network

A panel of dentists that contractually agree to provide treatment according to administrative guidelines for a certain plan, including limits to the fees they will accept as payment in full.

Open access

A plan feature that allows enrollees to visit the dentists of their choice (freedom of choice). Also sometimes used to describe an enrollee's ability to seek treatment from a specialist without first obtaining a referral from his/her primary care dentist.

Open enrollment

A period (usually a two-week or one-month period during the year) when qualified individuals (eligible employees) can enroll in or change their choice of coverage in group benefits plans.

Open network plan

A type of dental plan where enrollees can visit any licensed dentist and can change dentists at any time without contacting the benefits carrier.

Out-of-pocket costs

Any amount the enrollee is responsible for paying, such as coinsurance or copayments, deductibles and costs above the annual maximum.

Participating dentist

See "Contracted dentist."

Patient's share

The portion of a dentist's fee that an enrollee must pay for covered services, including coinsurance or copayment, any remaining deductible, any amount over plan maximums and/or any services the plan does not cover.

Preauthorization

A requirement that recommended treatment must first be approved by the plan before the treatment is rendered in order for the plan to pay benefits for those services.

Preferred provider organization (PPO) plan

A reduced fee-for-service plan that allows enrollees to visit any dentist, but encourages them to visit PPO network dentists to minimize out-of-pocket expenses. Enrollees usually pay less when visiting a PPO dentist.

Prepaid plan

A term used to describe a benefits plan in which a carrier prepays network dentists a capitated amount for each patient enrolled in (assigned to) his/her office. Enrollees receive all or most treatment through the dental office where they are enrolled and pay a predefined copayment for each procedure.

Preventive services

See "Diagnostic and preventive services."

Pre-treatment estimate

The insurance carrier's written estimate of benefits available as of a specific date, given to an enrollee or treating dentist in advance of proposed treatment. Pre-treatment estimates are subject to policy limitations and the patient's eligibility at the time the services are rendered. (May also be referred to as a predetermination.)

Primary enrollee

An individual (commonly, an employee or member of an association) who meets the eligibility requirements for enrollment in a dental plan. Family members of a primary enrollee are called dependents.

Provider

Any licensed dentist who performs dental health services for an enrollee. This includes general dentists and dental specialists (endodontists, periodontists, orthodontists, pediatric dentists, oral surgeons and prosthodontists).

Submitted fee

The amount that the dentist bills and is entered on a claim as the charge for a specific procedure.

Table program

A dental plan where benefits are based on a specific table or schedule of allowances or fees. The table lists the maximum amount that a plan will pay for each procedure. Enrollees are responsible for paying any difference between the amount the plan pays and the amount the dentist charges for the service. For non-contracted dentists, there is no limit to the amount the dentist may charge.

Usual fee

The amount commonly charged for a particular service by a dentist.

Waiting period

A stated period of time that a person must be enrolled in a plan before being eligible for benefits or for a specific category of benefits.