DELTA DENTAL®

PARTNERS FOR HEALTH

Understanding Your Explanation of Benefits

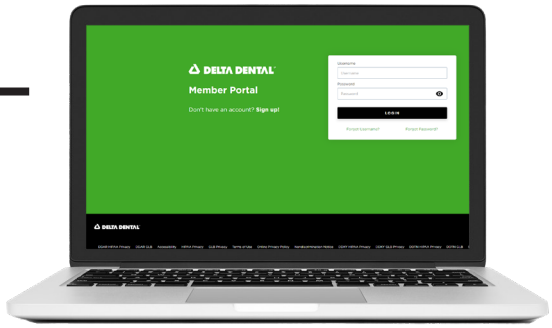
The Explanation of Benefits form is your key to understanding dental claim payments. We produce this form when your claims are processed to give you a record of how your dental benefits were used. We send the EOB directly to you, and it provides you with the information you need, including:

- **Dental services performed (procedure description)**
- **Dentist fees**
- **Delta Dental's payment**
- **Your payment**
- **Coordination of benefits information, if applicable**
- **Annual maximums used in the current benefit year**

We have included two samples in this brochure to help you understand your EOB:

- **Example A shows a complete and fairly simple claim payment.**
- **Example B shows areas of the EOB that would apply to a coordination of benefits.**

Member Portal



To access any information you may need about your dental coverage, visit the Member Portal at www.MemberPortal.com. The Member Portal provides enrollees and their dependents all the information they need to learn about their plan, review claims and claim payments, access a searchable dentist directory and more.

If you have any questions, please contact Customer Service at (800) 552-2498. Representatives are available Monday - Friday from 7 a.m. to 5 p.m. CT.

Example A—EOB (Simple Claim)

DELTA DENTAL

Explanation of Benefits

(THIS IS NOT A BILL)

1 Patient Name: JANE DOE

Date of Birth: 01/23/1945

2 Relationship: SPOUSE

3 Subscriber: JEFF DOE

Patient Acct: 123456789

4 Business/Dentist: FRIZ FLOSSMOOR, D.D.S.

License No.: 1234 / TN (NPI: 1234567890)

5 Check No.: 1234567890

6 Issue Date: 02/28/2024

7 Receipt Date: 02/28/2024

8 Claim No.: 1234567890123

Want to eliminate paper mailings and get instant access to your claims information? Our Member Portal allows you to view and print Explanation of Benefits (EOB) statements online. Enroll today and emails will be sent to you when new EOBs are available for viewing in Member Portal. **Go to www.DeltaDentalTN.com/members and sign up today!

9 Pay To: C=Custodial Parent
S=Subscriber
P=Provider
A=Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Contract Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL OF TENNESSEE 10							PRODUCT: 13				
CLIENT/ID: 11											
SUBCLIENT: 12											
NETWORK:	PREMIER DENTIST										
14	15	16	17	18	19	20	21	22	23	24	25
03	02/28/24	ORAL EXAM	90.00	41.00	49.00	41.00	.00	100%	41.00	0.00	P
21	02/28/24	XRAYS	80.00	51.00	29.00	51.00	.00	100%	51.00	0.00	P
30	02/28/24	CLEANING	110.00	66.00	44.00	66.00	.00	100%	66.00	0.00	P
		26 Total	280.00	158.00	122.00	158.00	0.00		158.00	0.00	

GENERAL MAXIMUM USED TO DATE: 158.00

DELTA DENTAL

DELTA DENTAL OF TENNESSEE
P.O. BOX 23470
NASHVILLE, TN 37202

Important Plan Information

www.DeltaDentalTN.com
FOR INQUIRIES: (800) 223-3104 (TTY users call 711)

27 Payment for these services is determined in accordance with the specific terms of your dental plan and/or Delta Dental's agreements with its contracting dentists. For inquiries regarding contracting dentists, please call the number listed above. Delta Dental's payment decisions do not qualify as dental or medical advice. You must make all decisions about the desirability or necessity of dental procedures and services with your dentist.

If your claim was denied in whole or in part so that you must pay some amount of the claim, upon a written request and free of charge, we will provide you with a copy of any internal rule, guideline or protocol or, if applicable, an explanation of the scientific or clinical judgment relied upon in deciding your claim. If you still believe your claim should have been paid in full, you may ask to have the claim reviewed. Your written request for a formal first level review must be sent within 180 days of your receipt of this EOB to the address listed. You may submit any additional materials you believe support your claim. A decision will be made no later than 30 days from the date we receive your request. If we again deny the claim, you may request a second level review. The manner in which to seek a second level review decision will be included with the letter informing you of our first level review decision. The second level review decision will be made no later than 30 days from the date we receive your request. If your claim is denied in whole or in part after both stages, you have the right to seek to have your claim paid by filing a civil action in court within one year from the final denial.

Your privacy is important to us. To access our HIPAA Notice of Privacy Practices, please visit our website.

ANTI-FRAUD TOLL FREE NUMBER: 888-281-9396 (option 5).
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help us lower these costs by contacting us at the number given above. You do not need to identify yourself.

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Example A—EOB (Simple Claim)

1. **Patient Name:** The first and last name of the person who received the dental treatment.
2. **Relationship:** Identifies the relationship of the patient to the subscriber.
3. **Subscriber:** The person who has obtained the health insurance. In the case of employer-sponsored health insurance, this is the employee.
4. **Business/Dentist:** The treating business or dentist name.
5. **Check No.:** The check number issued by Delta Dental.
6. **Issue Date:** The date the EOB was issued. This is also the date the claim was paid.
7. **Receipt Date:** The date the claim was received by Delta Dental.
8. **Claim No.:** The number assigned to the claim that corresponds to the EOB. This number and your subscriber ID number are needed to locate claims and should be used when making inquiries.
9. **Pay To:** This key is for the "Pay To" column in item #25. It lets you know where payment was sent.
10. **Plan:** The name of the plan under which you have dental coverage (e.g. Delta Dental of Tennessee).
11. **Client/ID:** The number assigned to the main group under which you have dental coverage. (This is usually your employer.)
12. **Subclient:** The number assigned to the particular category, branch or location under which you have dental coverage.
13. **Product:** The benefit plan selected by your group.
14. **Area/Tooth Code/Surface:** The number or letter of the tooth or area of the mouth that was treated. For area of the mouth, 01 = Upper Arch; 02 = Lower Arch; 10 = Upper right; 20 = Upper Left; 30 = Lower Left; 40 = Lower Right. (For orthodontic EOBs, see information on following page.)
15. **Date of Service:** The date treatment was rendered.
16. **Procedure Description:** A brief description of the procedure.
17. **Submitted Amount:** Amount submitted by the dentist.
18. **Maximum Approved Fee:** The portion of the dentist's submitted fee approved by Delta Dental for the procedure performed. Your out-of-pocket expense is based on this figure.
19. **Contract Dentist Savings:** The difference between what the dentist submitted and what Delta Dental will allow. This is the benefit of seeing a network dentist.
20. **Allowed Amount:** The portion of the dentist's submitted fee allowed by Delta Dental for the procedure performed. Your copayment percentage is based on this figure.
21. **Deductible/Patient Co-Pay/Office Visits:** The dollar amount that was subtracted from the allowed amount before calculating your payment and Delta Dental's payment. Within the column itself a deductible amount will be preceded with a D, a patient copay with either a PC or a C, and an office visit with an O or OV.
22. **Co-Pay %:** The percentage, as stated in your group's contract, used to calculate Delta Dental's payment.
23. **Payment:** The amount paid by your dental plan.
24. **Patient Payment:** The amount you are responsible for paying.
25. **Pay To:** Identifies whether Delta Dental sent payment to a custodial parent (C), you (S), or your dentist (P). See item #9.
26. **Total:** These are the column totals.
27. **ERISA Statement:** Delta Dental's claims appeal procedures as required by the federal law known as the Employee Retirement Income Security Act of 1974.

Example B—EOB (Coordination of Benefits/Processing Policies)

Pay To: C=Custodial Parent
S=Subscriber
P=Provider
A=Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Description	Submitted Amount	Maximum Approved Fee	Contract Dentist Savings	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: DELTA DENTAL OF TENNESSEE CLIENT/ID: SUBCLIENT:							PRODUCT:				
NETWORK:											
OTHER CARRIER: 1 OTHER DENTAL PLAN 2 OTHER CARRIER PAYMENT AMOUNT:											
ORIGINALLY SUBMITTED: 3	01/25/24	CLEANING	50.00	.00		.00					
REPLACED BY: 4	01/25/24	CLEANING	50.00	50.00		50.00					
POLICY CODE: BB0010 5											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND PLAN DETERMINED BY THE DENTIST AND PATIENT. 6											
BB0010. THE PROCEDURE CODE WAS CHANGED BASED ON THE INFORMATION SUB											

1. **Other Carrier:** The name of the primary dental carrier. (That is, the carrier that will pay first when you have coverage under more than one dental plan.)
2. **Other Carrier Payment Amount:** The amount paid by the primary carrier for the services listed.
3. **Originally Submitted:** The procedure code the dentist originally submitted on the claim form.
4. **Replaced By:** The procedure code by which Delta Dental based its payment according to the group's benefit plan allowances.
5. **Policy Code:** This code number refers to a Delta Dental processing policy. The policy code applies to the services listed directly above it.
6. **Explanation of Policy Codes:** The explanation of each policy code used.

Please note: When an adjustment is necessary for a previous claim payment, the EOB will show the original line information as well as the adjusted line information. The policy code(s) relating to the adjustment will be explained on your EOB.

Orthodontic EOBs

15. **Area/Tooth Code/Surface:** For orthodontic EOBs, this column is used to identify the stage of orthodontic treatment:

T = Total; total fee for orthodontic treatment plan
I = Initital; initial fee for banding or placement of orthodontic appliances
Numeric Value(s) (01-99) = The month of the treatment plan processed (for example: "01" would be the first month of treatment after banding, "02" would be the second month of treatment after banding, etc.)
L = Last; completion or last payment by Delta Dental for the orthodontic treatment plan
O = Only; only or one-time payment for orthodontic treatment

Please note:

- On this EOB, Delta Dental's total liability and your total liability for orthodontic treatment are shown. (Please see the information on the line with "T" in the tooth column.) Because this is merely a statement of liability for as long as the patient remains eligible and in treatment, these figures are not included in the column totals.
- Delta Dental will automatically make the monthly payments specified on the original orthodontic claim. If treatment is discontinued for any reason, notify Delta Dental immediately.
- When an adjustment is necessary for a previous claim payment, the EOB will show the original line information as well as the adjusted line information. The policy code(s) relating to the adjustment will be explained on your EOB.