# A Guide to your Explanation of Benefits

**For more information, contact Benefit Services at 800.237.6060.**

Ⓐ **Payment date** — the date the claim was paid.

Ⓑ **Dentist/facility** — the patient's dentist or dentist's office.

Ⓒ **Dentist ID number** — the dentist's ID.

Ⓓ **Network status** — the participating status of the dentist under the patient's plan.

Ⓔ **Subscriber name** — the name of the subscriber.

Ⓕ **Patient name** — the patient's information.

Ⓖ **Account** — the group number under the plan.

Ⓗ **Claim number** — the claim number.

Ⓘ **Tooth or cavity** — the tooth that was serviced, if applicable.

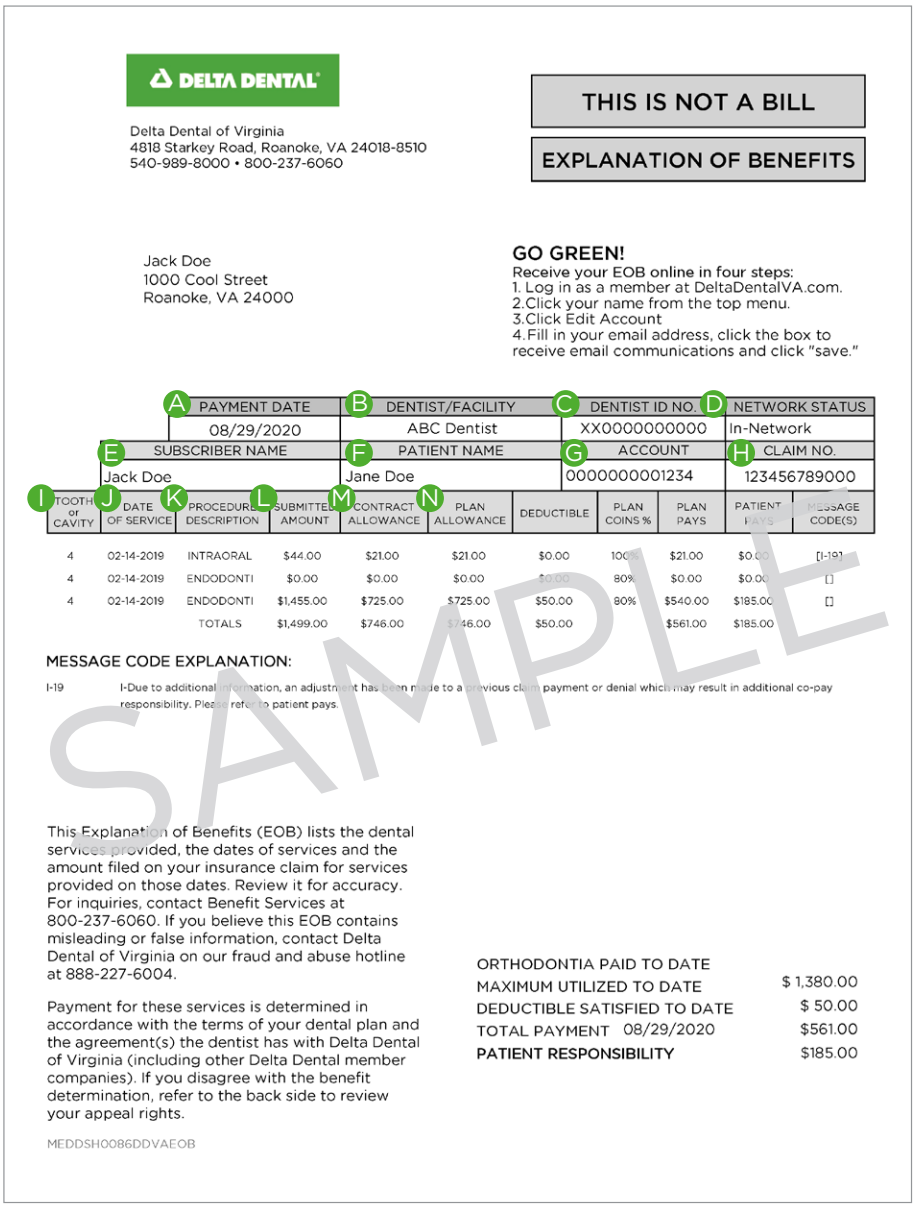
Ⓙ **Date of service** — the date service was provided to the patient.

Ⓚ **Procedure description** — a a brief description of the service.

Ⓛ **Submitted amount** — the amount submitted to Delta Dental by the dentist.

Ⓜ **Contract allowance** — the amount the participating dentist agrees to accept based on their participating agreement. If the dentist is out-of-network, this amount is the same as the Submitted Amount.

Ⓝ **Plan allowance** — the amount set by Delta Dental that a participating dentist has agreed to charge for a service.



DELTA DENTAL

Delta Dental of Virginia
4818 Starkey Road, Roanoke, VA 24018-8510
540-989-8000 • 800-237-6060

THIS IS NOT A BILL

EXPLANATION OF BENEFITS

Jack Doe
1000 Cool Street
Roanoke, VA 24000

**GO GREEN!**
Receive your EOB online in four steps:
1. Log in as a member at DeltaDentalVA.com.
2.Click your name from the top menu.
3.Click Edit Account
4.Fill in your email address, click the box to receive email communications and click "save."

| Ⓐ PAYMENT DATE | Ⓑ DENTIST/FACILITY | Ⓒ DENTIST ID NO. | Ⓓ NETWORK STATUS |
|---|---|---|---|
| 08/29/2020 | ABC Dentist | XX0000000000 | In-Network |
| **Ⓔ SUBSCRIBER NAME** | **Ⓕ PATIENT NAME** | **Ⓖ ACCOUNT** | **Ⓗ CLAIM NO.** |
| Jack Doe | Jane Doe | 0000000001234 | 123456789000 |

| Ⓘ TOOTH or CAVITY | Ⓙ DATE OF SERVICE | Ⓚ PROCEDURE DESCRIPTION | Ⓛ SUBMITTED AMOUNT | Ⓜ CONTRACT ALLOWANCE | Ⓝ PLAN ALLOWANCE | DEDUCTIBLE | PLAN COINS % | PLAN PAYS | PATIENT PAYS | MESSAGE CODE(S) |
|---|---|---|---|---|---|---|---|---|---|---|
| 4 | 02-14-2019 | INTRAORAL | $44.00 | $21.00 | $21.00 | $0.00 | 100% | $21.00 | $0.00 | [I-19] |
| 4 | 02-14-2019 | ENDODONTI | $0.00 | $0.00 | $0.00 | $0.00 | 80% | $0.00 | $0.00 | [] |
| 4 | 02-14-2019 | ENDODONTI | $1,455.00 | $725.00 | $725.00 | $50.00 | 80% | $540.00 | $185.00 | [] |
| | | TOTALS | $1,499.00 | $746.00 | $746.00 | $50.00 | | $561.00 | $185.00 | |

MESSAGE CODE EXPLANATION:

I-19 I-Due to additional information, an adjustment has been made to a previous claim payment or denial which may result in additional co-pay responsibility. Please refer to patient pays.

SAMPLE

This Explanation of Benefits (EOB) lists the dental services provided, the dates of services and the amount filed on your insurance claim for services provided on those dates. Review it for accuracy. For inquiries, contact Benefit Services at 800-237-6060. If you believe this EOB contains misleading or false information, contact Delta Dental of Virginia on our fraud and abuse hotline at 888-227-6004.

Payment for these services is determined in accordance with the terms of your dental plan and the agreement(s) the dentist has with Delta Dental of Virginia (including other Delta Dental member companies). If you disagree with the benefit determination, refer to the back side to review your appeal rights.

MEDDSH0086DDVAEOB

| | |
|---|---|
| ORTHODONTIA PAID TO DATE | |
| MAXIMUM UTILIZED TO DATE | $ 1,380.00 |
| DEDUCTIBLE SATISFIED TO DATE | $ 50.00 |
| TOTAL PAYMENT 08/29/2020 | $561.00 |
| **PATIENT RESPONSIBILITY** | $185.00 |

*Continued on next page*

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# A Guide to your Explanation of Benefits (*continued*)

**O Deductible** — the amount of covered services the patient must pay before Delta Dental pays.

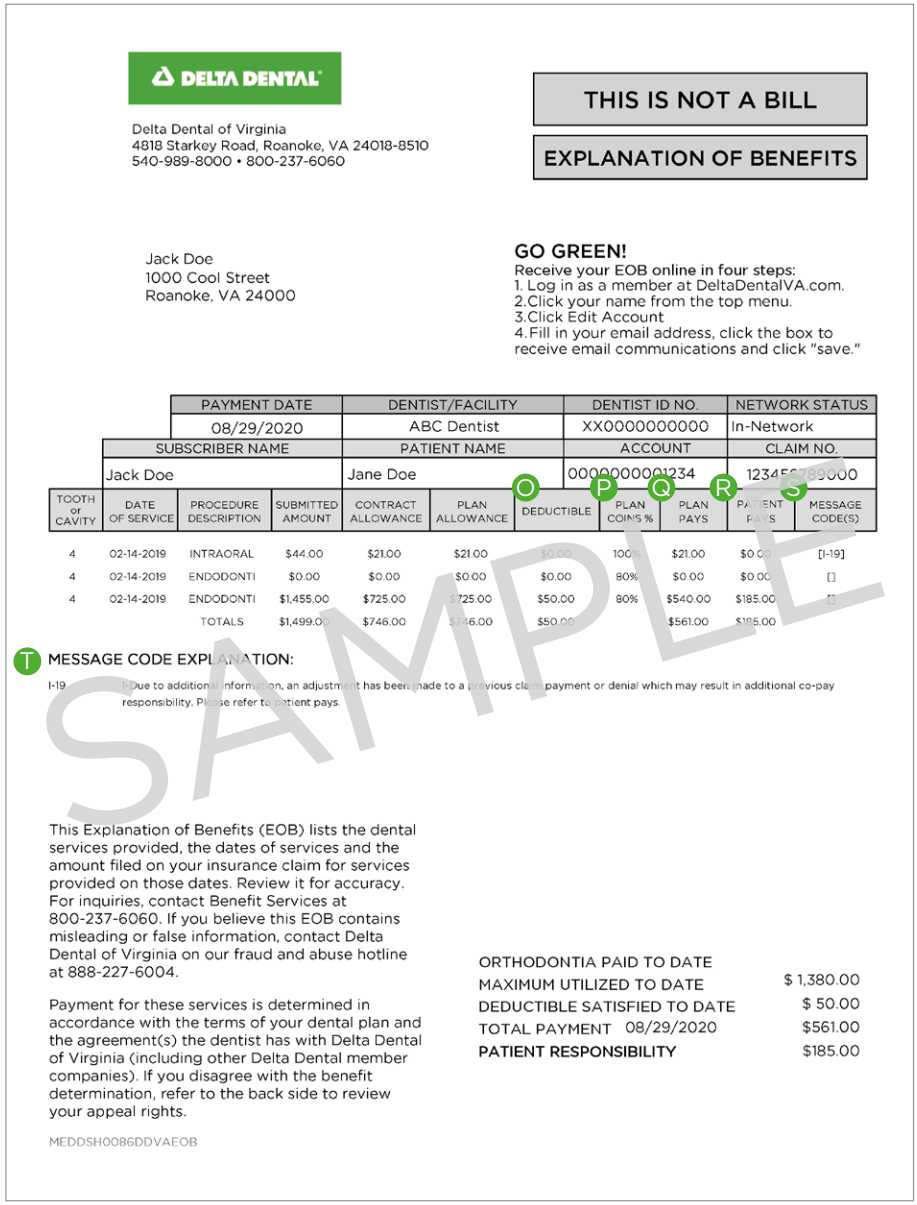
**P Delta Dental of Virginia plan co-insurance percentage** — the percentage of the Plan Allowance that Delta Dental pays.

**Q Delta Dental of Virginia plan pays** — the amount paid to the dentist or to you. Payment is made to you only when you visit an out-of-network dentist.

**R Patient pays** — the amount the patient owes to the dentist, which includes any deductible, co-insurance, and the difference in the Approved Amount and the Contract Allowance.

**S Message code** — the code that was used in processing the service.

**T Message code explanation** — an explanation of the processing policy codes.



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