

DENTAL EXPLANATION OF BENEFITS



Use the alphabetical glossary of terms below to help you navigate your explanation of benefits (EOB)

EXPLANATION OF BENEFITS													
INSURED: Jane A Doe			GROUP: Main Street Café, LLC				GROUP ID: 12345678		DATE: 1/15/2009				
FOR SERVICES FROM	TO	TYPE OF SERVICE	PROC CODE	TOTAL CHARGES	NON-COVERED CHARGES	DEDUCTIBLE	PROVIDER DISCOUNT/DISALLOW	REMAINING COVERED CHARGES	CO-PAY	PATIENT RESPONSIBILITY	TOTAL BENEFIT	BENEFIT PAID TO PROVIDER	COMMENTS
PATIENT: Jane A Doe						CLAIM: 091234567900							
PROVIDER: Jessica Jones DDS						PAYEE: Jessica Jones DDS							
0106	010609	Prophy:Adult	D1110	100.00	0.00	0.00	0.00	100.00	0.00	0.00	100.00	100.00	
0106	010609	Amal: 3 Surfaces	D2160	157.00	0.00	50.00	0.00	107.00	21.40	71.40	85.60	85.60	
0106	010609	Xray:2 Bitewings	D0272	50.00	0.00	0.00	10.00	40.00	0.00	0.00	40.00	40.00	9A8
TOTALS				307.00	0.00	50.00	10.00	247.00	21.40	71.40	225.60	225.60	
COMMENTS: 2													
<ul style="list-style-type: none"> Payment for these services is determined based on the specific terms of your dental plan or Delta's agreements with Delta Network Dentists. If you are covered by more than one health plan benefit, you or your provider should file all your claims with each plan. 													
9A8 The charge exceeds the amount allowed.													
Jane A Doe				has met \$		50.00 of the \$		50.00 patient deductible		for the 2009 benefit year.			
				has met \$		225.60 of the \$		1000.00 patient maximum		for the 2009 benefit year.			

BENEFIT PAID TO PROVIDER: The total dollar amount paid to the provider for the services rendered.

CLAIM: The claim number generated by the ODS system.

COMMENTS¹: ODS internal use only; please refer to written comments at the bottom of page.

COMMENTS²: The explanation of listed codes and other information regarding your benefits.

COPAY: The amount you owe on the remaining covered charges after your plan's benefits have been applied.

DEDUCTIBLE: Charges which have been applied to your plan's deductible. Any amounts listed in this column are your responsibility and subtracted from the remaining covered charges before any benefits are applied.

FOR SERVICES FROM TO: The date the service was provided.

NON-COVERED CHARGES: Amount (if any) that is a non-covered charge, and being denied.

PATIENT: The name of the patient.

PATIENT RESPONSIBILITY: Amount you are responsible for paying your provider, which is the

total of disallowed charges (charges not covered by ODS), charges applied to your deductible and copayments.

PAYEE: The provider, subscriber or healthcare location receiving payment.

PROC CODE: The procedure code number. This is not required and may not appear.

PROVIDER: The name of provider (dentist) seen by the patient.

PROVIDER DISCOUNT/DISALLOW: Amount you saved by using an in-network provider. Using an in-network provider helps reduce your out-of-pocket expenses.

REMAINING COVERED CHARGES: Amount less any disallowed charges and charges which were applied to your deductible and provider discount. Your plan's benefits are applied towards the amount listed in this column.

TOTAL BENEFIT: The total amount ODS will pay for services.

TOTAL CHARGES: The amount charged for services.

TYPE OF SERVICE: A description of the service performed.