Delta Dental Offers Enhanced Explanation of Benefits Statements

Delta Dental's **Explanation of Benefits** statement is presented in a readable, user-friendly format. Developed in consultation with dentists and members, the form is formatted for ease of reading.

What Delta Dental's Explanation of Benefits Statement Offers

1. **CONTACT INFORMATION**, including a special Customer Service toll-free phone number.
2. **A PAYMENT SUMMARY BOX**, providing at a glance details about charges, payments, deductibles, patient obligations, and Dentist Amount Non Billable (which shows the amount the patient is not billed for).
3. **PATIENT INFORMATION**, including patient's name, relationship to subscriber, benefit period, group ID and name, and plan type.
4. **CLAIM NUMBER** includes 15 digits.

continued on other side

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Explanation of Benefits – Dentist Copy

*See Reverse side if this is not your patient.

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DELTA DENTAL®

Delta Dental of New Jersey, Inc.
P.O. Box 222
Parsippany, NJ 07054

Claim Inquiries: 800-452-9310 **Visit us on the Internet: www.deltadentalnj.com**

PAYMENT SUMMARY

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Total Approved Charges	$000.00
Delta Dental's Total Payment	$000.00
Your Other Insurance Paid	$000.00
Applied to Deductible	$000.00
Dentist Amount Non Billable	$000.00
Patient Out of Pocket Payment Obligation	$000.00

DO NOT SEND PAYMENT TO DELTA DENTAL

JOHN SMITH DMD
1234 ANY STREET
SAMPLETOWN, NJ 00000-0000

3

MEMBER:	ROBERT JONES
PATIENT:	ROBERT JONES
RELATIONSHIP:	SUBSCRIBER
GROUP ID:	0000-0000
GROUP NAME:	ABC CORPORATION
PLAN TYPE:	PREMIER

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CLAIM NUMBER:	000000000000000
DATE OF ISSUE:	00/00/00
CHECK NUMBER:	0000000000
DENTIST ID NUMBER:	12345NJ
DENTIST NAME:	DR. JOHN SMITH
PAR STATUS:	PREMIER
BENEFIT PERIOD:	00/00/0000 – 00/00/0000

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6 Annual **PLAN MAXIMUM:** $0000.00 Individual **Used to Date:** $000.00

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TOOTH NO. OR LETTER	SURFACE	DATE OF SERVICE	SUBMITTED PROCEDURE NO.*	PAID PROCEDURE NO. *	SUBMITTED AMOUNT	APPROVED AMOUNT	AMT USED FOR BENEFIT CALC	DED	% COPAY	DELTA DENTAL PAYMENT	PROCESSING POLICIES
XX	XXXXX	00/00/0000	2391	2140	$000.00	$000.00	$000.00	$00.00	000	$000.00	000, 000, 000

***PROCEDURE NO. / DESCRIPTION**

2391 Resin based composite – one surface, posterior
2140 Amalgam – one surface, posterior

NOTICES
Payment was mailed to the subscriber.

PLEASE SEE REVERSE SIDE OF THIS FORM FOR INFORMATION RELATED TO OUR NOTICE OF PRIVACY PRACTICES, DEFINITIONS, AND OTHER IMPORTANT INFORMATION.

IMPORTANT NOTICE TO CLAIMANTS

1. Informal Review (Optional to Member)

The covered person (or authorized representative) and/or treating dentist may, within 60 days of the date of mailing of this EOB, request that we informally reconsider this claim decision by following the procedure described in No. 6 below; we will respond within 60 days and notify the member (or authorized representative) and treating dentist of our decision and the reason(s) therefor. If no request is submitted within 60 days, only a formal appeal may be filed. A request for informal review does not constitute an "appeal" for ERISA appeals purposes.

2. Formal Appeal

The covered person (or authorized representative) may, within 240 days of the date of mailing of this EOB, formally appeal this claim decision by following the procedure described in No. 6 below; we will issue our decision to the member (or authorized representative) within 30 days of our receipt of the appeal for ERISA claims and within 45 days of our receipt of the appeal for non-ERISA claims.

3. Right to Sue

A covered person must timely file a formal appeal (as described in No. 2 above) and receive our decision on the appeal as a precondition to commencing any legal proceeding challenging the claim determination.

4. Right to Receive Rules, Guidelines or Detailed Explanations

If the front side of this form indicates that a rule or guideline was relied on, you have a right to receive it free of charge. If the front side indicates that payment was not made for services because they were experimental or not medically necessary, you have a right to receive an explanation of the basis for that decision. To receive either, send your written request to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054.

5. Dentist Request to Speak with a Dental Consultant

A "dental decision" is a decision which is based upon a dental diagnosis or dental judgment. If the front side of this form reports a denial, reduction or failure to provide payment, in whole or in part, for a service based upon a "dental decision" AND (a) you are a New Jersey licensed dentist AND (b) you disagree with such determination, then you have the right to speak with a dentist at Delta Dental concerning the dental basis for the dental decision. As a precondition, you must submit a written and signed explanation of the basis for your disagreement within the time period for challenging the claim determination to Delta Dental, Attn: Adverse Determination Review, P.O. Box 617, Parsippany, NJ 07054. We urge you to include any documentation you want us to consider.

6. Procedure for Requesting Informal Reviews and Formal Appeals

Submit the following information and documentation:

(a) Dentist name, office name, address and license number
(b) Member name, Member ID number (which in many cases is the primary subscriber's social security number)
(c) Patient name and date of birth
(d) Claim number
(e) Whether this is for an informal review or a formal appeal
(f) Description of the reasons why Delta Dental should change its initial decision on the claim and the specific decision which you request
(g) Any supplemental information or diagnostic materials relevant to the claim in question
(h) In lieu of (a), (b), (c) and (d), attach a copy of the claim and the claim determination you are appealing

A form is available for you to use at http://www.deltadentalnj.com/HIPAA/law_compliance.shtml.

You must sign your request; if you are authorized to act for the covered person, you must state that. You may include information and/or documentation pertinent to the claim even if you had not previously submitted it to us. Informal review requests must be addressed to Delta Dental, Attn: Informal Review Department, P.O. Box 601, Parsippany, NJ 07054. Formal appeals must be addressed to Delta Dental, Attn: Formal Appeals Department, P.O. Box 601, Parsippany, NJ 07054.

7. Potential Voluntary Alternative Dispute Options

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency. Those persons covered under a self-funded program may also have a voluntary appeals program available to them; check with your Human Resources Department or Summary Plan Description (SPD) if applicable.

8. Notice of Privacy Practices

You may access Delta Dental's Notice of Privacy Practices on our website at www.deltadentalnj.com. You may also obtain a hard copy of this notice by contacting our compliance administrator at (866) 861-4716.

9. Coordination of Benefits

If you are covered by more than one health benefit plan, you should file all your claims with each plan and provide each plan with information regarding the other plans under which you are covered.

You should always submit your claim first to your primary carrier and, after receiving their determination, submit your claim to your secondary or tertiary carriers (if applicable).

10. Terminology and Definitions

Approved Amount: The total amount which the dentist is permitted to collect as payment in full for the specified service. It includes the dental benefit plan's payment as well as the patient's deductible and/or copay.

Amount Used for Benefit Calculation: The fee amount that the dental benefit plan provides for use in calculating the dental benefit plan payment for the specified service. The dental benefit plan payment may be less than this fee amount due to patient deductible, copay, plan limitations or exclusions.

11. Any procedures which are disallowed resulting in no Delta Dental payment or patient liability are in accordance with the group contract and dentist participation agreement.

12. Payment for all services is determined in accordance with the terms of the group's dental plan and/or with the terms of Delta Dental's dentist participation agreements.

If you have received this in error, please sign to confirm that you have not retained a copy of this document or any of the patient information. Please return this document to Delta Dental, Attn: Correspondence Department, P.O. Box 222, Parsippany, NJ 07054. Signature:_____

5. **DENTIST INFORMATION**, including the Delta Dental program in which he or she participates for that claim.

6. **MAXIMUM INFORMATION** includes all maximums applicable to the plan the patient is covered under instead of showing plan maximum only.

7. **DETAILED EXPLANATIONS AND DESCRIPTIONS OF INFORMATION IN THE COLUMNS**, including descriptions of each procedure number and explanations, if appropriate, of processing policies (up to 3 per line item allowed). Also features separate '**Submitted Procedure No.**' and '**Paid Procedure No.**' to better illustrate when an alternative benefit has been applied.

For questions about specific claims, contact the number for Claims Inquiries on your Explanation of Benefits statement, or e-mail Customer Service at **service@deltadentalnj.com**.