



Dental Insurance [DECODED]

“Are you being **Ripped Off** by your Traditional Dental Insurance?” **7 Insider Tips to Help you Save Time & Money**

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We get questions all the time about dental insurance and what I have discovered over the years I have been in practice, is that very few of our patients had any idea what their dental insurance covered or how to maximize their benefits. So, I decided to publish this report on what dental insurance is, how you can best use it to your advantage, and a little known and rarely discussed option that may be significantly better than traditional dental insurance. Also, in this report, I will expose some of the secrets that dental insurance companies don't want you to know.

I worked for a dental insurance company as a dentist for several years before going into private practice twenty-three years ago. While there, I saw things that most people would not want to believe. I was exposed to what happens “behind the curtain”, so to speak, in the dental insurance industry. Something you need to be clear on is this; The dental insurance company is not your friend. The dental insurance industry has been spoiled by corruption over time. It is big business and these companies do not care if you get good dentistry or not. They care about one thing...**THE ALMIGHTY DOLLAR!**

The way dental insurance companies make money (lots of it!) is to hold on to the funds that they get from you or your employer. They keep vast amounts of cash and holdings to earn interest. They lose money when they pay out your claim so you can imagine that reimbursing you for your dental treatment is not something they want to do.

Am I saying that dental insurance is bad? No. If you have dental insurance or what it should be called, a “dental benefits plan”, then that is not a terrible thing. People who own dental insurance tend to get more frequent care and thus keep their teeth longer. But you need to know how to use your dental insurance and make it work for you. I will show you how! The dental insurance story is one that might surprise you.



The **Dark & Dirty** Side Of Dental Insurance

Traditional dental “insurance” had its beginning in the 1960’s. It was created to provide people with more choices for dental care and the ability to afford regular dental visits to help maintain their teeth for a lifetime. At that time, benefits for a calendar year averaged about \$1000.00.

Right now, you are trying to think of what your yearly dental benefits are, aren’t you? Guess what? In over 50 years, the average benefit is almost **EXACTLY THE SAME!** However, the cost of dental insurance has risen exponentially. For anyone who chooses to purchase insurance without an employee benefit package, the cost can be massively prohibitive.

The word insurance is defined as “protection against a loss”. This term has been used in medicine because catastrophic loss can occur because of sickness or accident. The term “dental insurance” is a misnomer because people do own it to protect themselves against catastrophes. “Benefit” more aptly describes this allowance, which is often negotiated for an employee between their place of employment, and the “insurance” company.

Dental “insurance” companies have a table of benefit allowances that rarely exceed \$1500 per calendar year. In essence, the dental insurance companies are making you or your employer pay enormous amounts of money for the same dollar amount in benefits as they gave 50 years ago. If dental benefits were to have kept up with inflation such as they have with true insurance, they would amount to over \$10,000 per year!

Dental insurance companies often pull a little nasty trick on their subscribers called “denial of benefits”. They will say they cover something as a benefit, but then after dental work has been completed or is in the process of being approved, they decide to deny it. Their comeback almost always relates to something about protecting your interests from the “evil” dentist who just wants to do unnecessary procedures on you. This is surprisingly legal, but it is a **HUGE** lie, and a loophole designed to help them hold onto your money. The vast majority of providers would never do unnecessary dentistry on their patients. It is in direct conflict with our oath as healthcare providers and carries heavy penalties if discovered by dental boards and other regulatory agencies. The bottom line is this. The dentist and their team have been tasked with taking care of your dental health and wellness. This is a responsibility that we take very seriously. The dental insurance companies are responsible for being as profitable as possible to their shareholders. They **DO NOT** have **YOUR** best dental health interests in mind.

You Can Save **Thousands** of Dollars by Knowing What Questions To Ask About Your Dental Insurance Coverage!

The purpose of this report is not to go into exhaustive detail on how dental insurance works and the different types that are available. I will not try to explain the differences between HMO plans, PPO plans, Indemnity plans, etc. etc. Why waste time with that? All that information is available on the internet and through other resources. To be honest, it’s just not that important for you. What you **NEED** to know is how **YOU** can get the most out of your plan and **SAVE MONEY**.

***However, I will share with you the reason why some dentists, including myself, refuse to “shake hands” with dental insurance companies and become PREFERRED PROVIDERS. ***

Although our dental practice files all kinds of insurance, like many other dentists, we have chosen not to be assigned as providers for any insurance companies. This is because insurance carriers mandate that their “preferred providers” meet certain criteria. Like what, you may ask? Well, the criteria are never about a dentist’s credentials or the quality of care they perform. The only thing the insurance companies want is to come to an agreement on the fees being charged. The insurance companies bargain with the dentist to lower their usual and customary fees and in return, the insurance company will refer them patients by putting their name on a list of preferred providers.

That might sound like a good deal for you. Well, it’s not. You see, the dentist must make that money up somehow to cover their expenses. So, how will they do it? Maybe they will use a less expensive lab, work faster to see more patients, “sell” more dentistry, go with cheaper materials, or hire less qualified employees.

Don’t get me wrong, there are plenty of dentists who have good intentions that are also signed up with insurance companies as preferred providers. But all of them would “prefer” not to be (no pun intended). It is looked upon as a necessary evil to keep patients coming through the door. Many dentists feel that if the insurance company doesn’t refer them patients, they will have a difficult time finding patients to work on. These dentists essentially are held hostage by the insurance companies. The insurance companies abuse their preferred dentists and often take months to reimburse them for the work they have done. Feelings of discontent and resentment with the insurance companies are rampant. The danger that lies within is that if a dentist knows they must give you a significant discount, and often not receive payment for extended periods, will they treat you any differently than their patients who do not have insurance?

Our practice, along with some other offices, operate with the opposite perspective, aiming to offer the highest-quality treatment options and service to every patient, insurance or not.

Because we have never agreed to a contract with the insurance companies we can also act as a mediator for our patients in case the insurance company decides to conveniently deny benefits for whatever reason.

Preferred providers often must waive this right in their contracts and if you are denied benefits, you are on your own. Typically, an “out of network” dentist can still maximize your dental benefits and get you the reimbursement your insurance company has agreed to. The insurance companies don’t want you to know that though because they will have to pay out a higher amount of benefit than they would if you go to a “preferred” provider. That essentially means less profit for the insurance company. They also must pay the claim faster which prevents them from making more interest from the bank. Thankfully, there have been state laws passed that prevent the insurance companies from holding onto your benefits longer than 30 days (at least in North Carolina) if the assignment of benefits goes directly to the policy owner.

The most predictable way for you to get quality dental care, and for your dentist to provide you with this care while still using dental insurance, is to have your benefits assigned to you. In our office, we help maximize our patient’s insurance benefits by completing their claim forms, which are transmitted electronically by the end of the treatment day, if your carrier is up to date. This is all done through the internet on the most advanced digital filing system available. Then your insurance provider sends your reimbursement check directly to you. This process, called “direct assignment of benefits”, significantly reduces the likelihood of benefits being denied, and it allows claims to be processed much faster. Most patients receive their reimbursement checks within two weeks of their dental visit.

In more recent years we had an abundance of patients come to our practice who were desperately seeking more advanced care. Many of these individuals have needs that cannot be met by most general or family dentists. To try to be as accommodating as we can, we do make exceptions for patients who would prefer that benefits are assigned to us. That being said, it is not the most favorable way to take advantage of the benefits you may have. However, if a patient chooses to sacrifice maximizing their benefits over convenience, we can still help.

So, does this mean that you should always seek an out-of-network dentist? No. And I would never suggest that out-of-network dentists are better or more caring than a dentist who is considered “in-network”. But make sure you choose your dentist using criteria other than how they file your insurance. My late partner and I wrote an entire book about how to choose the best dentist for you and what conversations to have that would ensure you get the best care. This book, “Open Your Mouth! How the Right Conversation with Your Dentist Can Change Your Life.”, is available for free on our websites and if you prefer a hard copy, we are always happy to give you one when you visit our practice.

7 Questions Your Dental Insurance Carrier Is **Afraid** You Will Ask.

So, let’s get down to it. The essential questions you must ask to get the most from your dental benefits plan:

If you want to get the most out of your dental benefits plan, it is going to take a little work, but don’t worry, it’s not hard to do. Set aside a few minutes, dial the number on your insurance carrier card, and get ready for a quick conversation with a representative. You’ll need to have these questions handy and a pen or pencil and paper to take a few notes. Once you get a representative on the phone,

Here is your script:

“Good day! I would like to ask you a few questions about the coverage in the dental benefits policy I own.” Now, ask the following questions:

1 “What is the maximum annual plan benefit per covered person in your family? ”

In most cases, the annual benefit per year is \$1000 – \$2000 per family member. Most dental benefit plans have not changed in the last 15 years as mentioned earlier, so your actual benefit has lost value (a fact that dental insurance companies try to hide). However, a dollar is a dollar, and some benefit is better than no benefit.

2 What is the annual deductible of the plan? When and how is the annual deductible applied? Is it applied per covered person in the family or is it a combined deductible? Is the annual deductible waived for certain dental procedures, and if so which ones? (Ask for CDT codes)

The deductible is the amount you must pay before the plan benefits will pay out for procedures. An individual deductible must be met by each person on the benefit plan in some cases. A family deductible allows you to combine the deductible of all family members. Sometimes the insurance policy will waive the deductible for preventative procedures.

3 Does the plan require a waiting period before coverage goes into effect for certain dental services? Which services require a waiting period? How long is the waiting period? (You need to be specific when talking to your insurance carrier)

Most typically, there is a waiting period for dental implants, crowns, bridges, dentures, and other more complex procedures. This means once you are on the plan you will have to wait to have many dental procedures done or risk not getting reimbursed. On average the waiting period is one year before you will be eligible for certain dental procedures.

4 What, if any dental treatments are excluded from your dental plan? Ask the insurance carrier to give specific CDT codes.

Many times, insurance companies will only pay for an amalgam (silver filling) on the back tooth instead of a composite (tooth-colored filling). Even though most states strongly encourage dentists NOT to use amalgam. Why do they do this? Because they can, and they can keep more of your benefit dollars if they do. They will often use the term “alternative benefit” and pay out the amount that they would for a metal filling if you decide you want to have a tooth-colored one.

5 Who do I contact for information about further specifics of my plan, its coverage, or any other questions pertaining to the plan?

This information can usually be found on the back of your dental insurance card or the website.

6 How are claims for payment on dental services processed? How long does it take to process claims?

At our office and many others, all claims are filed electronically. Electronic filing helps to speed up the claims process. Most of the time you can expect a check from your insurance company within 30 days from the date of your service. In North Carolina, the law mandates that insurance companies pay subscribers within 30 days. If they don't, you have the right to pursue litigation against them.

7 What percentage of coverage does your plan allow for different types of procedures? Most commonly they are subdivided into preventative, major, and minor procedures.

This is again a question that the insurance company may need a specific CDT code. But for the most part, they should be able to give you a pretty good idea of what your reimbursement will be. The more specific you are the better chance of getting an accurate quote. Always ask the insurance representative what their maximum reimbursement is for the procedure or service in question. Do not tell them what your dentist's fee is. If you are going to an out-of-network provider, the insurance companies generally must reimburse you up to the maximum amount your plan allows. You will more than likely already have the fee from your dentist and can then determine what your coverage will be. Most of the time dentists are well within this range, even though the insurance companies will argue they are not.

So, there you have it.

The information you need to make dealing with your dental insurance carrier easier, and hopefully more beneficial to your wallet or purse. If you need more help or clarification on anything in this report, we at Ballantyne Dentistry are always happy to help.

If you are already a patient of ours then you know we will do our best to assist you in getting the maximum benefit from your dental insurance provider. If you are not a patient of ours, and you have concerns about the appearance of your teeth, can't eat the foods you love comfortably, are terrified of the dentist, or just have concerns about your overall or dental health, **PLEASE** call or email us. We want to help, and because we want to help, we think we can do things a little better than the insurance companies. So, take a look at this...

What if you **don't** have dental insurance but, are interested in having a **dental benefits package**?

A little known, and rarely discussed option.

Good News! Even though we help people with and without dental insurance benefits, we want to do more. At Ballantyne Dentistry we offer an alternative to dental insurance that is available to all our patients regardless of whether you have traditional dental insurance or not.



Ballantyne Dentistry **Dental Membership Plan**

To keep things simple, our plan is **less expensive**, provides **unlimited benefits**, and has **no waiting periods** or other tricks built into it. For over 12 years these types of dental membership plans have been used to create more access to dental care for more patients. To find out more just ask us. We often include this information in our new patient packets and have it available on our websites and throughout the office.

Our team is always happy to share more details with you. I hope this information was helpful and gave you a better idea of how to work with and around your dental insurance benefits if you have them. And, if you don't, now you have an alternative. Call or email us for more information about our practice and how we can help restore your confidence beyond your smile!



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