Glossary of Dental Insurance Terms

adjudication Processing a claim through a series of edits to determine proper payment. Auto-adjudication is processing a claim without any human interaction.
allowable charge The fees, on which program deductibles, maximums, and coinsurance percentage are based, that a dental program will reimburse a dentist for a service as defined by contract. This is the amount that can be charged back to patients. This is also referred to as the maximum plan allowance or maximum allowable charge. Dentists have agreed to accept a maximum plan allowance based on the agreements they have signed with Delta Dental. This does not apply to non-participating dentists.
approved amount The total fee that must be paid by the member company and the patient. Participating dentists have agreed to accept a maximum plan allowance based on agreements signed with Delta Dental. Non-participating dentists use the submitted amount.
balance billing Balance billing occurs when a participating dentist bills an enrollee for amounts disallowed by Delta Dental that are also not allowed to be charged to the enrollee. Participating dentists agree to accept the fee approved by Delta Dental as payment in full. Dentists may not bill an eligible Delta Dental patient for any difference or balance between the Delta Dental approved fee and the submitted fee. Out-of-network (non-participating) dentists are not limited in the amount they may balance bill.

DELTA DENTAL

beneficiary

A person who is eligible to receive insurance benefits.

benefit summary

An overview of an enrollee's dental benefit program, usually including co-payment percentages, deductibles, maximums, and non-covered services, often used at open enrollments. Also referred to as "benefit highlights." See summary plan description and evidence of coverage.

benefit year

The 12-month period to which each enrollee's deductibles, maximums, and other plan provisions are applied. Start and end date may vary from those of a calendar year.

CDT codes (Current Dental Terminology)

Under HIPAA, the American Dental Association's CDT codes are the required standard for electronic dental claims.

claim or claim form

Information submitted by a dentist or enrollee to establish that services were provided to an enrollee, from which processing for payment to the dentist or enrollee is made. A dentist is responsible for the accuracy of all information on a claim form. Claim forms can be submitted to carriers on paper or electronically.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is federal legislation that requires employers to offer continued health insurance coverage to employees and their dependents who have had their health insurance coverage terminated. It allows enrollees, spouses, and children to pay to continue their health benefits coverage for up to 18 months after their coverage is terminated (or up to 29 months if the individual is disabled). For example, a spouse who would lose eligibility after divorcing a covered employee could decide to pay his/her own premium to continue group health coverage.

coinsurance

The percentage of the costs of services paid by the patient. This is a characteristic of indemnity insurance, POS, and PPO plans. See copayment.

coordination of benefits (COB)

When a person is covered by more than one benefit plan (for example, a child who is covered by both parents' programs), the two sets of benefits are coordinated so that no more than 100 percent of the total covered expense is paid. Non-duplication of benefits is a contract provision that further limits coverage.

copayment The enrollee's share of payment for a given service. The copayment is usually expressed as a percentage of the dentist's fee, but can be expressed as the enrollee's preset share of payment for a given service. See coinsurance.
cost sharing Financing arrangement whereby the enrollee in a health plan must pay some of the costs to receive care.
covered services Services for which payment is provided under the terms of the dental benefit contract.
deductible The total amount (usually expressed as an annual figure) enrollees must pay toward treatment before their health benefits are paid. The deductible plus the copayment and amount over the annual maximum are often referred to as the enrollee's out-of-pocket costs. Under Delta Dental benefit plans, diagnostic and preventive services are often exempt from a deductible.
dentist filed fees A participating dentist's submission of fees for procedures common to their practice and reported most frequently on dental claims.
diagnostic and preventative procedures These procedures typically include oral examinations, cleanings, x-rays, fluoride treatment, and space maintainers. Check your plan for specifics.
disallowance A denial by a health care payer for portions of the claimed amount. Examples would include coordination of benefits, services that are not covered, or amounts over the fee maximum.
dual coverage When an enrollee has coverage under more than one benefit plan. The primary and secondary carriers coordinate the two plans so that the primary carrier pays its portion first and the secondary carrier may pay the remainder. See coordination of benefits and non-duplication of benefits.
emergency services Dental services that are immediately required to relieve pain, swelling, or bleeding, or required to avoid jeopardizing the patient's health.

endodontist

Dental specialist who treats the root and nerve of the tooth.

explanation of benefits (EOB)

An industry term for the notice that enrollees receive after a claim is processed. The EOB provides information about the fees charged, what procedures were provided, and the enrollee's payment portion.

general dentist

General dentists provide a full range of dental services for the entire family.

group

Term used to describe a dental benefit customer or purchaser, usually an employer or a union/labor trust.

Heath Insurance Portability and Accountability Act of 1996 (HIPAA)

This federal initiative becomes effective in stages over several years. Title I of HIPAA was enacted to ensure that people can keep their health insurance when changing jobs. Title II of HIPAA requires adherence to coding and transmission standards for electronic health care transactions as well as to privacy and security requirements to protect health care information and anti-fraud measures. See the Administrative Simplification section of the *Department of Health and Human Services'* website for more information.

in-network

Term used to describe a participating dentist or a service provided by a participating dentist. See network.

limitations/exclusions

Services that are limited or excluded from a dental benefit plan. The enrollee is usually responsible for the fee for services that are not benefits of the dental benefit plan. These services are called optional services.

maximum/ annual maximum/maximum benefit

The maximum payment your dental plan will make within a given time period. Some plans have no maximum. Some maximums apply to the lifetime of the benefit plan; others apply to a particular time period (calendar year, benefit year, etc.) or to particular services (such as a separate maximum for orthodontic benefits).

network

Both words refer to the dentists who have agreed to provide treatment within certain administrative guidelines for certain programs (participating dentists). The Delta Dental Premier, Delta Dental PPO and DeltaCare programs all have distinct dentist networks. Although network and panel are synonymous, network is the preferred term.

national group/account A group with subscribers in more than one state.
non-participating Any dentist who does not have a contractual agreement with your dental carrier to provide dental services to enrollees of a Delta Dental benefit plan. See participating.
oral pathologist Dental specialist who diagnoses diseases of the mouth from the study of tissue samples.
oral surgeon Dental specialist who removes impacted teeth and repairs fractures of the jaw and other damage to the bone structure around the mouth.
orthodontist Dental specialist who straightens or moves misaligned teeth and/or jaws, usually with braces.
out-of-network Term used to describe a non-participating dentist or a service provided by a non-participating dentist. See network.
out-of-pocket costs The portion of dental fees that the enrollee pays. Depending on the circumstances, it may include a copayment, a deductible, and any amount exceeding the plan's maximum and optional services not covered by the plan.
participating dentist These words refer to dentists who contract with your dental plan and abide by certain administrative guidelines.
pediatric dentist Dental specialist who generally limits treatment to children and teenagers.
periodontist Dental specialist who treats gums, tissue, and bone that support the teeth.

premium A premium is the monthly payment customers make to their dental plan for fully insured plans.
prosthodontist Dental specialist who replaces missing teeth with artificial materials, such as a bridge or denture.
provider A dentist or other practitioner, such as a dental hygienist.
specialist A dentist who has received advanced training and is certified in one of the recognized dental specialties: endodontics, orthodontics, oral surgery, pediatric dentistry, periodontics, and prosthodontics.
subscriber Subscribers are the persons counted in a group (generally employees or members of the group). Enrollees include both subscribers and their covered dependents. See enrollee.
summary plan description (SPD) An enrollee booklet for members of an ERISA plan, similar to an evidence of coverage (EOC) or a benefit summary.