

Redesigned Explanation of Benefits

New Explanation of Benefits example:



Delta Dental of Kansas
P.O. Box 789769
Wichita, KS 67278-9769

JOHN SAMPLE
123 ANY STREET
ANYTOWN, US 12345

Explanation of Benefits

THIS IS NOT A BILL. PLEASE COORDINATE WITH YOUR DENTIST FOR ANY APPLICABLE PAYMENT.
You recently visited the dentist and we wanted to show you the care you received and who pays what. This Explanation of Benefits explains what your dentist charged, what we cover, our network savings and what you may owe to the dentist.

CLAIM DETAIL:

Claim Number: 000555000555

Patient: Jane

Subscriber: John

YOUR DENTIST CHARGES:	PAID BY YOUR OTHER INSURANCE PLAN: (IF APPLICABLE)	PAID BY YOUR DELTA DENTAL PLAN:	YOUR IN-NETWORK SAVINGS:	YOUR SHARE: (THIS IS NOT A BILL)
\$XX	\$XX	\$XX	\$XX	\$XX

Service Date	Dental Service	Tooth No.	Surface/ Arch/ Quad	Your Dentist Charges	Your Delta Dental Plan Charges Allowed	Your Deductible* Applied	Your Delta Dental Plan Coinsurance*	Over Annual Maximum*?	Paid by Your Delta Dental Plan	Your Share	Reason Code**
2/10/20	Example Service	-	-	\$XX.XX	\$XX.XX	\$XX.XX	100%	No	\$XX.XX	\$XX.XX	555
2/10/20	Example Service	-	-	\$XX.XX	\$XX.XX	\$XX.XX	100%	No	\$XX.XX	\$XX.XX	-
2/10/20	Example Service	-	-	\$XX.XX	\$XX.XX	\$XX.XX	100%	No	\$XX.XX	\$XX.XX	000
TOTAL				\$XX.XX	\$XX.XX				\$XX.XX	\$XX.XX	

****REASON CODE:**

555: Reason code information.

000: Reason code information.

CLAIM PAID TO:

Dentist: Dr. Dentist

Claim Paid Date: 2/20/2020

Check Number: 123456


BENEFIT SUMMARY FOR <PATIENT>:
(BENEFIT PERIOD: 1/1/2020 - 12/31/2020)

	Paid to Date	Annual
Deductible:	\$XX.XX	\$XX.XX
Family Deductible:	\$XX.XX	\$XX.XX
Annual Maximum:	\$XX.XX	\$XXXX.XX
	Paid to Date	Lifetime
Orthodontics Maximum	\$XX.XX	\$XXXX.XX

Benefit Period Annual Maximum Remaining for <Patient>: \$XXXX.XX

Contact our Customer Service Team at 800-234-3375 or [DeltaDentalKS.com/Contact](https://www.DeltaDentalKS.com/Contact).

Old Explanation of Benefits example




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EXPLANATION OF BENEFITS

(This is not a bill)



CHECK NO. 00000
DATE OF ISSUE 06/02/20XX

DENTIST LICENSE 00000

PATIENT ■ JOHN

PROVIDER ■ DR. DENTAL PROVIDER

TOOTH NO OR LETTER	ARCH SURFACE QUAD	DESCRIPTION OF SERVICE	DATE OF SERVICE	BILLED AMOUNT	MAXIMUM ALLOWABLE	PAY CODE	CONTRACT ALLOWED	PAY CODE	DEDUCTIBLE OR OTHER MAXIMUM	COPAY %	OTHER INSURANCE (COB)	PATIENT BALANCE	DELTA DENTAL PAYMENT	REF CODE	
CLAIM#: 1-0000-000-0															
		PERIODIC EXAM	06/02/XX	\$XX.XX	\$XX.XX	B	\$XX.XX		.00	100	.00	.00	\$XX.XX		
		4 BITEWING XRAY	06/02/XX	\$XX.XX	\$XX.XX	B	\$XX.XX		.00	100	.00	.00	\$XX.XX		
		CLEANING-ADULT	06/02/XX	\$XX.XX	\$XX.XX	B	\$XX.XX		.00	100	.00	.00	\$XX.XX		
FOR BENEFIT YEAR STARTING 1/01/20XX											TOTALS:		.00	\$XXX.XX	
\$XXX.XX OF 2000.00 ANNUAL MAXIMUM PAID TO DATE .00 OF 50.00 ANNUAL DEDUCTIBLE MET TO DATE															
** PAYMENT CODES ** B = PAYMENT BASED ON DELTA DENTAL'S MAXIMUM PLAN ALLOWANCE. PAYMENT FOR SERVICES IS DETERMINED IN ACCORDANCE WITH THE SPECIFIC TERMS OF THE MEMBER'S DENTAL PLAN OR OF DELTA DENTAL'S AGREEMENTS WITH DELTA DENTAL PARTICIPATING DENTISTS.															
<hr/> <p>FRAUD & ABUSE HOTLINE: To report any suspected fraud or abuse contact us at (316) 462-3343 or (877) 264-9381 or email us at reportfraud@deltadentalks.com.</p> <hr/> <p>Questions? Contact Delta Dental of Kansas' customer service staff at (316) 264-1099 or (800) 234-3375. Or send us an email containing the subscriber's name, date of service, subscriber number and question to moreinfo@deltadentalks.com. Visit the Subscriber Connection at www.deltadentalks.com to retrieve claims information, view benefits/eligibility, print an ID card, estimate your flexible spending account or download a Sonicare Electric Toothbrush Rebate form.</p>															

Page 1 of 2

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