

GLOSSARY

Accidental Injury: A dental accidental injury involves damage to the natural, sound and healthy tooth or tooth structure.

Allowable Amount: The amount which a local Blue Cross and Blue Shield Plan has established as full payment to a Participating Dental provider in accordance with the terms of the Provider agreement.

American Dental Association (ADA): Office Headquarters: 211 East Chicago Avenue, Chicago, Illinois 60611. Telephone: 1-800-621-8099. Web site: www.ada.org.

Benefit: A service provided to a member that a dental insurance plan will pay for. Also, payment provided for covered services.

Benefit Period: The specific period of time in which charges for covered services must be incurred in order to be eligible for payment by insurance.

Calendar Year: A twelve-month period beginning January 1 and ending December 31 each year.

Claim: A request for payment for services provided. Claims may be submitted electronically or on a current, universal ADA-approved claim form.

CDT(Current Dental Terminology): manual of current dental procedure codes, approved by and available from the American Dental Association.

Coinsurance: A percentage of the applicable reimbursement amount that the member's contract requires the member to pay for a covered service. For example, if the dental plan pay 80% of the allowed amount, the member would be responsible to pay the remaining 20% .

Coordination of Benefits: A system which permits members to receive benefits from all dental plans under which they have coverage while assuring that the total, combined payment from the plans is not more than the total charge for the service.

Copayment (copay): A fixed dollar amount, of the applicable reimbursement amount, that the member's contract requires the member to pay for a Covered Service. The provider may collect copayments at the time of service.

Coverage: The specific benefits offered to a member under a dental plan.

Covered Service: Dental service and supplies provided to a member that qualifies for payment under the terms of a member's contract.

Deductible: The dollar amount that a member must pay each calendar or contract year before Regence begins to make payments. For example, the member might be responsible for the first \$50 (or other set deductible dollar amount) for covered services during the benefit year.

Dependent: A husband, wife, child or legally recognized individual who is covered under the member's benefit contract.

Dental Professional's Web Page: Informational web page.

Dual Coverage: Coverage under two different dental contracts.

Electronic Claims: Submitting claims electronically via a software system and a telecommunications device.

Excluded Service: A service which is not covered by a member's benefit plan.

Explanation of Benefits (EOB): A statement sent to a member by a dental insurance plan which explains the action taken on a claim and gives information about any payment, denial or member responsibility.

Explanation of Claims Processed (EOCP), Remittance Advice, or Voucher: A form sent to a Participating Provider by a dental insurance plan which explains the action taken on a claim and gives information about any payment, denial or member responsibility.

Fee-For-Service: A type of benefit plan that reimburses the provider based on the individual procedure(s) performed.

Group: The employer, union, association or other organization that provides dental insurance for a member and enrolled dependents.

Group Number: The number used to identify the employer or group that provides dental insurance for a Member and enrolled dependents.

Health Insurance Portability & Accountability Act of 1996 (HIPAA): Federal statute designed to:

- Improve efficiency in health care delivery by standardizing electronic data interchange.
- Protect confidentiality by providing unique health identifiers for individuals, employers, health plans and health care providers.
- Establish security standards to protect the confidentiality and integrity of "individually identifiable health information," past, present or future.

Hold Harmless: To “adjust,” “write-off” or not charge a Member for balances other than those amounts identified as patient responsibility such as deductible, coinsurance, copayment amounts and for services that are not a benefit of the Member’s contract.

Identification Number: The number used to identify the Member assigned by Regence. The number is no longer the subscriber’s Social Security number.

Maintenance of Benefits: A system which permits members to receive benefits from all dental insurance plans under which they have coverage, while maintaining patient responsibility for coinsurance and/or copayment amounts. For additional information please refer to the Reimbursement section of this manual.

Maximum Allowable Charge: The maximum dollar amount that Regence will allow for Covered Services.

Maximum Benefit: When payments for services rendered total an amount specified in the member’s contract, no further payment will be made by Regence. When the maximum benefit is for a specified time period such as a calendar year, no further payment will be made during the remainder of the specified time period.

Member: A person covered under any Regence Plan, as well as participants in other Blue Cross and Blue Shield Plans who may require services while in any of Regence's service areas.

Member Contract: A contract between Regence and an individual or group in which Regence agrees to provide, indemnify for, or administer health care benefits.

Necessary Dental Care: The following criteria are used to determine if a service is necessary:

- It is the appropriate type, level, amount, and frequency of care necessary to treat a dental condition or injury that is harmful to the health of a member.
- It is the least costly, appropriate treatment and location that can be used safely to treat the Member’s condition.
- It is consistent with widely accepted standards of practice.
- It could not have been omitted without adversely affecting the member’s condition or quality of care.
- It is not primarily for the convenience of the member, the dental provider, or any other person.

National Provider Identifier (NPI): A standard unique health identifier for dental providers, other health care professionals and facilities. This identifier, once

implemented in 2007 will be used to identify the provider by all health plans, including Medicare and Medicaid.

Nonparticipating Provider: A provider who does not have an effective contract with Regence to provide services and supplies to members in the state in which s/he practices.

Participating Provider: Any dental provider or dental group who is legally qualified to provide dental services or supplies; has contracted with Regence, directly or through intermediaries, to furnish Covered Services to members; and is eligible for reimbursement under a member contract.

Primary Plan: The dental plan that has the primary responsibility to pay benefits when a member is covered by more than one dental insurance plan.

Provider: A licensed dental provider who is eligible to provide covered services.

Provider Agreement: Contract and/or Exhibits signed by a participating dental provider indicating agreement to abide by our dental and reimbursement policies. Providers who have signed this agreement are known as participating, contracted, or network providers.

Provider Identification Number (PIN): A number assigned by a Regence Plan that identifies the Provider by name, address and tax identification number. A PIN is required on every claim submission. This will be replaced with the NPI in 2007.

Regence: A global term used to identify Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah, and Regence BlueShield (in Washington) as a group.

Regence Online Services: Web-based applications available to our members, Participating Providers and facilities, and our employees regarding Regence-specific information.

Remittance Advice: A form sent to a provider by a dental insurance plan that explains action taken on claims and gives information on any payment accompanying the form. Also known as a voucher or explanation of claims processed (EOCP).

Secondary Plan: The plan which pays any balances remaining up to its coverage limits after the primary plan has paid when a member is covered by more than one dental insurance plan.

Tax Identification Number: The number the provider uses to report earnings to the Internal Revenue Service.

The Regence Group (Regence): The holding company for Regence BlueShield of Idaho, Regence BlueCross BlueShield of Oregon, Regence BlueCross BlueShield of Utah; Regence BlueShield (in Washington), Regence Life and Health Insurance Company, Asuris Northwest Health (not a BlueCross BlueShield licensee), and their respective subsidiaries.

Utilization Management: Process of evaluating and determining the appropriate use of health care resources and promoting the efficient, cost-effective use of health care benefits. Utilization management activities include pre-authorization, case management, discharge planning and retrospective review.

Voucher: A form sent to a provider by a health insurance plan that explains action taken on claims and gives information on any payment accompanying the form. Also known as a remittance advice or explanation of claims processed (EOCP).

Voucher Adjustments/Credit/Deduct: Standard procedure utilized to deduct overpayments from future vouchers.

Waiting Period: Period of time a member may be required to wait after enrolling to become eligible for certain benefits.

Write-Off: To “adjust,” “hold harmless” or not charge a member for balances other than those amounts identified as patient responsibility such as deductible, coinsurance, copayment amounts and for services that are not a benefit of the member’s contract.