Prestige Dental II Helpful Hints:
Voluntary Dental Insurance provides dental insurance coverage for eligible employees. Dental insurance insures employees against a portion or all of the cost associated with dental care. Generally, eligible employees are those employees working at least 30 hours or more. However, Prestige II has defined eligibility to mean anyone employee working a minimum of 20 hours a week.

Employees Pay All:
Generally voluntary dental insurance is established so that the employee pays 100% of the premium. Generally, voluntary plans are more costly than a "Group" dental plan because there is generally better participation under a Group plan, which an employer is contributing to.

What is the minimum participation requirement?
Generally, dental insurance carriers require that at least 1 employee be participating in a voluntary plan. However, with these minimal participation requirements, premiums will be more expensive. (Insurance is a risk and if the participation requirement is minimal in a plan, there is a greater risk to the insurer, as they do not have the premium volume to cover their exposure.)

What are Elimination Periods?
Before employees become eligible for various parts of the insurance coverage, most dental insurance carriers require that certain elimination period be satisfied. By and large, the more expensive and complicated the procedure, the longer the applicable elimination period tends to be. Dental benefits are often divided into 4 classifications of coverage usually designated as A, B, C or D - or - Type 1,2,3 or 4 service levels.

Coverage A usually pertains to Preventive or Diagnostic type services including Examinations, cleanings and fluoride treatments

Coverage B usually pertains to Basic or Restorative type services including X-rays, fillings and space maintainers; Additionally, simple extractions are usually classified in this category

Coverage C usually pertains to Major type services including bridges, crowns and onlays; Additionally, Oral Surgery, Endodontics, Periodontics, Denture Repair and Emergency Treatment generally fall into this category

Coverage D usually pertains to Orthodontic services (braces). Generally, when coverage D is elected, children are eligible for coverage up to age 19. Adult orthodontia is available through some insurance plans if added as an additional benefit. There is usually an extra cost associated with this expanded benefit.

Eligible Expenses: Expenses must be incurred while the Policy is in force and the person is covered by the Policy. To be an Eligible Expense, the dental services must be performed by a licensed Dentist acting within the scope of his/her license; a licensed Physician performing dental services within the scope of his/her license; or a licensed dental hygienist acting under the supervision and direction of a dentist.

Coordination of Benefits: This plan will be coordinated with any other group, blanket or franchise plan under which an individual will receive benefits. This helps keep the cost of the Plan reasonable.

Pretreatment Review: If the course of treatment will exceed $300, we will require prior review. We must be given the Dentist's treatment plan consisting of a description of the planned treatment with estimated charges and diagnostic x-rays. We will determine Eligible Expenses and state how much we will pay for the treatment. Our determination may suggest an alternate, less expensive Course of Treatment, if it will produce professionally satisfactory results. If you do not request a pretreatment review, we will pay for the least expensive method of treatment regardless of the method actually used.

Please note: As with all of the provisions and items discussed on this Web site, these provisions will vary from insurance carrier to insurance carrier and may vary from state to state.

Paying The Dentist
When choosing a benefits plan, it is important to know who pays what to whom. Dental plans can be categorized into the following areas based on the compensation and treatment provided:

Indemnity Plans. This type of plan pays the dentist on a traditional fee-for-service basis. The patient and/or the employer pay a monthly premium to an insurance carrier, which directly reimburses the dentist for the services provided. Insurance companies usually pay between 50 percent and 80 percent of the dentist's fee for covered services; the patient pays the remaining 20 percent to 50 percent. These plans often have a pre-determined deductible, a dollar amount that varies from plan to plan, that the patient must pay
before the insurance carrier will begin paying for care. Indemnity plans also can limit the amount of services covered within a given year and pay the dentist based on a variety of fee schedules. Some typical features of these plans:

- High deductibles before coverage begins (well-designed plans don't apply the deductible to preventive services)
- Probationary periods on certain procedures that last up to a year
- Annual dollar limit on benefits
- Chose your own dentist
- Your average monthly cost: $15 to $25
- Companies selling these plans are regulated by state insurance departments.

**Capitation Plans.** This type of plan provides comprehensive dental care to enrolled patients through designated provider dentists. A Dental Health Maintenance Organization (DHMO) is a common example of a capitation plan. The dentist is paid on a per capita (per head) basis rather than for actual treatment provided. Participating dentists receive a fixed monthly fee based on the number of patients assigned to the office. In addition to premiums, client co-payments may be required for each visit. Some typical features of these plans:

- Monthly premiums (some require you to prepay a year's worth)
- Co-payments for office visits
- Free preventive or routine care
- You must select from an approved network of dentists
- May have an initial enrollment fee
- Annual dollar cap
- Your average monthly cost: $5 to $15
- Companies selling these plans are regulated by state insurance departments.

**Preferred Provider Organizations:** Another true insurance plan, a Preferred provider organizations (PPO) falls somewhere between an indemnity plan and a dental HMO. This plan allows a particular group of patients to receive dental care from a defined panel of dentists. The participating dentist agrees to charge less than usual fees to this specific patient base, providing savings for the plan purchaser. If the patient chooses to see a dentist who is not designated as a "preferred provider," that patient may be required to pay a greater share of the fee-for-service. A group of dentists agrees to provide services at a deeply discounted rate, giving you substantial savings — as long as you stay in their network. Unlike the more restrictive DHMO, though, you can go out of network and still receive some benefits. Some typical features of these plans:

- Monthly premiums
- Annual dollar cap
- You must stay within the approved network of dentists or pay higher deductibles and co-payments
- Your average monthly cost: $20-25
- Companies selling these plans are regulated by state insurance departments.

**Direct Reimbursement Plans.** Under this self-funded plan, an employer or company sponsor pays for dental care with its own funds, rather than paying premiums to an insurance carrier or third party. The patient pays the dentist directly and, once furnished with a receipt showing payment and services received, the employer reimburses the employee a fixed percentage of the dental care costs. The plan may limit the amount of dollars an employee can spend on dental care within a given year, but often places no limit on services provided. Patients can select a dentist of their choice and, in conjunction with the dentists, can play an active role in planning the treatment most appropriate and affordable to ensure optimum oral health. Some typical features of a direct reimbursement plan:

- Neither you nor your employer pay monthly premiums
- Freedom to choose any dentist
- Typical employer cost: depends on the number of employees and benefit caps
- Benefits usually capped at $500 to $2,000 annually.

**Dental Discount:** This type of dental plan is not insurance. The managing organizations have negotiated with local dental offices to establish a set price for a particular dental procedure and offer deep discounts (some up to 70%) off the regular ADA pricing code. This plan has several advantages over traditional dental insurance plans, namely, there are no exclusions for pre-existing conditions. This allows a patient to receive immediate coverage for work without meeting any waiting period requirements.
Prestige Dental II Glossary of Terms:

**AAP** - American Academy of Periodontology - dedicated to advancing the art and science of periodontics and improving the periodontal health of the public. Membership consists of specialists in the prevention, diagnosis and treatment of diseases affecting the gums and supporting structures of the teeth and in the placement and maintenance of dental implants.

**AAPD** - American Academy of Pediatric Dentistry - dedicated to improving and maintaining the oral health of infants, children, adolescents, and persons with special health care needs.

**ABCPD** - Alliance for the Best Clinical Practices in Dentistry - an organization that encourages the development of evidence-based prevention and treatment protocols through the process of organizing focused seminars.

**Abscess** - acute or chronic, localized inflammation associated with tissue destruction.

**ADA** - American Dental Association - promotes the public's health through commitment of member dentists to provide high-quality oral health care and promotes accessible oral health care for everyone. The organization also enhances the integrity and ethics of the profession by strengthening the patient/dentist relationship and providing services through its initiatives in education, research, advocacy and the development of standards.

**AGD** - Academy of General Dentistry - serves the needs and represents the interests of general dentists. The Academy fosters their continued proficiency through quality continuing dental education in order to better serve the public.

**Amalgam** - an alloy used in direct dental restorations; a "silver filling."

**Attrition** - the normal wearing down of the surface of a tooth from chewing.

**Baby bottle tooth decay** - severe decay in baby teeth due to sleeping with a bottle of milk or juice. The drink's natural sugars combine with bacteria in the mouth to produce acid that decays teeth.

**Beneficiary** - see enrollee.

**Bitewing Radiograph** - x-rays of the top and bottom molars and pre-molars to show decay between teeth or under fillings.

**Bruxism** - involuntary clenching or grinding of the teeth.

**Caries** - (tartar) hard deposit of mineralized material, or calcified plaque, that adheres to teeth.

**Caries** - tooth decay.

**CMS** - Centers for Medicare and Medicaid Services - formally know as the Health Care Financing Administration (HCFA); a division of the Department of Health and Human Services (DHHS). The organization administers the Medicare, Medicaid, and Child Health Insurance Programs and helps pay the medical bills for more than 75 million beneficiaries. In conjunction with the Departments of Labor and Treasury, it helps millions of Americans and small companies obtain and keep health insurance coverage and helps eliminate discrimination based on health status for people buying health insurance.

**Covered persons** - see enrollee.

**Covered services** - service for which payment is provided under the terms of the dental benefit contract.

**Crown** - the artificial covering of a tooth with metal, porcelain or porcelain fused to metal; covers teeth that are weakened by decay or severely damaged or chipped.

**Customary fee** - the fee level determined by the administrator of a dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.

**Deciduous Teeth** - baby teeth or primary teeth.

**Dental Health Maintenance Organization (DHMO)** - a benefit program in which enrollees receive all or most treatment through the dental office where they are enrolled. The dentist receives a single monthly payment from the benefits carrier for each enrolled patient, no matter how many services that patient receives.

**DHHS/HHSS** - Department of Health and Human Services - federal department that oversees the federally funded programs that provide services such as prenatal screening, immunization, child care, nutrition, exercise, long-term care regulation and autopsies. It enables individuals, families, and communities to be healthy and secure, and to achieve social and economic well being.

**DOL** - Department of Labor - federal department that oversees issues relating to workplace safety and health, pensions and benefit plans, employment and other issues related to the American workplace.

**DPO** - a dental benefit plan in which participating dentists agree to accept a list of specific fees as the total fees for dental treatment provided

**Eligible person** - a person who is qualified to receive benefits under a dental benefit program.

**Endodontist** - having no teeth.

**Endodontics** - a dental specialty concerned with treatment of the root and nerve of the tooth. An endodontist is a dental specialist in this field.

**Enrollee** - a person who receives benefits under a dental benefit contract (also known as: beneficiary, covered person, insured, member).

**ERISA** - Employee Retirement Income Security Act of 1974 - administered by the Pension and Welfare Benefits Administration (PWBA) of the Department of Labor. The Act established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs in order to address public concern that funds of private pension plans were being mismanaged and abused.

**Fee-for-service** - a method of paying practitioners on a service-by-service rather than a "salaried basis"

**Fee schedule** - a list of the charges established or agreed to by a dentist for specific dental services.
**Fluoride** - a chemical compound that prevents cavities; makes the tooth surface stronger so that teeth can resist decay.

**Gingivitis** - an inflammation of the gums surrounding the teeth caused by a buildup of plaque or food particles.

**Gum disease** - see periodontitis.

**Halitosis** - bad breath

**Health Maintenance Organization (HMO)** - a legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period of time at a fixed price. An organized system of health care delivery that provides comprehensive care to enrollees through designated providers. Enrollees are generally assessed a monthly payment for health care services and may be required to remain in the program for a specified amount of time.

**HIAA** - Health Insurance Association of America - advocate on behalf of the industry in the states and in the nation's capital. The organization tracks health-related regulatory activity in key federal agencies; participates in rulemaking; provides information on recently enacted legislation; provides guidance on implementation of federal health initiatives; and works closely with member companies to provide information and feedback to federal officials.

**HIPAA** - Health Insurance Portability and Accountability Act of 1996 - the law's primary intent is to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs through simplification.

**HRSA** - Health Resources Services Administration - a division of DHHS. The organization directs national health programs that improve the nation's health by assuring equitable access to comprehensive, quality health care for all.

**Indemnity plan** - a dental plan where a third-party payer provides payment of an amount for specific services, regardless of the actual charges made by the provider. Payment may be made either to enrollees or, by assignment, directly to dentists (e.g., schedule of allowances, table of allowances, or reasonable and customary plans).

**Indemnity schedule** - see table of allowances.

**Insured** - see enrollee.

**Malocclusion** - improper alignment of biting or chewing surfaces of the upper and lower teeth.

**Maximum allowable charge** - see maximum benefit.

**Maximum allowance** - the maximum dollar amount a dental program will pay toward the cost of a dental service as specified in the program's contract provisions (e.g., UCR, table of allowances).

**Maximum benefit** - the maximum dollar amount a program will pay toward the cost of dental care incurred by an individual or family in a specific time period (also known as: maximum allowable charge).

**Maximum fee schedule** - a compensation agreement in which a participating dentist agrees to accept a prescribed sum as the total fee for one or more covered services (also known as: maximum allowable reimbursement).

**Member** - see enrollee.

**NADP** - National Association of Dental Plans - a trade association that promotes and advances the HMO/PPO sector of the dental benefits industry to improve consumer access to affordable, quality dental care.

**NAIC** - National Association of Insurance Commissioners - assists state insurance regulators, individually and collectively, in serving the public interest and achieving fundamental insurance regulatory goals.

**Network** - a collective expression for all dentists who have contractually agreed to provide treatment according to administrative guidelines for a certain program.

**NIDCR** - National Institute of Dental and Craniofacial Research - promotes the general health of the American people by improving their oral, dental and craniofacial health. Through research and the development of researchers, the NIDCR aims to promote health, to prevent diseases and conditions, and to develop new diagnostics and therapeutics.

**NIH** - National Institutes of Health - part of the U.S. Department of Health and Human Services. The organization conducts research; supports the research of non-Federal scientists in universities, medical schools, hospitals, and research institutions. It also helps in the training of research investigators and fosters communication of medical information.

**Non-participating (non-par) dentist** - any dentist who does not have a contractual agreement with Ameritas Dental to render dental care to members of a dental benefit program.

**Orthodontics** - a dental specialty concerned with straightening or moving misaligned teeth and/or jaws with braces and/or surgery. An orthodontist is a dental specialist in this field.

**Participating (par) dentist** - a dentist who has entered into an Ameritas Participating Provider Agreement and provides dental care services to members; designated by a participating Plan as a participating dentist.

**Panoramic radiograph** - a single large x-ray of the jaws taken by a machine that rotates around the head.

**Pedodontics** - a dental specialty concerned with treatment of children. A pedodontist is a dental specialist in this field (also known as: pediatric dentist).

**Periodontics** - a dental specialty concerned with treatment of gums, tissue and bone that supports the teeth. A periodontist is a dental specialist in this field.

**Periodontitis** - inflammation and loss of connective tissue of the supporting or surrounding structure of the teeth (also known as: gum disease).

**Plaque** - a bacteria-containing substance that collects on the surface of teeth. Plaque can cause decay and gum irritation when it is not removed by daily brushing and flossing.

**Point-of-service** - arrangements in which patients with a managed care dental plan have the option of seeking treatment from an "out-of-network" provider. The reimbursement for the patient is usually based on a lower table of allowances with significantly reduced benefits than if the patient had selected an "in-network" provider.
**Prevailing fee** - the fee most commonly charged for a dental service in a given area.

**Prophylaxis** - (prophy) a professional cleaning to remove plaque, calculus (mineralized plaque) and stains to help prevent dental disease.

**Prosthodontics** - a dental specialty concerned with restoration and/or replacement of missing teeth with artificial materials. A prosthodontist is a dental specialist in this field.

**Provider** - a unique individual dentist (preferred providers, general dentists, specialty providers, practicing providers).

**Radiograph** - x-ray.

**Reasonable and Customary (R & C) Plan** - a dental benefit plan that determines benefits based only on "Reasonable and Customary" fee criteria (also see Customary fee, Reasonable fee).

**Reasonable fee** - the fee charged by a dentist for a specific dental procedure that has been modified by the nature and severity of the condition being treated and by any medical or dental complications or unusual circumstances. Therefore, it may differ from the dentist's "usual" fee or the benefit administrator's "customary" fee (also see customary fee, reasonable fee).

**Scaling** - removal of plaque, calculus, and stain from teeth.

**Schedule of allowances** - see table of allowances.

**SCHIP** - State Children's Health Insurance Program - created from The Balanced Budget Act of 1997; expands health care coverage for children who are not covered by Medicaid.

**Sealant** - a thin plastic material used to cover the biting surface of a child's tooth to prevent tooth decay.

**Subscriber** - the person, usually the employee, who represents the family unit in relation to the dental benefit program (also known as: primary subscriber, enrollee, insured, covered person, beneficiary).

**Table of allowances** - A list of covered services with an assigned dollar amount that represents the total obligation of the plan with respect to payment for such services, but does not necessarily represent the dentist's full fee for that service (also known as: schedule of allowances).