alberta dental association + college

Dental Plan (dental Insurance) Terms

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

Balance billing – the amount the patient is billed that was not covered by their dental plan.

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

Co-Payments - also called co-insurance—is the portion of the bill that is the patient's responsibility. Many dental plans have co-payments, or in other words, a percentage of the claim amount that is not covered by the dental plan. For patients, even if the plan description of benefit coverage indicates 100% coverage of dental fees, insurers often have a maximum payable amount that may be lower than the dentist's fee for the service.

Deductible – The amount of a dental expense for which the patient is responsible to pay before a dental plan will pay for benefits. The deductible may be an annual or one-time charge, and may vary in amount from program to program.

Dual coverage - When dental treatment for a patient 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. See coordination of benefits (COB).

Limitations and exclusions - Dental plans often 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 dental plan.

Major services - A category of dental services that usually includes crowns, dentures, implants and oral surgery. (This may vary by dental plan.) The patient may need to have a predetermination/preauthorization completed to determine if the major service is covered by the dental plan and to what extent.

Out-of-pocket costs - Any amount the patient is responsible for paying, such as coinsurance or copayments, deductibles and costs above the annual maximum.

Preauthorization - A statement by a dental plan indicating that proposed treatment is covered under the terms of the benefit contract. Some plans require a dentist to submit a treatment plan to a dental plan for approval before treatment is begun. Usually received in response to a predetermination request. Pre-treatment estimates are subject to the dental plan limitations and the patient's eligibility at the time the services are rendered. See preauthorization above. See predetermination below.

Predetermination – a request to a dental plan to provide an estimate (preauthorization) of the patient's reimbursement for proposed treatments. The estimate provided by the dental plan to a patient or treating dentist in advance of proposed treatment. Pre-treatment estimates are subject to the dental plan limitations and the patient's eligibility at the time the services are rendered. See preauthorization above.

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.