Myths About Dental Insurance

1. My insurance should pay for all my care

TRUTH: Insurance is meant to help fray the costs of dental care. No insurance pays 100% for all procedures and there can be large discrepancies in the benefits provided based on the contract the employer has selected with the insurance company.

In the 1960's yearly insurance maximums were $1,000-1,500. Today many plans still have these same maximums. Adjusted for inflation these maximums should be around $6,000 in today's dollars.

2. If I have two insurances, I should not have any remaining balance for treatment

TRUTH: Most of the time you will still have a balance for treatment. Some treatments may not be covered by either insurance company. Additionally the secondary insurance may not make any additional payment if the primary insurance has paid more than the secondary insurance's "usual and customary fees."

3. Insurance company benefits and limitations are in place to help guide me to what procedures are necessary and which are not.

TRUTH: Benefits and limitations are set by each insurance company and may have no relationship to what is necessary and what is not. For example, many insurance companies have age restrictions for sealants, frequency limitations for radiographs (x-rays) and fluoride, and many do not cover nitrous oxide (laughing gas). Science and clinical experience have proven these treatments to be beneficial and necessary.

4. Insurance companies' usual and customary fees are an accurate representation of what dentists should be charging.

TRUTH: "Usual and customary" is a term coined by insurance companies and has no relationship whatsoever to what is truly usual and customary. It is a misleading term that has resulted in customers feeling they are being overcharged when in fact the dental insurance company is underpaying or provides poor benefits. "Usual and customary" fees can vary greatly with different insurance companies. If the fees were actually usual and customary, shouldn't they be similar between the different companies and plans? Generally speaking, a plan that is less costly to the employer will usually have a lower usual and customary fee schedule.

5. The dental office has to work with me to get better benefits

TRUTH: Although many offices will file your insurance as a courtesy, none are under any obligation to do so. Insurance companies are under no obligation to take our phone calls, provide correct information, and are increasingly difficult to get in touch with. Additionally, insurance companies will only pay what they are going to pay based on the

plan's benefits and limitations. If you feel your benefits are deficient, we advise you to talk to your employer or HR to inquire about contracting with a better plan.

6. A dentist who is a "preferred provider" has been vetted by the insurance company to be a better dentist, clinically and ethically

TRUTH: "Preferred provider" is a misleading term created by insurance companies. It does not mean the dentist is in any way better than a non-preferred provider. It only means that the provider has chosen to join the insurance company's network.

Finally and most importantly:

7. The insurance company cares about my health

TRUTH: Insurance companies are in business to make a profit. They are not in the healthcare business. They care no more about your health than your auto insurance cares about the health of your car.