

A Guide to Understanding Your Explanation of Benefits (EOB)

- Dental insurance carrier
- The name of the person who is the policy holder
- The name of the person who received the services
- The name of the provider billing for the services (including provider number)
- United Concordia Dental's unique customer ID for the member
- The number that was assigned to the claim
- The member's email address
- The date that the EOB was printed
- Description of services performed along with their procedure codes
- The dates each service was performed
- The amount the provider billed for each service
- The amount recognized by the member's plan. Example: When a provider is participating (in network), the rate that has been negotiated for the service
- The amount paid by your United Concordia Dental plan
- Portion of the bill that is not covered by your plan (this can include coinsurance, deductible, copayment amounts or amounts not covered by your plan)

1 UNITED CONCORDIA®

DENTAL EXPLANATION OF BENEFITS

KEEP FOR YOUR TAX RECORDS

2 Subscriber: NAME **5** ID Number: Page: 1 of 2
3 Patient: NAME **6** Claim number: **8** Date: 05/28/2015
4 Provider: DENTIST NAME (000999999) **7** Email:

9	10	11	12	13	14	15
PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES) *TOOTH DESCRIPTION*	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
1 SURF RESIN POSTERIOR (001) D2391 *14/F*	4/09/15	85.00	74.00	44.40	29.60*	COINSURANCE Q1030
SCALING/PLANING 1-3 TEETH (001) D4341	4/09/15	60.00	.00	.00	60.00*	A8023
Totals		145.00	74.00	44.40	100.60	

Q1030 These services were performed by a Participating Provider. This Provider has agreed not to bill you for the difference between the PROVIDER'S CHARGE and the ALLOWANCE for this service.

A8023 No payment can be made. Previous payment was made for a related periodontal procedure in the same area of the mouth.

You can view or print a copy of our Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices by visiting our website at www.ucci.com and clicking on the HIPAA Privacy Notice button or calling 1-866-215-2352 (toll free) to request a copy.

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

UNITED CONCORDIA®
 PO Box 69407
 Harrisburg, PA 17106-9407

17 Name
 Street
 City, St ZIP

18 **HAVE A QUESTION?**
 PLEASE CALL 1-800-332-0366
 Business Hours: 8am-8pm E.T.
 Service for the Deaf via TDD Equipment
 is available at 1-800-345-3837.

THIS IS NOT A BILL

Current Dental Terminology © American Dental Association

- Indicates an additional message explaining billing (a footnoted explanation indicates the reason)
- Depending on your plan, you may be responsible to the provider for the amounts in the "amount not paid" column, marked with an *
- The policy holder's name and mailing address
- United Concordia Dental's toll-free customer service number

Note: Not all EOBs are the same. The format and content of your EOB depends on your benefit plan and the services provided. Deductibles and copayment amounts vary.

UNITED CONCORDIA® DENTAL
 Protecting More Than Just Your Smile®

19. A percentage of the allowance that is your responsibility. For example, if a filling is covered at 60% of the allowance, you are responsible for the other 40% of the allowance

20. A summary of the patient's benefit year/period, including what has been applied to the patient's maximum and/or deductible

Dental Terms to Know

Coinsurance

The percentage above the allowance that is your responsibility.

Allowance

The amount allowed by your coverage for each service. If you see a participating provider they accept this as payment in full. If you see a non-participating provider and their charge is higher, they may bill you the difference.

Deductible

The initial portion of payment applicable to certain service for which you are responsible. This amount must be met once during the benefit year/period before certain services will pay at the covered percentage of allowance. You may or may not have a deductible on your plan. You may have an individual deductible amount and a family deductible amount.

Maximum

The maximum that United Concordia will provide over a benefit period, calendar year, or lifetime. For example, you may have a \$1,500 maximum per benefit period. United Concordia will pay a total of \$1,500 towards your claims for that benefit period.

Participating Provider

A licensed in-network dentist who is contracted with some or all of our networks. This provider has agreed to accept our allowance as payment in full. This includes United Concordia's portion of the payment, your coinsurance, and deductible.

Non-Participating Provider

A licensed out-of-network dentist who is not contracted with some or all of our networks. If this dentist is not contracted in the network that your plan uses, the dentist is not required to accept our allowance as payment in full.

1 UNITED CONCORDIA®

DENTAL EXPLANATION OF BENEFITS KEEP FOR YOUR TAX RECORDS

2 Subscriber: NAME

5 ID Number:

Page: 2 of 2

3 Patient: NAME

6 Claim number:

8 Date: 05/28/2015

4 Provider: DENTIST NAME
(000999999)

7 Email:

16 * Depending on the terms of your coverage, you may be held responsible to the provider for the amounts in the AMOUNT NOT PAID column. These amounts are indicated with an (*) asterisk.

19 COINSURANCE – A specified percentage of the allowance which is your responsibility.

The Provider has been paid the amount shown in the AMOUNT PAID column.

20 PATIENT SUMMARY FOR:

Patient Name: NAME

Identification Number:

Benefit Period: 09/01/14 – 08/31/15

For this benefit period, \$163.40 has been applied to your \$1,500.00 individual program dollar maximum.

You or the provider acting on your behalf has the right to file a written or oral appeal of an adverse benefit determination within 180 days of receipt of this notice. Review of appeals will be completed within 60 days by a reviewer different from, and independent of, the initial reviewer. You will be provided with a notice of the appeal decision. All relevant records, explanations of scientific or clinical judgment and criteria associated with an adverse benefit determination are available free of charge upon request. You are entitled to bring civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974, following the plan's one level appeal process.

Manage your dental benefits online with My Dental Benefits

Current Dental Terminology © American Dental As

Looking for more information? You can log in to *My Dental Benefits* at UnitedConcordia.com/mdb

A *My Dental Benefits* account helps you:

- Check claims and payments
- Monitor deductibles and maximums
- Print ID cards
- Elect paperless EOBs
- Evaluate your oral health with My Dental Assessment



The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos de ayuda lingüística gratuita. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。

UNITED CONCORDIA® DENTAL

UnitedConcordia.com