



AAPD Buyer's Guide to Dental Benefits



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Foreword

This buyer’s guide is intended to educate employers about the various types of dental plans that exist in the market so that you may make informed decisions when selecting a dental plan for you and your employees. This guide offers several considerations and questions to ask yourself prior to choosing the most appropriate dental plan for your company’s employees. It will also help you determine who to provide coverage for under your plan and suggest a plan design to optimize dental health for your employees and their families.

If you have further questions, please contact your broker, benefits professional, state dental society or AAPD Dental Benefits Manager Mary E. Essling at (312) 337-2169, ext. 36.

Why Offer Comprehensive Dental Benefits for Children?



The Advantages of Offering an Adequate Dental Benefit Plan

Dental health is a key factor to preserving one's general health. Employers and other health plan sponsors offer dental benefits for a variety of reasons. Offering a dental benefits plan makes economic sense. A frequently overlooked reason for employee absences or poor work performance is dental disease or discomfort for the employee or employee's children. And as every human resources professional knows, days lost can mean money lost. A quality dental benefits plan can aid in the recruitment and retention of employees. Dental benefits are consistently cited as one of the most sought after employee benefits.

Many medical needs and treatments are unpredictable, catastrophic, costly and a high insurance risk. In contrast, most dental needs and treatments are predictable, non-catastrophic, low cost and low risk. Dental disease is usually preventable, with the exception of damage due to an accident. Dental treatment begins with relatively low-cost diagnostic procedures, such as exams and X-rays. If decay or disease is detected, the sooner it is treated, the less expensive that treatment will be. The dental needs of an employee group are highly predictable, so a dental benefit plan can often be self-funded. Extremes in cost and utilization (evident in many medical benefits) are rarely observed in dental benefit programs.



Questions Employers and Decision Makers Should Ask Before Selecting and Purchasing a Dental Plan



- What are the demographics of my employee population? Do I have young adults with families or is the population older? Does this geographic area have fluoridated water? What are the dental-related risks of my employee population?
- Do the contract provisions include age limitations? Are children under the age of 3 covered?
- Will employees retain the freedom to choose their own dentists?
- Is the type of treatment determined by the patient and the dentist?

- Does the plan cover diagnostic, preventive and emergency services? Will it cover preventive services such as sealants and fluoride treatments, which may save patients money in the future? Will it provide for full-mouth X-rays?
- What type of routine and specialized dental care is covered? Does the plan cover stainless steel crowns, interceptive and comprehensive orthodontic treatment, appliance therapy, pulpal therapy, and oral surgery for children and patients with special health care needs?
- What major dental care is covered? Does the plan treatment cover temporomandibular disorders?
- Will the plan allow for referrals to pediatric dentists and other specialists? If so, will the dentist be limited to a list from which to choose? Does the plan recognize the pediatric dentist as a primary care provider?
- How does the plan provide for emergency treatment? What provisions are made for emergency care when you are away from your geographical home area?
- If the plan requires monthly premiums, what percentage of that money goes to actual care and not to overhead or administration?



Factors to Consider When Selecting Your Employee Dental Benefit Plan



The American Academy of Pediatric Dentistry (AAPD) believes that all infants, children, adolescents and individuals with special health care needs must have access to comprehensive preventive and therapeutic oral health care benefits that contribute to their optimal health and well-being. This brochure is intended to assist policy makers, third-party payers, and consumer groups/benefits purchasers to make informed decisions about the appropriateness of oral health care services for these patient populations. This section provides a comprehensive overview of dental insurance plans such as indemnity plans and managed care plans.

The AAPD encourages all third-party payers to consult the AAPD when crafting benefit plans to best serve the oral health interests of infants, children, adolescents and individuals with special health care needs. These model services are predicated on establishment of a dental home—defined as the ongoing relationship between the dentist (i.e., the primary oral health care provider) and the patient, inclusive of all aspects of oral health care, starting **no later than 12 months of age**. Expected benefits of care should outweigh potential risks. The value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment. Consistent with AAPD clinical guidelines, the following services should be included in comprehensive dental benefit plans (available on the AAPD Web site at <http://www.aapd.org>).

- Preventive services:
 - o Initial and periodic examinations of the dentition and oral cavity, including medical and dental histories, furnished in accordance with the periodicity schedule found in the Guideline on Periodicity or when oral screenings by other health care providers indicate a risk of caries or other dental or oral disease;
 - o Education for the patient and the patient’s family on measures that promote oral health as part of initial and periodic well-child assessment;
 - o Age-appropriate anticipatory guidance and counseling on non-nutritive oral habits, injury prevention, and tobacco use/substance abuse;
 - o Application of topical fluoride at a frequency based upon caries risk factors; See the Policy on Caries Risk Assessment;
 - o Prescription of dietary fluoride supplement based upon a child’s age, caries risk, and fluoride level of the water supply or supplies;
 - o Application of pit and fissure sealants based on caries risk factors, not based upon patient age or time lapsed since eruption;
 - o Dental prophylactic services at a frequency based on caries risk factors.
- Diagnostic procedures consistent with guidelines developed by organizations with recognized professional expertise and stature, including radiographs in accordance with recommendations by the US Food and Drug Administration and the American Dental Association.
- Restorative and endodontic services to relieve pain, resolve infection, restore teeth, and maintain dental function and oral health. This includes interim therapeutic restorations, a beneficial provisional technique in contemporary pediatric restorative dentistry.

- Orthodontic services including space maintenance and services to diagnose, prevent, intercept, and treat malocclusions, including the management of children with cleft lip or palate and congenital or developmental defects. These services include, but are not limited to, initial appliance construction and replacement of appliances as the child grows.
- Dental and oral surgery which shall include sedation or general anesthesia and related medical services that shall be furnished on an inpatient basis when medically necessary.
- Periodontal services to resolve gingivitis, periodontitis, and other periodontal diseases or conditions in children.
- Prosthodontic services, including implants to restore oral function, that are consistent with guidelines developed by organizations with recognized professional expertise and stature.
- Diagnostic and therapeutic services related to the management of orofacial trauma. When the injury involves a primary tooth, benefits should cover complications for the developing permanent tooth.
- Drug prescription for preventive services, relief of pain, and/or treatment of infection.
- Medically necessary services for preventive and therapeutic care in patients with medical, physical, or behavioral conditions. These services include, but are not limited to, the care of hospitalized patients, sedation, and general anesthesia in outpatient or inpatient hospital facilities (i.e., operating room).
- Behavior guidance services necessary for the provision of optimal therapeutic and preventive oral care to patients with medical, physical, or behavioral conditions. These services may include both pharmacologic and non-pharmacologic management techniques.
- Consultative services provided by a pediatric dentist when the dental home has been established with a general practitioner or when requested by another dental specialist or medical care provider.

Important questions to ask when choosing and purchasing a dental plan

1. Does the plan cover **diagnostic**, **preventive** and **emergency** services? If so, to what extent? Most dental plans provide coverage for selected diagnostic services, preventive care and emergency treatment that are basic for maintaining good oral health. But the extent or frequency of the services covered by some plans may be limited. Depending upon which services the plan covers, the patient may be required to pay the dentist directly for a portion of even basic care. It is important for the individual who owns the policy to understand how much treatment is covered in any given year. Every dental plan is different.

2. What **routine corrective treatment** is covered by the dental plan? What share of the costs will be the patient's? While preventive care lessens the risk of serious dental disease, additional treatment may be required to ensure optimal health. A broad range of treatment can be defined as routine. Most plans cover 70 percent to 80 percent of such treatment. Patients are responsible for remaining costs.
3. What **major dental care** is covered by the plan? Since dental benefits encourage the patient to obtain preventive care, which often eliminates the need for major dental work, most plans are restrictive when it comes to paying for major dental work. Most plans cover less than 50 percent of the cost of major treatment. Most plans limit the benefits – both in number of procedures and dollar amount – that are covered in a given year. Patients must be aware of these restrictions. Major dental care includes restorative care (gold restorations and individual crowns), oral surgery (removal of impacted teeth and complex oral surgery procedures), periodontics (treatment of complicated periodontal disease requiring surgery involving bones, underlying tissues or bone grafts), orthodontics (braces), dental implants (either surgical placement or restoration), and prosthodontics (fixed bridges, partial dentures and removable or fixed dentures).
4. Will the plan allow **referrals to specialists and is there a limitation of age for referrals**? Will the patient be allowed to obtain services from a pediatric dentist or other specialist? Some plans limit referrals to specialists. The dentist may be required to refer the patient to a limited selection of specialists who have contracted with the plan's third party. Also, the plan may require the patient to obtain permission from the plan administrator before being referred to a specialist and often an age limitation for referrals is included in the provisions. Before choosing a plan that has such limitations, it is important to **make sure qualified specialists** are available in the local area. Look for a plan with a broad selection of different types of specialists. Parents will most likely prefer a plan that allows a pediatric dentist to be his/her child's primary care dentist. While many general practitioners are qualified to perform some specialized services, complex procedures often require the skills of a pediatric dentist with special training. Patients should discuss the options with their dentist before deciding who is best qualified to deliver treatment. **Choose a plan with no age limitations for referrals.** Patients with special health care needs often exceed the typical "age of child" contract provisions and are denied coverage.
5. Can the patient obtain care **when they need to**? If an HMO plan is selected, the patients must have a clear understanding of the dentist's policies as well as the plan's dentist-to-patient ratio. It's the best way to ensure that access to care is not unduly restricted.

6. Will the plan provide benefits to patients who may also be covered by **another dental plan**? It is not unusual for employees to be eligible for dual benefits. That is, an employee/dependent may be covered under one company's plan as well as under that of his/her other parent/spouse's employer. In analyzing options, make sure to look for a plan that allows coordination of benefits.

As with all plan information, the AAPD believes that applicable Coordination of Benefits (COB) provisions should be clearly defined and described in employee benefit booklets and available on carrier Web sites.

COB is governed by state insurance law when the medical or dental plan is a regulated carrier. While insurance law can vary from state to state, most states follow a model adopted by the National Association of Insurance Commissioners.

With the growth of employer-sponsored medical and dental plans and collectively bargained plans that operate under the federal Employee Retirement Income Security Act (ERISA) plans, the variability in COB clauses has expanded. A provision called non-duplication has also been added to some ERISA and other plans.

Definition of a primary carrier

- The plan covering the patient, other than as a dependent, is the primary plan.
- When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.
- When a determination cannot be made in accordance with the above, the plan that has covered the patient for the longer time should be considered as primary.
- When one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.

When carriers are licensed by the state, state COB regulations provide guidelines by which the primary carrier and secondary carrier(s) are determined. Contact the National Association of Dental Plans at http://www.ada.org/prof/resources/pubs/adanews/images/080505_benefits_table01.pdf for a chart that helps determine which carrier to bill first.

Insurance Limits, Coinsurance and Deductibles

Coinsurance is the term used to describe when payment for dental services is shared. Some dental plans might pay 100 percent of the fees for the first \$500 of dental expenses submitted each year, then pay 80 percent up to a maximum of \$3,000 in expenses. The patient is responsible for paying the remaining share of these fees.

If a dental plan includes an insurance deductible, then the patient is responsible for payment of this fee before the plan covers any expenses. For example, if a plan states that they have a \$75 deductible, then the patient will pay the first \$75 of dental fees each year before the plan begins to cover services.

Pre-determination of Benefits

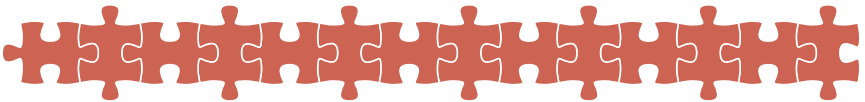
Some plans encourage the patient or dentist to submit a treatment proposal to the plan administrator before receiving treatment. After review, the plan administrator may determine: the patient's eligibility, the eligibility period, services covered, the patients required co-payment and the maximum limitation. Some plans require predetermination for treatment exceeding a specified dollar amount. This process is also known as preauthorization, precertification, pretreatment review or prior authorization.

Understanding Dental Fees

Dental insurance plans differ in the level of reimbursement offered for certain procedures and on annual dental spending caps. Some plans may limit the waiting period before certain dental treatments are rendered. Additionally, plans typically have exclusions, meaning that costs for certain dental procedures will not be reimbursed. It is extremely important that you, as the decision maker for dental benefits, understand the contract provisions and understand the dental needs of the insureds and their dependents.



Types of Dental Benefit Plans



Misconceptions

A common misunderstanding by the general public is that insurance carriers do not offer a “good” dental plan to employees. In truth, the insurance carriers are willing to sell their various levels of products to employers but, as with everything, the richer the plan, the more costly the product. Employers typically budget a certain amount they are willing to spend on employee benefits. The dental insurance plan that an employer purchases is one that meets budgetary allowances or is the result of collective bargaining and may not necessarily be adequate or realistic coverage for employee dental needs.

What are the different kinds of dental insurance plans available in the market?

Two major types of dental insurance exist: indemnity plans and managed care plans.

Dental Indemnity Plans (Fee for Service [FFS])

An indemnity dental insurance plan is typically administered by a third party, usually an insurance company, and pays for all or part of the dental treatment. The employee/patient has complete freedom of choice in selecting a dentist. If the patient is happy with their established dentist, changing dentists could have a negative effect on the quality or quantity of care the family receives. Because routine visits to the dentist reduce the likelihood of developing serious dental disease, it's best for patients to maintain an established relationship with a trusted dentist.

This type of plan also allows a patient to go directly to a specialist without a referral by a general dentist.

- These dental insurance plans use a Usual, Customary, and Reasonable (UCR) fee schedule. This allows the insurance company to pay its maximum benefit up to a preset percentage of a dentist's submitted charges, the UCR. To arrive at the UCR, the dentist's fee is compared to the fees that are submitted by other practicing dentists within a specific geographical area (usually the zip code). If the charges are higher than the plan's fee schedule, then the benefit percentage is calculated on the UCR, not the dentist's actual fee. For an indemnity plan, the patient's co-payment would be the difference between the benefit and the UCR. It is important to note that exceeding the plan's UCR fee does not mean that the dentist has overcharged for the procedure. There is a wide fluctuation and lack of government regulation on how plans determine the UCR fee. Often, specialists' fees are not considered separately when determining UCR fee schedules.
- Insurance providers will pay up to 100 percent of preventive dental care and varying amounts for other services

Direct Reimbursement (DR)

Direct Reimbursement is a self-funded dental benefits plan that reimburses patients according to *dollars spent* on dental care, not type of treatment received. It allows the patient complete freedom to choose any dentist. Instead of paying monthly insurance premiums, even for employees who do not use the dentist, employers pay a percentage of actual treatments received. Moreover, employers are removed from the potential responsibility of influencing treatment decisions due to plan selection or sponsorship.

Managed Care Plans (PPOs, DHMOs and POSs)

Employees often prefer managed care plans because the premium costs are low. These dental insurance programs require the employee to select the dental health care provider from a list of providers. The insurance carrier will pay for some fees directly and the dentist will offer special discounts to patients with this type of insurance who choose a dentist from within the specified network. There are a few types of dental managed care plans:

Dental Preferred Provider Organization (PPO) Insurance Plans

A PPO is regular indemnity insurance combined with a network of dentists under contract to the insurance company to deliver specified services for set fees and according to the provisions of the contract. Contracted dentists must usually accept the maximum allowable fee as dictated by the plan, but non-contracted dentists may have fees either higher or lower than the plan allowance. Patients may be penalized by receiving a smaller benefit when they receive services from a non-contracted dentist.

Plan purchasers should consider the following when reviewing a PPO dental plan:

- What percentage of the premium is used for administration?
- Will the amount of the discount influence patients to change their dentist?
- Will the amount of the discount the dentist is required to offer affect the number of treatment options for the plan's covered individuals?
- What is the liability for the employer if the plan influences provider selection or treatment?
- What are the criteria for selection of providers for the plan?
 - o Does it have enough dentists under contract to adequately serve the group?
 - o What is the geographic distribution of patients to dentists?
 - o Does it allow for referrals to pediatric dentists and other specialists?
 - o Are dentists limited to referring patients to contracted specialists?

Dental Health Maintenance Organization (DHMO) Insurance Plans

The DHMO Plan has a network of dentists. However, these dentists offer a discount to clients who are part of the same insurance company because the insurance company offers them a prepayment. In general, when using these plans, the patient can only go to dentists in the network. If the patient chooses a dentist out of network, the insurance pays nothing.

When the plan purchaser reviews a DHMO or capitation plan, the following factors should be considered:

- What percentage of the premium is used for administration?
- Does the employer have access to sufficient information to determine the level and amount of treatment received by each member of the group?
- What is the utilization rate for patients in this program? What is the average waiting period for an initial appointment? What is the average period between appointments?
- What is the dentist/patient ratio for the program? What are the criteria for selecting dentists to participate in the program? What is the geographic distribution of patients to dentists?
- What is the ratio of dentists accepted to the program to those who applied to participate? How many dentists voluntarily withdrew from the program over the past two years?
- What is the capitated rate of compensation for the dentists? Is it sufficient compensation for the needs of the covered patient population? What provisions are made for unforeseen utilization or difficult cases?
- What are the benefits for patients requiring a specialist's care? How are specialists selected and compensated? Does the plan have adequate specialist participation?
- Who controls treatment decisions — the patient and the dentist or the dental plan? Many plans require dentists to follow treatment plans that rely on a Least Expensive Alternative Treatment (LEAT) approach. If there are multiple treatment options for a specific condition, the plan will only pay for the least expensive treatment option. If the patient chooses a treatment option that may better suit his/her individual needs and long-term oral health, the patient will be responsible for paying the difference in cost. It's important to know who makes the treatment decisions under the chosen plan. These cost-control measures may have an impact on the quality of care you'll receive.

Dental Point of Service (POS) Insurance Plans

This type of dental insurance offers the option of using a dentist who is part of the insurance plan network or the option of seeing a dentist who is not part of a network. When signing up for a POS plan, the patient decides which type of dental care professional they wish to see. Patients are allowed to change their mind. In most cases, patients will pay more for using dentists who are not part of a network.

Discount Dental Plans

These plans are designed for individuals, families and groups looking to save money on their dental care needs. Participating dental care providers have agreed to accept a discounted fee from plan members as payment-in-full for services performed. As a plan member, you simply show your membership card when visiting any participating plan provider to receive dental services at discounted fees.

Advantages:

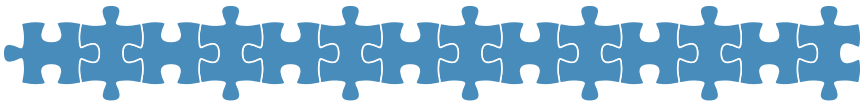
- Application process simpler; enrollment can be immediate and plans can be activated quickly.
- Discounts are immediate. The fees are agreed upon ahead of time between the plan and the provider. Dental care is discounted by the provider at the time of service, provided the care rendered falls under one of the discounted services. The percent discounted and which services are discounted will vary according to the plan specification.

Disadvantages:

- Reliance on the network dentists. It may be difficult to find a local dentist who participates in the discount plan.
- The patient needs to carefully research the plans. Patients who select these types of plans need to review the type of discounts and the quality of the dentists in the network before choosing the plan. The discounts only apply for those dentists who participate. In more remote regions, it may be difficult for a family to locate a dentist who participates.
- The plan is a discount plan and not dental insurance. The plan provides discounts on care but the patient is still largely responsible for the cost of the treatment. In these plans, preventive services are usually discounted at much higher rates compared to restorative services. The patient is still responsible for the cost of care at the time of the appointment. There may be services that are not discounted. The patient needs to be very familiar with what the plan covers ahead of time. After discounts are applied for the services, the patient is responsible for the fee.



Definitions



Contract dentist – A dentist who agrees to provide specified services at specific levels of reimbursement under the terms and conditions stipulated by the contractual provisions.

Contract term – The period of time for which a contract is written.

Deductible – The amount of a dental expense for which the beneficiary is responsible before a third party will assume any liability for payment of benefits. The deductible may be an annual or one-time charge, and may vary in amount from program to program.

Dental Insurance – Also known as pre-payment plans or third-party coverage, is a benefit designed to cover a portion of the cost for dental care services. The employer or employee purchases coverage by paying a monthly premium. In turn, the insurer agrees to pay for some or all of the employee’s dental care, as per the agreement, up to a specific coverage limit. In many cases, the employer may have arrangements in place to directly pay the agreed portion to the employee. If employees need care exceeding this cap amount, they will be responsible for paying the balance.

Eligibility Date – The date an individual and dependents become eligible for benefits under a dental benefits contract. The date is often referred to as the “effective date.”

Fee-for-Service – A freedom of choice arrangement under which a dentist is paid for each service provided according to the full fees established by the dentist.

Flexible Spending Account (FSA) – An employee reimbursement account primarily funded with employee-designated salary reductions. Funds are reimbursed to the employee for health care (medical and dental), dependent care, or legal expenses, and are considered a nontaxable benefit.

Freedom of Choice – The concept that a patient has the right to choose any licensed dentist to deliver his or her oral health care without any type of coercion.

Managed Care – A type of dental plan that is a contractual agreement in which the payment, reimbursement or utilization is controlled by a third party. This concept represents a cost containment system that directs the utilization of health care by:

- a) restricting the type, level and frequency of treatment; b) limiting the access to care;
- c) controlling the level of reimbursement for services; and d) controlling referrals to other dentists.

Preauthorization – A statement by a third-party payer 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 third-party payer for approval before the treatment is started.

Precertification – Confirmation by a third-party payer of a patient’s eligibility for coverage under a dental benefit plan.

Predetermination – A process used to determine the benefits available for dental services that are planned by the dentist: an estimate of the amount payable by the plan if services are rendered when the patient is eligible. Under some programs, predetermination by the third party is required when covered charges are expected to exceed a certain amount.

Reimbursement – The payment made by a third party to a beneficiary or to a dentist on behalf of the beneficiary, toward repayment of expenses incurred for dental services covered by the contractual arrangement.

Self-funded plan – A program for providing employee benefits financed entirely through the employer, in place of purchasing such coverage from a commercial carrier.

Third-Party Administrator (TPA) – An individual or company that processes and pays claims for self-funded plans. The TPA undertakes no financial risk for claims incurred.

Third-Party Payer – Party to an insurance or prepayment agreement, usually an insurance company, prepayment plan, or government agency responsible for paying the provider designated expenses incurred on behalf of the insured.

Utilization – The extent to which the members of a covered group use a program over a stated period of time; specifically measured as a percentage determined by dividing the number of covered individuals who submitted one or more claim by the total number of covered individuals.

Please contact the American Academy of Pediatric Dentistry (AAPD) at benefits@aapd.org if you have questions when crafting and funding your dental benefit plan.

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