

Understanding your Explanation of Benefits

All dental plan members receive an explanation of benefits (EOB) after each dentist visit. An EOB is not a bill — it lists the services provided and a breakdown of what's covered in your plan. Always review your EOB to make sure the services listed and the amount billed are correct.

Your EOB includes the following information:

- 1 The person or employee who originally enrolled in this dental plan
- 2 Your member ID number
- 3 The date we processed your claim
- 4 A quick view of how much we paid and what you may owe



YOU RECEIVED DENTAL CARE FROM WEST SHORE DENTAL GROUP

This is your Dental Explanation of Benefits. It shows what we paid and what the dentist charged for your dental care. **This is not a bill. Keep for your tax records.**

- 1 Subscriber:
- 2 Patient ID: **123456789001**
- 3 Process Date: **December 1, 2020**

You visited an **in-network** dentist. This means they agreed not to bill you for the difference between what they normally charge and what we allow.

4 Cost Summary	
Allowed Amount	\$112.04
Paid Amount	\$60.02
You may owe the dentist *	\$52.02
See Service and Cost Breakdown for details	

* The amount you may owe the dentist could include your coinsurance, copays, maximums, deductibles and rejected or denied services.

 **To learn more**
WWW.ARKANSASBLUECROSS.COM

 **Have a Question?**
PLEASE CALL 1-888-223-4999
Business Hours: 8am-8pm E.T.
Service for the Deaf via TTY Equipment is ava

 **DENTAL CUSTOMER SERVICE**
P.O. BOX 69437
HARRISBURG, PA 17106 -9437



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- 5 The full charge for these services
- 6 The discounted amount in-network dentists accept as payment
- 7 The difference between the full charge and the discounted amount
- 8 How much another insurance plan paid, if you have one
- 9 The amount you owe toward your annual deductible
- 10 A set amount you pay each time you get a covered service
- 11 A percentage of the allowed amount that you pay
- 12 The amount not covered by your dental plan
- 13 How much your dental plan paid
- 14 The amount you may owe the dentist, which could include your coinsurance, copayments or deductibles



Service and Cost Breakdown

Patient: 5 6 7 8 9 10 11 12 13 14 Patient ID: 123456789001 Claim Number: 12345678900

Service	Charges	Allowed Amount	Amount Over Allowed	Other Insurance Paid	Deductible	Copay	Co-insurance	Not Covered	Paid Amount	Amount You Owe	Notes
RECEMENT CROWN 11/24/2020	\$125.00	\$60.11	\$64.89 Q1030	\$0.00	\$50.00	\$0.00	\$2.02	\$0.00	\$8.09	\$52.02	
LIMITED ORAL EVALUATION 11/24/2020	\$102.00	\$51.93	\$50.07 Q1030	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$51.93	\$0.00	
Total	\$227.00	\$112.04	\$114.96	\$0.00	\$50.00	\$0.00	\$2.02	\$0.00	\$60.02	\$52.02	

Notes / Not covered

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

DEDUCTIBLE - The initial portion of payment applicable to certain services for which you are responsible.

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

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.

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- 15** The amount you must pay each year before your dental plan begins to share in the cost of services — you may have a deductible for the family, and each person covered by the plan may also have a deductible
- 16** The amount you've already paid toward your yearly deductible
- 17** How much of the deductible is left to pay
- 18** Your total deductible amount for the year
- 19** The most your plan will pay toward dental care in a year
- 20** The amount your plan has already paid toward dental care
- 21** How much your plan will continue to pay
- 22** The total amount your plan will pay in a year

				
Plan Features this Year				
15	Deductible	16 Applied	17 Remaining	18 Total
	Individual Deductible FULL NAME	\$50.00	\$0.00	\$50.00
	Deductible FAMILY	\$50.00	\$100.00	\$150.00
19	Maximum	20 Applied	21 Remaining	22 Total
	Individual Program Dollar Maximum FULL NAME	\$60.02	\$1,439.98	\$1,500.00
Plan period: 01/01/2020 - 12/31/2020 Group Number 123456 Deductible and Maximum amounts applied year-to-date. Deductibles may not apply for certain services.				



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