DIRECT REIMBURSEMENT[SM]

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DENTAL PLANS
benefits made simple

ADA®

Dear Benefits Professional:

At your request, the American Dental Association is pleased to provide you with this supplemental information on Direct Reimbursement (DR®) — a simple, self-funded way to provide a dental benefit for your employees. DR is strongly supported by the ADA as a cost effective way to provide a dental plan that gives patients the freedom to choose their dentists.

Information in this kit guides you through a step-by-step process for implementing and administering a Direct Reimbursement plan. The kit covers the material in-depth, in order to ensure that your questions are answered and your needs met. However, don't let the scope of this material obscure one of the plan's greatest features— its simplicity.

Think of DR as a familiar and straight-forward accounting process: Once a company has implemented a DR plan, an employee simply visits the dentist of his or her choice, receives treatment and arranges for payment. The employee then presents the employer or plan administrator with a paid receipt or proof of treatment and is reimbursed for all or part of the expense, according to the plan design.

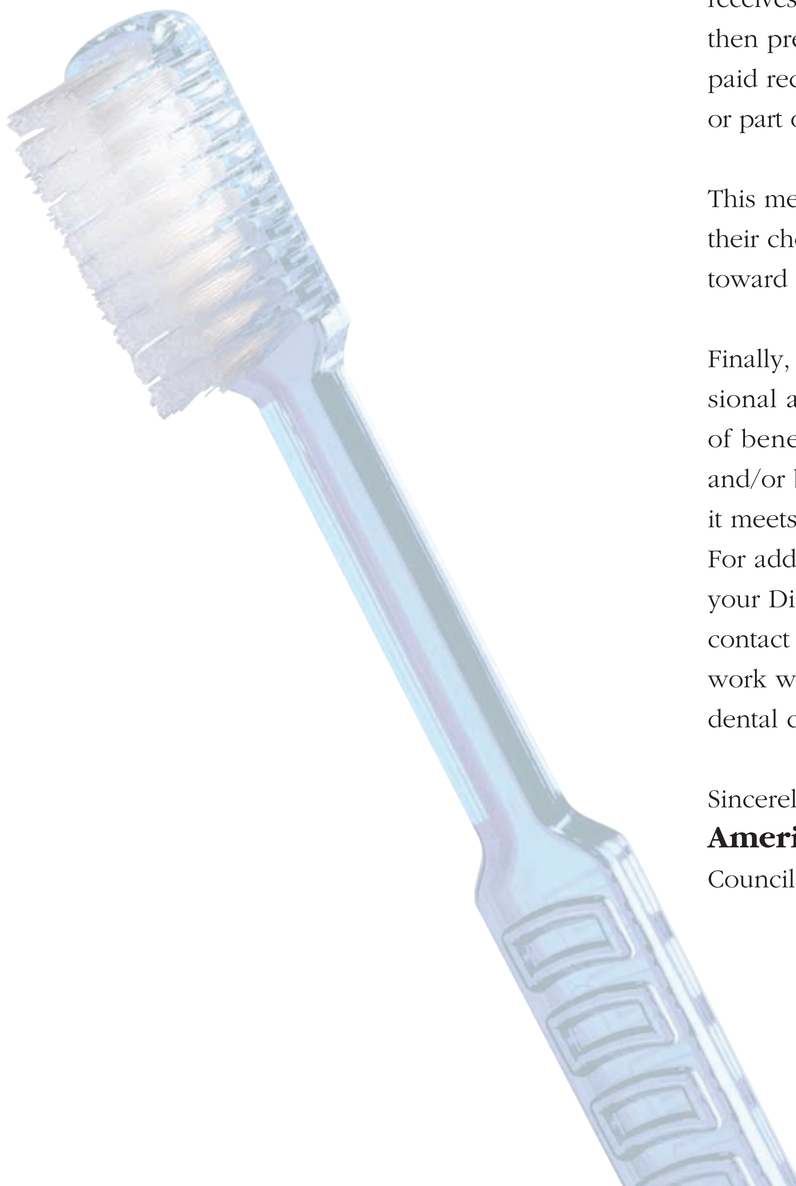
This method ensures that employees go to the dentist of their choice and that virtually all of the money spent goes toward dental treatment.

Finally, this kit provides suggestions for seeking professional assistance in the planning and/or administration of benefits. You should have your accountant, lawyer and/or benefits consultant review the plan to ensure that it meets your needs and complies with all applicable laws. For additional assistance or an actuarial cost projection for your Direct Reimbursement dental plan, please feel free to contact ADA staff at **1-800-232-1890**. We are eager to work with you to ensure that high-quality and affordable dental care is available to you.

Sincerely,

American Dental Association

Council on Dental Benefit Programs



Administering a DR Plan: Common Questions & Concerns

One of the advantages of Direct Reimbursement is the simplicity it offers: It's simple to implement and simple to administer. The following pages answer the most common questions employers ask about implementing and administering a DR plan. In addition, you may contact your benefits consultant/broker, the ADA or your state dental society, if you have specific questions about DR.

What are my options for administering a DR plan?
In general, companies have two options when it comes to administering a DR plan:

1. *Self-administration,* which involves the tracking of employee reimbursements according to the plan design. This simple, check-writing function is comparable to the familiar reimbursements made for employee expense accounts. In addition, computer software has been created to simplify the process of DR self-administration. The ADA knows of various companies that produce and sell such software.

2. *Third-party administrators* (TPAs) commonly offer their services for companies that do not wish to self-administer. For a reasonable fee, TPAs simply process the paperwork without assuming any financial risk.

Where do I go to find a TPA?
Seek out a company that specializes in benefits plans. In addition to your broker or benefits consultant, the ADA and your state or local dental society may be able to assist you in identifying some of the TPAs in your area who administer DR plans for companies similar to yours.

With a DR plan, do I need claim forms for the dentist?
Simplicity of claims administration does not require the dentist to complete a form. However, the American Dental Association recommends the use of a form that requires both the dentist's signature and the employee's signature to assure clarity and validity of claims.

What about other forms?
Suggested sample Explanation of Benefits, Enrollment, and Claim forms are included in the pocket of this booklet.

Instructions for their completion begin on page 6 of this booklet. All forms you intend to use should be reviewed by your attorney or benefits consultant.

Is it necessary to file federal government forms?
A DR dental plan must file an IRS form 5500 if it either covers 100 or more employees, or is funded by a trust. Employers are also required to distribute a Summary Plan Description (SPD) to employees, but are no longer required to file SPDs with the Department of Labor. SPDs provide employees with all they need to know regarding the plan design and the filing and appeal of claims. See the section entitled "Implementing the Plan" in this booklet for more information.

How important is coordination of benefits?
For small firms, probably not very important. Typically, coordination will reduce claims 5 to 15%. For large firms, reduction may be significant. Failure to coordinate, in effect, subsidizes plans of other area employers. Your company's TPA, broker or benefits consultant may provide suggestions that you can use. The ADA's Dental Benefit Information Service also can offer suggested policy regarding coordination of benefits; you may contact the office at **800-232-1890** with questions.

Is it necessary to have a trust fund?
Direct Reimbursement plans may not require a trust fund if they are not funded by after-tax employee contributions. However, if employees are required to make after-tax contributions to the cost of benefits, it is a federal requirement that such funds cannot be commingled with employer funds, and a separate trust would be needed. At the present, a trust is not required for before-tax employee contributions made under a "cafeteria" or "flex" plan. Please refer to the section in this booklet on "Federal Requirements."

If I decide I want a trust, how do I set it up?
Consultants, brokers or TPAs specializing in benefit plans may do this for you as one of the services they provide. The ADA may be contacted for information on the companies that provide these services, or you may wish to consult with your own attorney.

A trust can be filed for exemption under Section 501(c) (9) of the IRS code. There are significant tax advantages available to larger employers (in general, those with 200 or more employees) via use of this device. Under any circumstance, an employer should file its trust for a tax number using form SS-4 and must file an annual information tax return. Whichever trust mechanism you use, it should be reviewed by your attorney and accountant.

With Direct Reimbursement, how can the employer determine how the employees utilize the benefit dollars?
This is up to the employer. The simplicity of Direct Reimbursement is that it does not require the employer to keep track of exactly what treatment is received, except to the extent necessary to ensure that the treatment qualifies for tax-exempt reimbursement. Nevertheless, there is nothing to preclude an employer from requiring that the ADA's Claim Form be used for reporting the treatment rendered. The employer needs to determine if such information is necessary, recognizing that the greater the amount of data collected and reviewed, the greater the administrative expense of the Plan.

Other types of insured plans that attempt to influence treatment with limited levels of reimbursement (e.g. only two cleanings covered for each calendar year) do not necessarily meet the treatment needs of all employees. Under Direct Reimbursement, the employee knows the reimbursement levels, and can prioritize treatment accordingly. While specific treatments or procedures may not be known to the employer, it knows where the benefit dollars are going — for actual dental treatment — rather than taxes, profit, reserves and administrative costs involved with other types of plans.

Direct Reimbursement puts employers directly in contact with the claims process. Doesn't this also put them in the uncomfortable position of being responsible for claim review or denial?
Yes, but that position should not be uncomfortable under a Direct Reimbursement program. Reasons for claim denial include cases where the employee was not eligible for the benefit or had reached the maximum benefit payment, or if the claim appeared to be fraudulent. In the first two cases, the basis for denial could be easily documented, and would not be a problem for the employer. In the case of fraud, the employer will need to be closely involved since such deception may be grounds for disciplinary action.

The other side of the employer involvement with the claims process is that the employees receive the benefit in the form of a check paid directly from the employer. This helps the employees to realize that the benefit is real money, paid by the company they work for, to assist in payment for their dental care.

Your cost is determined by the benefit limits of your plan. While it has been the experience of the ADA that employers may realize cost savings under this type of dental plan, the actual cost of an employer's Direct Reimbursement program will depend on the design of the plan and the dental needs of the group covered. The employer may wish to use cost estimates to help in decisions concerning benefit design and budgets. The ADA, in cooperation with a nationally respected actuarial firm, has developed an actuarially sound cost estimation service to assist employers. These are estimates only, provided to all interested employers upon request.

Cost Assumptions

Cost estimates are developed using assumptions about the benefit plan, the employer and employees, based on the information provided by the employer. These assumptions must be reasonable and appropriate if the estimate is to be valid. A copy of the form to be completed by the employer in order to obtain this cost estimate has been included in the pocket of this folder. If you currently offer more than one dental benefit plan to your employees, please complete a separate form for each plan. You may make copies of this form.

Characteristics Taken into Consideration

Cost estimates are developed using specifications for a proposed benefit plan design. The estimates are generally not valid if the specifications change.

Important features of the plan design which are considered in developing the estimate include:

1. Covered Services
2. Claim Payment Rules
3. Benefit Formula
4. Effective Date
5. Employee Eligibility Rules
6. Participation Levels

In addition, there are several features of the employer which are considered in developing the cost estimate, namely:

1. Location
2. Size
3. Dental Benefit History
4. Turnover Rate

Characteristics of employees are also a factor since visiting the dentist is largely a matter of personal habit. Some people visit the dentist regularly, some rarely visit and others never seek professional dental care. The ADA's cost estimate system adjusts expected costs on a group-by-group basis to reflect differences in use patterns of employees based on:

1. Occupational Status
2. Gender Distribution among the Employee and Spouse Populations

Cost Trends

The cost estimates provided by the ADA are developed for the first year of the proposed Direct Reimbursement plan. The estimates do not apply to subsequent years, because so many factors may affect costs over time.

Note: When completing the Cost Estimation System Data Sheet, please read the top of each sheet carefully and call the ADA if you have any questions. Proper completion of the data request forms is crucial to a timely turnaround and valid estimate. Incomplete or inaccurate information will result in delays in preparation of the cost estimate. While every attempt will be made to provide actuarially sound information, it is important to note that this should be relied upon as an estimate only.

Federal Requirements

Filing Requirements

The following information relates to Department of Labor and Internal Revenue Service filing requirements involving self-funded plans, including DR.

Benefits Paid without a Trust:

Number of Covered Employees*	IRS Form	Certified Plan Financial Statement
2 to 99	None	No
100 & over	5500	No

Benefits Paid from a Trust:

Number of Covered Employees*	IRS Form	Certified Plan Financial Statement
2 to 99	5500 C	No
100 & over	5500	Only if a trust is used

*The number of employees is measured on the first day of the plan year.

If a Form 5500 is required, each employee must receive an annual summary of the form.

Note: Trusts must also file an information type Federal Tax Return. The form to be used is governed by whether the Trust has requested, and been awarded, tax exempt status. Consult your accountant or tax attorney for advice.

The criteria which usually govern whether a trust is utilized are:

1. If there are after-tax employee payroll deductions, the federal law forbids commingling of employee/employer funds for more than 90 days. If payroll deductions are deposited in a trust account prior to use in paying claims, they are considered appropriately segregated.
2. If employee payroll deductions are before-tax through a cafeteria plan (also called a Section 125 or "flex" plan), current law does not require use of a trust.
3. If there is a trust in place for medical, it is usually employed for all health benefits, including dental benefits.

Note: If a Section 125 plan is in use, there is no need for a formal legal trust.

The fact that employees are required to pay co-payments or satisfy deductibles does not make it necessary to use a trust. A trust is needed only if employees are required to make payments to the employer, or have after-tax amounts withheld from their compensation. In the unlikely event that a former employee elects to continue coverage under COBRA, use of a trust may become necessary.

Considerations Regarding Cosmetic Treatment

On January 1, 1991, an amendment to Section 213(d) of the Internal Revenue Code took effect. It requires employees to pay taxes on benefits received from their employer for "cosmetic surgery or other procedures" unless the treatment is necessary to correct a congenital deformity, personal injury, or disease.

Under this law, a cosmetic procedure is "any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease." Employees are also prohibited from taking a personal tax deduction for these expenses and from paying for such expenses through before-tax contributions to a Section 125 plan. Payments to employees for cosmetic surgery should be reported as taxable income of the employee. Payment of cosmetic procedures through a Direct Reimbursement plan is not recommended, even if the payment is reported as taxable income. The reason is that if cosmetic procedures and other procedures are subject to the same overall benefit limit, the IRS may assert that all benefits under the plan are taxable. The ADA Plan Document does not permit payment of cosmetic procedures, even on a taxable basis.

The Internal Revenue Service has not issued guidelines telling employers how to interpret or implement the new law. The ADA believes that dental benefits will not be significantly affected by this law. This is due to the fact that the vast majority of dental treatments "meaningfully promote the proper function of the body or prevent or treat illness or disease" and therefore are excluded from the IRS definition of cosmetic treatment. Until guidance is issued by the IRS, employers should consult their attorney, accountant or other professional advisor for additional advice.

COBRA

A Direct Reimbursement plan is subject to COBRA unless the employer had fewer than 20 employees on at least half of the business days of the preceding year. For this purpose, all employees (including part-time employees), and employees of certain related companies, are counted even if they are not eligible for the plan.

If the Direct Reimbursement plan is subject to COBRA, employees who terminate employment must be given the right to continue their coverage for at least 18 months, and covered dependents who cease to be eligible must be permitted to continue their coverage for up to 36 months. Although they may be charged the full cost of their coverage (based on the average claims experience plus a 2% administrative fee), they must be given the opportunity to elect the coverage.

Implementing the Plan

The first step in implementing a Direct Reimbursement dental benefits plan is to complete a Summary Plan Document (SPD), which serves as the legal document governing the plan. A completed Summary Plan Document must be kept on file by the company administrator. In addition, a summary of the Summary Plan Document, called the Summary Plan Description, must be given to all covered employees. The Summary Plan Description provides covered employees with all they need to know regarding the plan design and the filing and appealing of claims. It also summarizes their legal rights under the plan.

A sample Summary Plan Document is included in the pocket of this booklet. This particular sample has been designed to function as both the employee plan description and the legal document governing the plan. This document, if properly completed, should meet all federal requirements for health and welfare plans. Although the Summary Plan Document is protected by copyright, permission is hereby granted to distribute the completed Summary Plan Document to covered employees and other appropriate audiences. This document cannot be used to create a Section 125 plan funded with before-tax employee contributions. To set up such a plan, you should consult a benefits professional.

Whether you use the ADA Summary Plan Document or create your own, you should consult your attorney, accountant or other benefits professional to review the completed document.

Instructions for completing the ADA Sample Summary Plan Document

1. Title

Fill in your company name, address, phone number, Plan number, and your Employer Identification Number. The Plan number must be a three digit number starting with a 5 (e.g. 501, 502, 503). Be sure the Plan number does not duplicate a number assigned to your group hospital or other benefit plans. The Employer Identification Number is your corporate federal ID number that appears on tax returns that identifies you to the federal government.

The remainder of the information refers to the manner in which your Plan is funded. If the Plan will be funded by a Trust, substitute the following wording for the boxed information:

Funds for payment of dental claims are paid into a Trust. The Trust is known as the Employee Benefits Trust. All funds received by the Trust shall be applied toward payment of claims and reasonable expenses of administration of the Plan. The Trustee is the person in charge of the operation of the Trust and is [Here fill in the name and address of the person designated as the trustee. The trustee must be either one or more individuals or a bank. It cannot be the corporate employer.]

2. Plan Execution

The first entry is your company's name. The second entry is the name of your Plan. The third entry is, again, your company's name. If you intend to fund your Plan through a trust, insert this information here as it appears in the Title.

3. Schedule of Benefits

Your first step is to determine the level of dental benefits you intend to provide. For guidance, revisit this booklet's companion piece, "Direct Reimbursement: An Introduction," as well as the section in this booklet on "Direct Reimbursement Costs." In addition, consider the following information on determining annual maximums and co-payment levels for covered expenses:

Annual Maximum Benefits Paid — Decide whether the maximum should apply individually per person, or to the entire family, marking out the option you do not choose to use. Next, enter the annual maximum allowable reimbursement (per person or per family, depending on the option you chose). Your plan's annual maximum should be determined by a number of factors including budget, previous dental coverage, company benefits philosophy and information received with the DR cost estimate. If you are in doubt you may want to initially elect a smaller annual maximum rather than a larger one. Benefits can be gradually increased; reductions can be harder on employees.

Co-payment Levels for Covered Expenses — Enter the percentage rates you have determined for employer and employee shares of the dental expenses. Employer and employee shares must combine to equal 100% for a given amount of dental expense.

The following examples are provided as illustrations. The percentages included in your plan document will depend on the specific plan you have designed.

Example A
Co-payment Levels for Covered Expenses:

Amount of Dental Expense	Employer Share	Employee Share	Paid Benefits
First $100	100%	0%	$100
Next $500	80%	20%	$400
Next $2000	50%	50%	$1000

Maximum Annual Benefits Paid: $1,500

Example B
Co-payment Levels for Covered Expenses:

Amount of Dental Expense	Employer Share	Employee Share	Paid Benefits
First $100	100%	0%	$100
Next $250	80%	20%	$200
Next $2000	50%	50%	$1000

Maximum Annual Benefits Paid: $1,300

Example C
Co-payment Levels for Covered Expenses:

Amount of Dental Expense	Employer Share	Employee Share	Paid Benefits
First $100	100%	0%	$100
Next $500	80%	20%	$400
Next $1000	50%	50%	$500

Maximum Annual Benefit Paid: $1,000

Example D
Co-payment Levels for Covered Expenses:

Amount of Dental Expense	Employer Share	Employee Share	Paid Benefits
First $1000	50%	50%	$500

Maximum Annual Benefits Paid: $500

You may wish to limit the benefits for employees hired during the plan year. If so, simply include the reduced Schedule of Benefits in your Summary Plan Document with an explanation of its purpose.

4. Definitions

Employer — Your correct corporate name should appear identifying you as "Employer." Also include your street address (not P.O. Box) here. This is a federal requirement.

Plan — Federal law requires that your Plan have a name (e.g. ABC Company Dental Benefits Plan).

Eligible Employee — Enter the minimum number of hours you consider for full-time employment. If you wish to require more than 25 hours per week, you should consult a qualified tax advisor to ensure that your plan will satisfy the IRS regulations.

Eligible Dependents — A fairly liberal definition of dependents has been used. If you prefer, you may copy the definition used in your group medical policy for consistency. Children are usually covered to age 19. If you do not want the coverage to extend through college, eliminate that wording.

Waiting period — Enter the period of time (if any) you feel is appropriate for your organization; for example, one month, three months or one year.

Administrator — Fill in the blank with "the Employer" unless the plan is to be administered by someone other than the employer. If this is the case, the other administrator (and his or her address and telephone number) should be identified in the space provided. This section is a federally required provision. Note: Many third-party administrators (TPAs) will not consent to be formally designated as the "Administrator," but will act only as the Employer's agent. Check with your TPA before inserting its name here.

5. Filing Dental Claims

Insert title and location of department for claim submission. If you choose not to require employees to pay for covered dental expenses prior to reimbursement, replace the phrase "paid bill" with "unpaid bill."

6. Additional Information

Administration of Plan (SPD, page 4) — Fiscal records for the Plan, necessary for filing with the IRS, are maintained for fiscal years. These fiscal years may not necessarily coincide with your corporate fiscal period. They do, however, determine when federal filings are needed. The month to be inserted is usually the month prior to the month of the effective date of the Plan. For example, if your plan is effective May 1st, your plan Year would end on the last day of April annually. If you employ fewer than 100 employees and don't use a trust, consult your tax advisor, since you may not need to file annual reports.

Acceptance of Legal Notice — You should enter "the Employer." If a trust is involved, this section should also include the Trustee.

Plan Amendment or Termination — This section is required by federal law.

Appealing a Claim — This section is required by federal law.

7. Rights of Employees (ERISA)
This section is required by federal law.

8. Change in Plan Provisions
With experience, you may choose to revise your dental plan.

If you make any material changes to the plan, you must distribute a written summary of material modifications to all covered employees. You must completely update the plan document and distribute new copies to all employees every five years (or 10 years if there have been no material modifications).

Instructions for Completing Forms: Enrollment, Claim, and Explanation of Benefits
The administration of any benefits plan necessitates the use of specific forms. Due to the simplicity of the plan, Direct Reimbursement keeps the needed forms to a minimum. Sample forms are included in the pocket of this booklet.

1. Enrollment Form
The enrollment form is needed to maintain a record of eligible employees and dependents. You may wish to include the company name on the top of the form.

Status Change — This should be used in the event there is a change in coverage for the employee, due to a change in employment status, family situation or other circumstances affecting the eligibility or desire for coverage.

The remaining questions on the sample enrollment form are self-explanatory. Dates of birth are needed to determine coordination of benefits with spouse coverage and age of dependent children.

If your plan requires an employee contribution for employee and/or dependent coverage, this form could include a list of coverage options and their corresponding payroll deductions.

2. Claim Form
Also included in the pocket of this booklet are the following:

A.) The "Sample Claim Form" is the standard ADA claim form recognized and used by dentists around the country.

General rules are:
1. If the claim is for an employee, your Plan is primary and another plan's benefits are disregarded in calculating benefits.
2. If the claim is for your employee's spouse, the spouse's plan is primary. In this instance, you may wish to request information from the spouse's insurer so that duplicate coverage is not paid. Upon receipt of this coverage information, you can pay any dental expenses not paid by the spouse's insurance company but never more than you would have paid if the spouse did not have other coverage.
3. According to the National Association of Insurance Commissioner's model regulation, if the claim is for a dependent child, the plan of the parent whose birthday is earlier in the year is primary.
4. You should develop your own rules for situations where the parents are divorced or there are step-children or foster children.

Patient Signature — It is recommended that this be required for claim reimbursement.

Authorization of Payment to the Dentist — This is an optional signature box to authorize payment directly to the dentist. If your plan does not allow for payment directly to the dentist, the box should be omitted or ignored.

If the plan allows for payment directly to the dentist, and payments total an aggregate amount of $600 or more in a calendar year, there is an obligation to file a Form 1099 with the IRS on payments made.

Dentist's Signature — It is recommended that this be required for claim reimbursement.

B.) The "Simplified Sample Claim Form" requires payment prior to reimbursement. It can be adapted to a plan which does not have that requirement by deleting the statement on payment in full. You may also choose to design your own claim form; your benefits consultant or broker may design a form for you, as can your TPA, if a TPA will be administering the plan for you.

3. Receipt for Reimbursement and Dental Explanation of Benefits (EOB)
This form is completed by the designated individual responsible for paying claims. The employer should retain a copy and federal law requires that the employee receive a copy as well.

Employers should add the company name to the top of the form and use it as a receipt given to the employee with the reimbursement check. The language of the EOB should be kept simple so that information provided on the form is self-explanatory.

There are spaces on the EOB to indicate "previous payments" and "annual benefits paid." If your plan bases its annual maximum on a family total, substitute the word "family" for "patient" on these two lines.

It is recommended, but not required, that the EOB include a summary of the dental benefits plan design for clarification of the benefit calculation (see sample form). This information may be added to the bottom of the form in the space provided.

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