DELTA DENTAL®

Understanding Your Explanation of Benefits (EOB)

After a trip to the dentist's office, you'll likely receive an EOB from your dental benefits carrier explaining the procedures performed and what is covered by your dental plan.

A

This section contains subscriber and patient identification information, dentist name and the claim number, which you'll need to check on a claims status or dispute a claim.

B

The **Procedure Code** and **Procedure Description** explain the services received at the dentist's office.

C

Submit Amount is the amount the dentist charged for the services.

D

The **Approved Amount** shows Delta Dental's contracted fees for each procedure. **Allowed Amount** is the amount determined by the dental benefit plan. These amounts are often the same. If they differ, it's because of provisions in the contract your employer purchased.

E

If you have a procedure that is not completely covered by Delta Dental, the **Deductible Applied** is the amount applied to the service. You must pay the deductible before Delta Dental picks up its share of the tab (coinsurance).

F

Delta Dental Co-Pay identifies the percent the plan will cover per procedure.

G

Patient Payment is the amount the patient owes the dentist. Your dentist should not bill you more than this amount. **Delta Dental Payment** is the amount Delta Dental paid your dentist for services rendered.

H

This section includes detail about Delta Dental's payment to your dentist.

DELTA DENTAL

Delta Dental
123 Smile Street
Chicago, IL 12345

John Doe
456 Any Street
Chicago, IL 12345

A

Claim Number:	1-2222-333-44
Group Name:	DELTA DENTAL PLANS ASSOC
Subscriber:	JOHN DOE
Subscriber ID#:	XXXXX5555
Patient:	JANE DOE
Patient DOB:	01/31/1970
Dentist:	IRA M. DENTIST

Other Carrier Paid: 0.00

EXPLANATION OF BENEFITS **THIS IS NOT A BILL**

B C D E F G

Service Date	Proc. Code	Procedure Description	Submit Amt	Fee Adjust	Approved Amt	Allowed Amt	Deductible Applied	Delta Dental Co-Pay	Patient Payment	Delta Dental Payment
12/30/2014	120	EXAM	49.00	8.00	41.00	41.00	0.00	100	0.00	41.00
12/30/2014	274	BITEWINGS-4	62.00	6.00	56.00	56.00	0.00	100	0.00	56.00
12/30/2014	1110	CLEANING	94.00	16.00	78.00	78.00	0.00	100	0.00	78.00
		TOTALS	205.00	30.00	175.00	175.00	0.00		0.00	175.00

Payment To	Date	Check Number	CheckAmount
SMILE DENTAL CARE	20150115	4664249	175.00

H

For Benefit Year: 01/01/2014 – 12/31/2014

The amount applied to this individual's benefit year deductible is: $0.00
The amount applied to this individual's annual benefit year maximum is: $647.70
The amount applied to this individual's orthodontic maximum benefit is: $0.00
The amount applied to this individual's out-of-pocket limit is: $0.00

* Some EOBs will have additional messages to help patients understand why a procedure wasn't paid.

Delta Dental of Arizona
DeltaDentalAZ.com