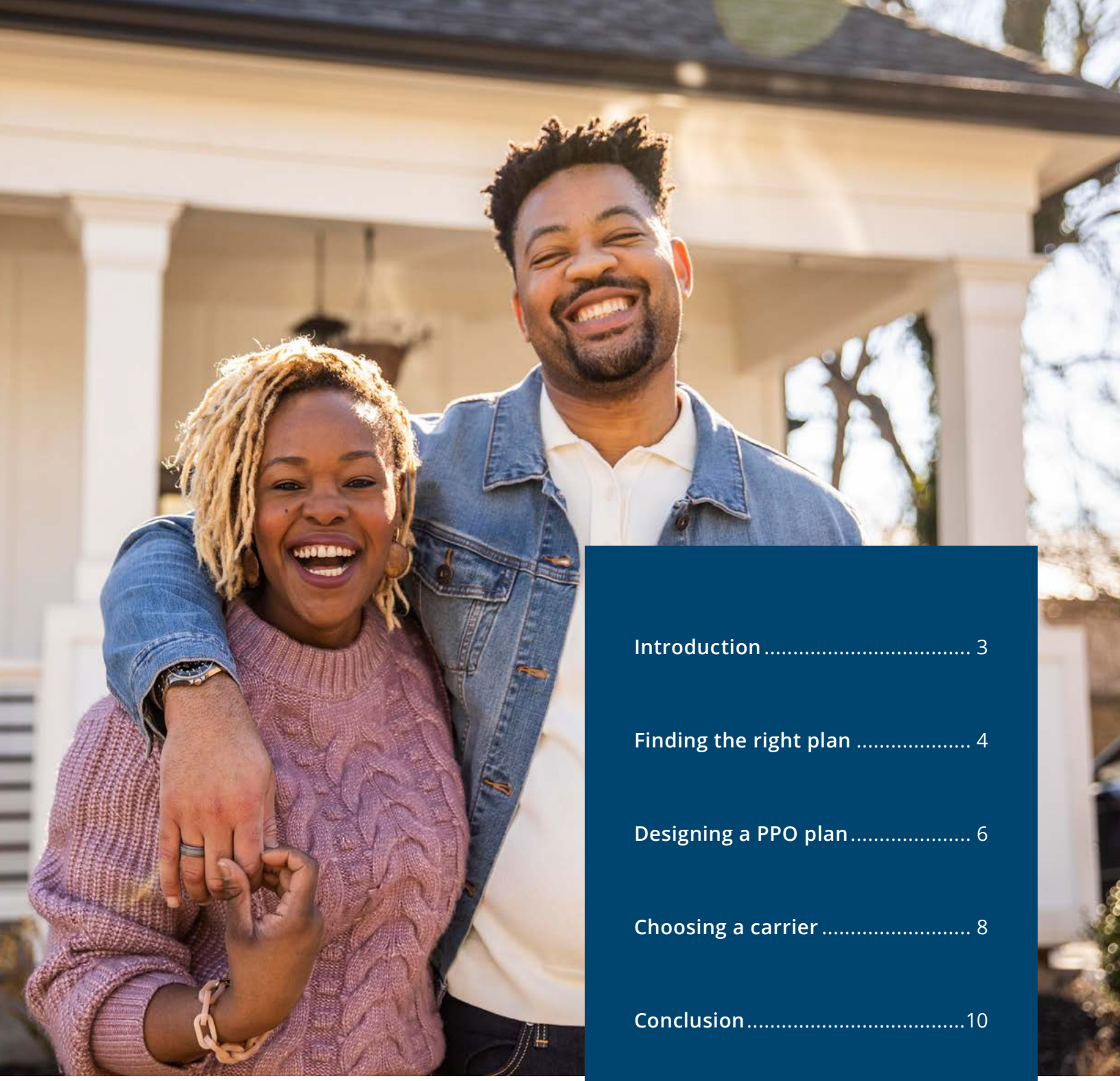
Drill down into dental insurance

The small business guide to group dental coverage



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Introduction

Choosing a dental insurance plan is a big decision

As a small business, you want the best for your employees, because their well-being is essential to your company's growth. Dental coverage is near the top of workers' "most desired benefits" list, because they recognize that oral health is critical to overall health — for themselves and their families.[1]

As a result, offering dental benefits is important to your company's ability to find and keep great workers. But the plan needs to meet your employees' specific needs, have conveniently located providers and come at a **cost your small business can afford**.

That's a lot to chew on. So, when it comes to shopping for dental benefits, you might be confused or even overwhelmed by the number of options you have and the number of factors you need to consider.

That's where this guide comes in. If you're a **first-time dental buyer**, it can help you narrow down the types of plans you shop for and the carriers you consider. If you're looking to **change insurance carriers**, it provides helpful tips and reminders of what you should expect when switching. No matter what you need, this guide is intended to help small businesses make sense of workplace dental insurance — so you can choose the right plan with confidence.

WHY OFFER DENTAL INSURANCE TO YOUR EMPLOYEES?

Helps you get and keep the best talent

Employees rank dental benefits in their top three things to consider when making employment decisions.[1]

Helps employees stay engaged and productive

U.S. companies lose $45 billion in productivity annually due to untreated dental disease.[3]

Helps keep your people healthy

Poor oral health is linked to several serious conditions, including oral cancer, diabetes, heart disease, stroke and premature birth. But routine dental care can prevent oral health problems and reveal signs of disease earlier, making conditions easier and more affordable to treat and control.[2]

Does all this at an economical cost

With employee-paid plans or shared-funding arrangements, you and your employees can get all the benefits of dental insurance, without breaking the bank. And plans provided through the workplace give employees access to discounts and lower group rates they could not typically get on their own.

Finding the right dental plan

Dental plans come in many flavors: PPO, DHMO and discount programs to name a few. Which plan is right for your business? Choosing a plan type depends on many factors, including your workforce demographics, your location, your budget and how much plan administration you want to shoulder. Here's how some common types of plans work, and how they differ.

Managed-care plans

Managed-care plans are designed to control costs by encouraging employees to get preventive dental care and use pre-approved providers. There are two main types of managed-care plans: Preferred Provider Organizations (PPOs) and Dental Health Maintenance Organizations (DHMOs).

PPOs

PPOs are the dental plans **most commonly offered by small businesses**. A PPO plan helps employees get the care they need by covering a portion of their dental care costs, as determined by the plan design you choose. For example, many plans pay 100% of charges for diagnostic and preventive services, and 50% to 90% of the charges for other types of treatment. (You can read more about designing your plan in the next section of this guide.)

In addition, the plan contracts with a network of providers who agree to provide services to plan members at predetermined, discounted rates.

Employees can choose to see any dentist, but they will have lower out-of-pocket costs when they visit providers who are in the network. For example, let's say an employee needs to have a cavity filled:

- If the employee uses an **in-network provider**, the provider would discount their rate for filling a cavity, and charge the amount designated in the provider contract. The plan and employee would pay their designated percentages of this charge, according to the plan design.
- If the employee uses an **out-of-network provider**, the discounted rate would not be available, and the provider would likely charge their full price for the service. The plan and employee would then pay their designated percentages of this higher rate for the service.

DHMOs

In a DHMO, participating providers receive a monthly payment for each insured person from the insurance carrier. Employees receive a list of services covered by the plan, along with the cost they will pay for each — kind of like a menu in a restaurant. In that respect, pricing for DHMO plans is transparent and easy to understand.

However, each employee must select and use an in-network DHMO provider. Employees may be covered for emergency services with an out-of-network provider, but plan benefits are often unavailable unless they see their selected in-network DHMO provider. The in-network provider also has discretion over what services to provide and what materials to use, within the boundaries of the DHMO contract.

Discount dental programs

A discount dental program is not insurance. It's kind of like belonging to a warehouse club: A person pays an annual fee to belong, and gets access to discounts from dentists who accept the discount program. Employees have to use participating providers, and the program determines the discounts, but providers determine the fee schedules.

While the fee for a discount-program membership will generally be much lower than the premiums for actual dental insurance, employees typically pay more for dental care when using these programs.

Most common dental plans and how they differ

PPO

- Most common dental plan offered by small businesses
- Provides access to a network of participating providers at reduced fees
- Typically allows employees to see any provider, although they may have higher out-of-pocket costs if they see an out-of-network provider
- Typically requires deductibles and co-insurance, and has an annual maximum benefit

DHMOs

- Lower premium-cost option
- Requires employees to select a network provider as their primary care provider for services
- Limits out-of-network benefits to emergency services only
- Typically does not require deductibles, coinsurance or annual maximum benefit; employees pay a fixed amount (or co-pay) for covered services

Discount plans

- Not insurance; typically low cost
- Providers agree to participate in the plan and provide services at a discount
- Members pay an annual fee for access to discounted fees

Which plan type is right for you? That depends on your workforce, your location, your budget and more.

Type of plan	Employees can see any provider	Discounts available at network providers
PPO	✓	✓
DHMO	✗	N/A
DISCOUNT PROGRAM	✗	✓

Designing a PPO plan

Selecting coverage amounts, frequency and more

If you choose a PPO plan you'll be able to tailor it to suit your budget and the needs of your employees. Your insurance broker or carrier representative can help you identify the right plan design(s) for your group at the price point that works for your small business.

Annual maximums and deductibles

Most plans cap the total amount they will pay for a covered person per year **(annual maximum)**. Many also require that a covered person satisfy a **deductible** before benefits are payable. Employers can choose the maximum and deductible amounts that best suit their workplaces.

Covered services

You can determine **what services you will cover**. In addition to preventive and basic services, you may choose to cover major services such as crowns or implants. You may also choose to offer orthodontia and determine who will be covered — for example, children only or adults and children.

Service classifications and frequency

Plans also offer some flexibility in specifying **how services are classified** (preventive, basic or major) and the **number of times** they are covered in a given time period. This lets you tailor your plan to meet your employees' needs.

Co-insurance

Plans generally let you choose from a range of co-insurance percentages for certain types of services. The plan pays the chosen percentage, and the employee pays any remaining costs out of pocket.

- Most plans cover **diagnostic and preventive services** at 100%. Fully covering these services can encourage employees to get preventive care, helping reduce the need for expensive corrective care in the future.
- For **basic and major services**, you can usually choose from a range of coverage percentages, typically 50% to 90%.

TYPICAL DENTAL SERVICE CLASSIFICATIONS

Diagnostic and preventive services

X-rays

Cleanings

Other preventive care like fluoride treatment

Basic services

Fillings

Extractions

Other simple corrective procedures

Major services

Root canals

Crowns and bridges

Dental implants

Other major corrective procedures

Waiting periods

You can decide whether employees and dependents are covered **immediately** or whether they must complete a waiting period before services are paid. You can also choose the length of the **waiting period,** and have different waiting periods for different services. Many plans have three- to six-month waiting periods for basic services and six- to twelve-month waiting periods for major services.

Premiums

You can also decide who will pay the premiums for your plan. While many employees pay the total premium for dental, you can choose to enrich your plan by helping employees with the cost of this critical benefit.

- **Employee-paid coverage**. Many smaller businesses that offer dental plans require the premiums to be paid 100% by their employees. Employees benefit by getting group rates they couldn't get on their own.
- **Employer-paid and shared-funding coverage**. If your budget allows, paying all or part of the dental premium can help keep your employees healthy and happy. As costs rise for all health care services, helping with the cost of dental care can go a long way toward keeping employee satisfaction high and turnover rates low. When they have increased access to more affordable care, employees are also more likely to participate in the plan and get preventive treatment, which may help avoid more serious health care costs.

Consider higher-risk employees in your workforce when designing your plan. For example, you may want to offer an additional exam for pregnant employees, who are at higher risk for dental concerns.

Choosing a carrier

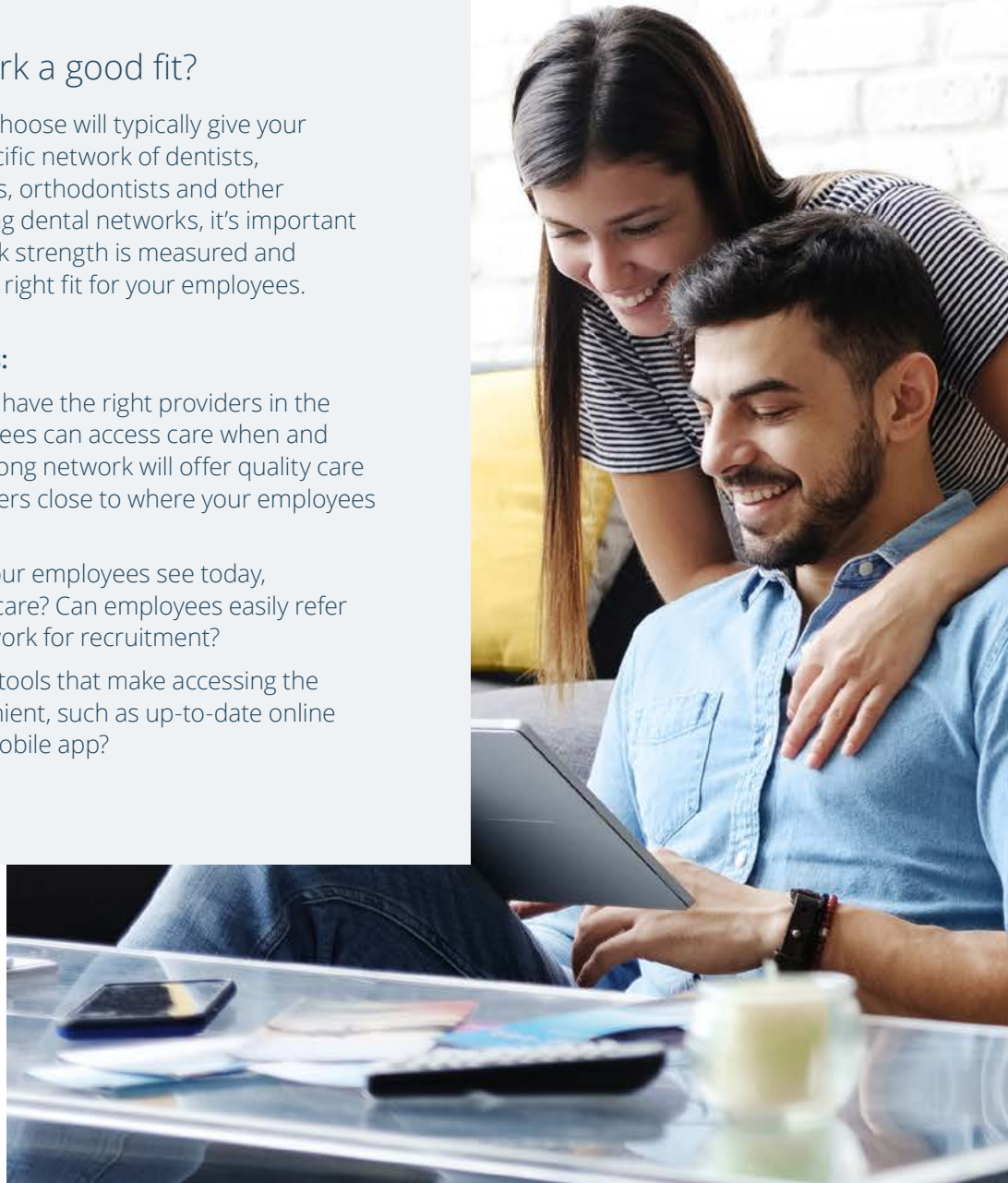
When it comes to companies offering group dental plans, you've got a lot of choices. But not all insurance carriers are created equal. Cost is clearly important, but don't base your decision solely on price. The strength of the provider network and the quality of the carrier's service will contribute mightily to your employees' satisfaction — and your own.

Is the dental network a good fit?

The insurance carrier you choose will typically give your employees access to a specific network of dentists, periodontists, endodontists, orthodontists and other specialists. When comparing dental networks, it's important to understand how network strength is measured and whether the network is the right fit for your employees.

Consider these questions:

- Does the dental network have the right providers in the right locations so employees can access care when and where they need it? A strong network will offer quality care from credentialed providers close to where your employees live and work.
- Does it have providers your employees see today, minimizing disruption in care? Can employees easily refer their dentists to the network for recruitment?
- Does the carrier provide tools that make accessing the network easy and convenient, such as up-to-date online provider directory and mobile app?



CARRIER TIPS

- Look for a carrier who can provide attractive, **easy-to-understand materials** to help you talk with your employees, so they'll be able to make informed decisions about their dental benefits.
- Look for a carrier with a variety of **communication capabilities** to fit how your company operates and how your employees prefer to get information.
- Look for a carrier who can **easily enroll dental benefits** within your preferred enrollment system or method. Bonus points for carriers that offer multiple employee benefits, which can significantly reduce your HR department's administrative burden by integrating tasks like account setup, enrollment and billing.

FIRST TIME BUYER?

Look for:

- Coverage that can be tailored for your small business — and your employees
- Strong local dental provider network
- Employee education capabilities and enrollment support

THINKING ABOUT SWITCHING CARRIERS?

Focus on:

- A strong provider network that would bring minimal disruption to your employees
- Flexible plan designs to meet your specific needs
- Customer service you can count on
- Integration with other benefits you offer, for simplified administration

Does the carrier have service you can count on?

Different carriers can provide different services to make it easier for you to offer dental benefits and easier for employees to use them. Look for streamlined solutions for benefits management and employee access. Bonus points for carriers who provide one point of contact to help implement the plan, enroll employees and answer your billing questions — and who handle all claims administration in-house.

Here are some other things to look for:

- **Explaining the plan to employees**. Consider how you'll inform your employees about the plan you've chosen. You'll need to let them know how the plan works, how to find a provider, who can be covered and what costs they'll be responsible for.
- **Encouraging employees to enroll**. Techniques like one-to-one conversations, group meetings, workplace posters, website messages and email campaigns can help employees understand why you're offering dental coverage and why they should enroll.

Once your employees have enrolled, they are likely to begin using their coverage right away.

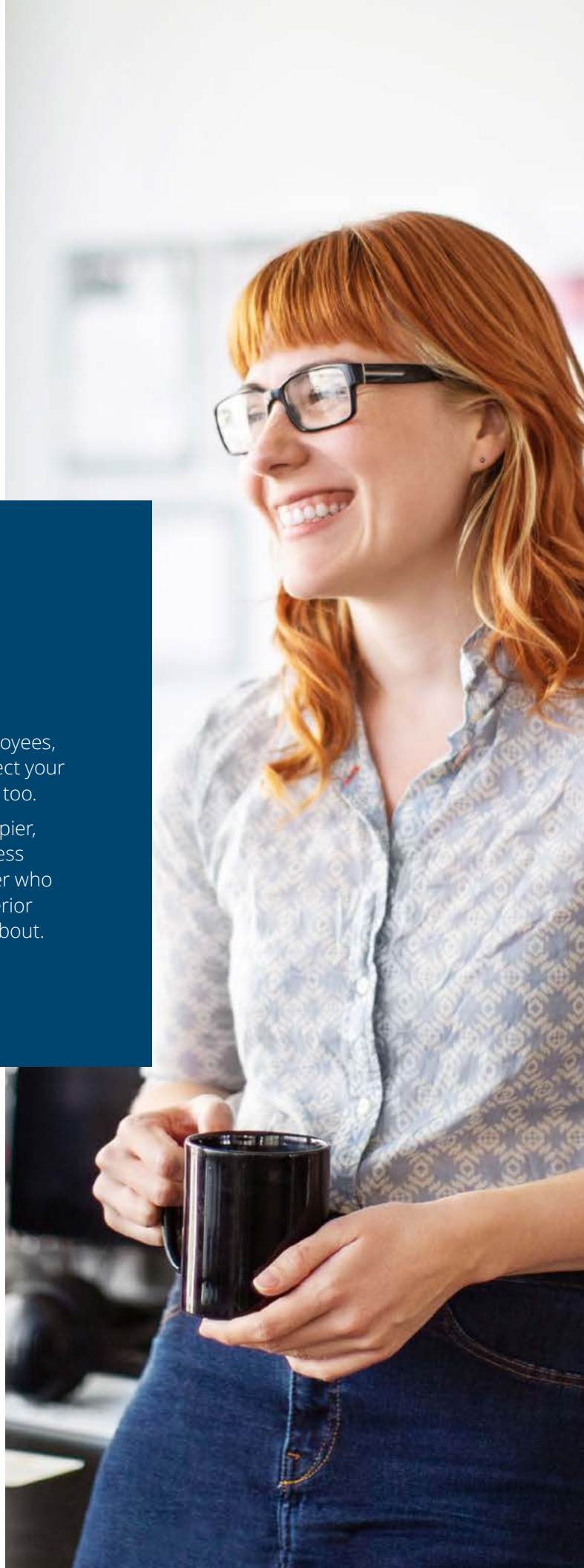
Here's what you should be able to expect from your dental carrier:

- **Helpful customer service**. When employees have questions or issues to resolve, they should be able to reach your carrier in an easy and intuitive way — through an 800 number or online, for example. Questions should be answered promptly by well-trained and knowledgeable people.
- **Simple access to information**. Employees should be able to easily get provider information and manage their claims — through a user-friendly online portal or mobile app, for example. Some carriers offer access to a library of educational materials and resources, which can be a real plus.

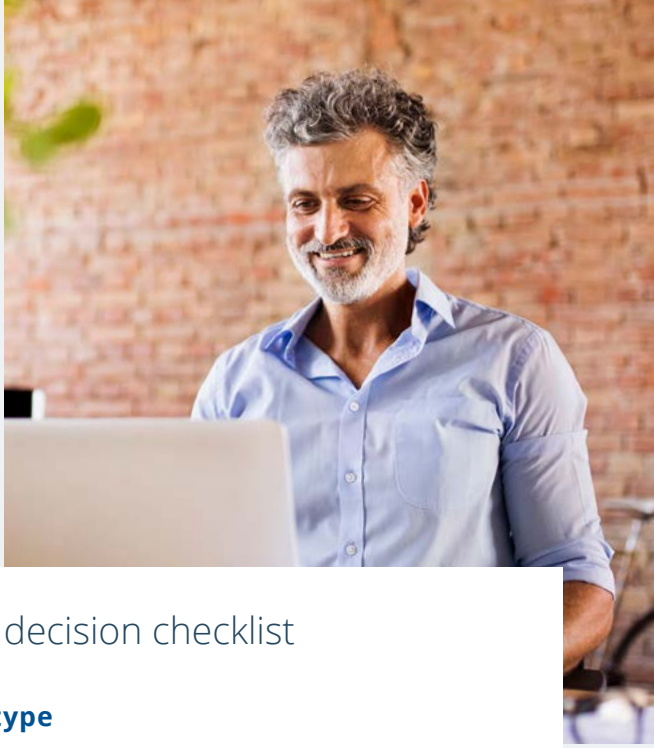
The last word

Your choice of a dental plan means a lot to your employees, and to your company. That's because when you protect your employees' oral health, you protect your bottom line, too.

When you think about it, it just makes sense that happier, healthier employees will help you achieve your business goals. So it's important to choose a plan from a carrier who can give all of you excellent, affordable care and superior customer service — something everyone can smile about.



What to look for in a dental carrier



Reputation & experience

Look for an insurer with a longstanding reputation. Established carriers are more likely to pay claims quickly, have good provider relationships and offer superior customer service.

Network strength

Because coverage costs less when employees use network dentists, check out the strength of the carrier's dental network. Does it have enough providers to choose from near where your employees live and work? Can your employees keep their current dentist?

Benefits administration solutions

Look for a carrier who makes it easy to administer your benefits. You can significantly reduce the burden on your HR department by choosing a carrier that streamlines billing and claims processing, while offering multiple employee benefits.

Communication & enrollment resources

You'll have an easier time getting your plan up and running if you have a carrier who can help you educate employees about the plan and enroll it alongside your other benefits. Ask about communication and enrollment resources when you interview carriers.

Plan decision checklist

Plan type

- [ ] Do you want a PPO plan, to lower costs while still offering flexible plan design, provider choice and quality of care?
- [ ] A DHMO, to make costs predictable and transparent for you and your employees?
- [ ] A dental discount program, to provide some low-cost benefits?

Provider network

- [ ] Does the plan you're considering have an adequate number of providers near where your employees live and work?

Plan design

- [ ] Will you or your employees pay the premiums (or share them)?
- [ ] What level will you set for annual maximums and deductibles?
- [ ] What level of coverage will the plan provide for specific treatments and services?
  - 100% coverage for preventive care?
  - Endodontic or periodontic services covered as basic or major service?
  - Orthodontic care for children and adults?
  - Extra screenings for at-risk people like expectant mothers?
  - Oral cancer screenings?

Dental insurance terms

Here are some terms you might come across when researching dental plans, along with their definitions.

Annual maximum: The maximum dollar amount a plan will pay out for care in a 12-month period.

Balance billing: When a provider bills a person for the difference between the provider's charge and the allowed amount.

Benefit: The amount a plan pays for a dental procedure or service.

Carrier: Any insurer, managed-care organization, or group hospital plan, as defined by applicable state law.

COBRA: A federal law that may allow a person to temporarily keep health coverage after their employment ends, they lose coverage as a dependent of the covered employee, or another qualifying event. If a person elects COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, they pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Co-insurance: The percentage of costs of a covered service a person pays (20%, for example) after they've paid their deductible.

Co-pay: A fixed amount ($20, for example) a person must pay for a covered service after they've paid their deductible.

Deductible: The amount a person pays for covered services before their insurance plan starts to pay.

Dependent: Spouse or child of an insured person who is eligible for dental insurance coverage. Eligible dependents may vary by state.

Exclusions: Services that a person's insurance or plan doesn't pay for or cover.

Maximum allowable charge: The maximum dollar amount a dental program will pay toward the cost of a dental service as specified in the program's contract provisions.

Maximum benefit: The maximum dollar amount a dental plan will pay toward the cost of dental care in a given period.

Pretreatment estimate: A written estimate of benefits available as of a specific date and time, given to an employee or treating dentist in advance of proposed treatment.

Preventive and diagnostic services: Dental procedures concerned with preventing dental diseases through protective and educational measures (e.g., exams, cleanings, x-rays and fluoride).

Waiting period: The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

[1] Employee Benefits Research Institute, The State of Employee Benefits: Findings From the 2018 Health and Workplace Benefits Survey, 2019.

[2] Mayo Clinic, Oral health: A window to your overall health, 2019.

[3] Center for Disease Control and Prevention, Division of Oral Health at a Glance, 2021.

Dental solutions

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