

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.



DELTA DENTAL

Delta Dental
123 Smile Street
Chicago, IL 12345

John Doe
456 Any Street
Chicago, IL 12345

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**

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

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

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.



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).

H

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

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

Cómo comprender LA EXPLICACIÓN DE BENEFICIOS (EOB por sus siglas en inglés)

Después de una visita al dentista, Ud. probablemente recibirá una EOB de la compañía de seguro dental que indica los procedimientos que se hicieron y los servicios cubiertos por su plan dental en particular.

A

Esta sección contiene la información identificable del abonado o del paciente, el nombre del dentista y el número de la reclamación, lo cual Ud. necesita para revisar el estatus o para disputar alguna reclamación.

B

El código de procedimiento (**Procedure Code**) y la descripción del procedimiento (**Procedure Description**) explican los servicios recibidos en la oficina del dentista.



C

El monto presentado (**Submit Amount**) es la cantidad por pagar que cobró el dentista para los servicios.



D

El monto aprobado (**Approved Amount**) indica las cuotas contratadas con Delta Dental para cada procedimiento. El monto permitido (**Allowed Amount**) es el costo determinado por el plan de beneficios dentales. Muchas veces estas cantidades son equivalentes. Si son diferentes, es debido a las provisiones en el contrato que compró su empleador.



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**

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

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

F

El co-pago de Delta Dental (**Delta Dental Co-Pay**) identifica el porcentaje que cubre el plan por cada procedimiento. %

G

El pago del paciente (**Patient Payment**) es la cantidad por pagar que debe el paciente al dentista. Su dentista no debe facturarle más de esta cantidad. El pago de Delta Dental (**Delta Dental Payment**) es el monto que pagó Delta Dental a su dentista por los servicios prestados.



E

Si Ud. tiene un procedimiento que no está completamente cubierto por Delta Dental, el deducible aplicado (**Deductible Applied**) es el monto aplicado al servicio. Ud. tiene que pagar el deducible antes de que Delta Dental pague su porción de la cuenta (coaseguro).

H

H

Esta sección incluye detalles sobre el pago por Delta Dental a su dentista.

* Algunas de las EOB tienen mensajes adicionales para ayudar al paciente a entender por qué no se ha pagado algún procedimiento.