# Discover dental terminology

*The numerous terms used in association with dental insurance plans can be confusing, especially to those outside of the insurance industry.*

We've put together this handy reference list of definitions for terms often found on a dental benefits summary or contract. The category (preventive, basic, major) under which carriers classify specific benefits will affect pricing and out-of-pocket exposure for members.

### *Annual maximum*

The most a dental plan or dental policy will pay toward the cost of dental services each year.

### *Annual open enrollment*

The time period each year in which an employee can elect or modify coverage for benefits without a qualifying event. Not all carriers offer this, especially with a voluntary plan.

### *Balance billing*

When a provider is not in the insurance company's network, the member is responsible for paying the remaining balance between the provider's charges and the amount of reimbursement received from the insurer.

### *Benefit period*

A benefit period typically lasts 12 months and determines when benefits start over. There are two types of benefit periods: a calendar year and a plan year.

***Calendar year*** – Benefits will reset on January 1 regardless of the effective date.

***Plan year*** – Benefits will reset each year on the effective date (rolling 12 months).

### *Blind versus steered plan designs*

***Blind plan designs*** – Both in-network and out-of-network benefits are the same.

***Steered plan designs*** – Out-of-network coverage is less than in-network and is intended to steer utilization to the network.

### *CDT codes (commonly referenced as ADA codes)*

The purpose of CDT codes is to achieve uniformity, consistency and specificity while accurately documenting dental treatment. Providers use CDT codes to submit claims to insurance companies for payment of services.

### *Composite versus amalgam fillings*

***Composite or resin*** – Both refer to a white filling.

***Amalgam*** – Refers to a silver filling.

Many carriers down-code reimbursement from composite to amalgam, which can increase out-of-pocket costs for members.

### *Discount*

The difference between the provider's billed charge and the allowed amount (agreed-upon fee schedule). This only applies to network claims. Typically, the deeper the discount, the smaller the network.

### *Endodontics*

A specialty associated with dental pulp (most commonly root canals) and typically covered in basic or major services.

### *Frequencies and age limits*

These may vary among different carriers. They are important factors to consider when moving dental plans, since they can impact members out-of-pocket costs. If the service is provided to members more frequently, it may not be covered and the member will be responsible for payment.

A couple of examples:

- ***Replacement of crowns*** – Some carriers offer replacement after five years, some seven or even 10.
- ***Fluoride treatment*** – Some carriers offer coverage through age 15, some 18. Coverage can vary between one or two treatments per year.

### *Implants*

Surgically implanted into the jaw bone to support a dental prosthesis (crown, bridge, denture). Implants are not always covered. Some carriers cover implants as a standard benefit while others offer as a rider.

### *Late-entrant penalty*

If an employee declines coverage when it is initially offered and later decides to elect coverage, some services may be subject to late-entrant penalties (waiting periods) commonly 6, 12 or 24 months. See the definition of "waiting period" below.

### *Lifetime maximum*

The maximum amount a dental carrier will pay in benefits to a member during that member's lifetime. There is typically a lifetime maximum applied to orthodontic services that do not renew each year.

### *Periodontics*

Typically covered in basic or major services, periodontics is a specialty associated with gums and other supporting structures of the teeth.

### *Sealants*

Protective coating used for children to prevent cavities. Sealants are typically covered in preventive or basic services, but are occasionally found in major.

### *Waiting period*

The time necessary to be enrolled before a carrier will pay claims for that member. This may apply to every enrollee, or just late entrants. Waiting periods are common for groups with no prior coverage. They can be six, 12 or 24 months and can apply to basic, major and ortho categories.