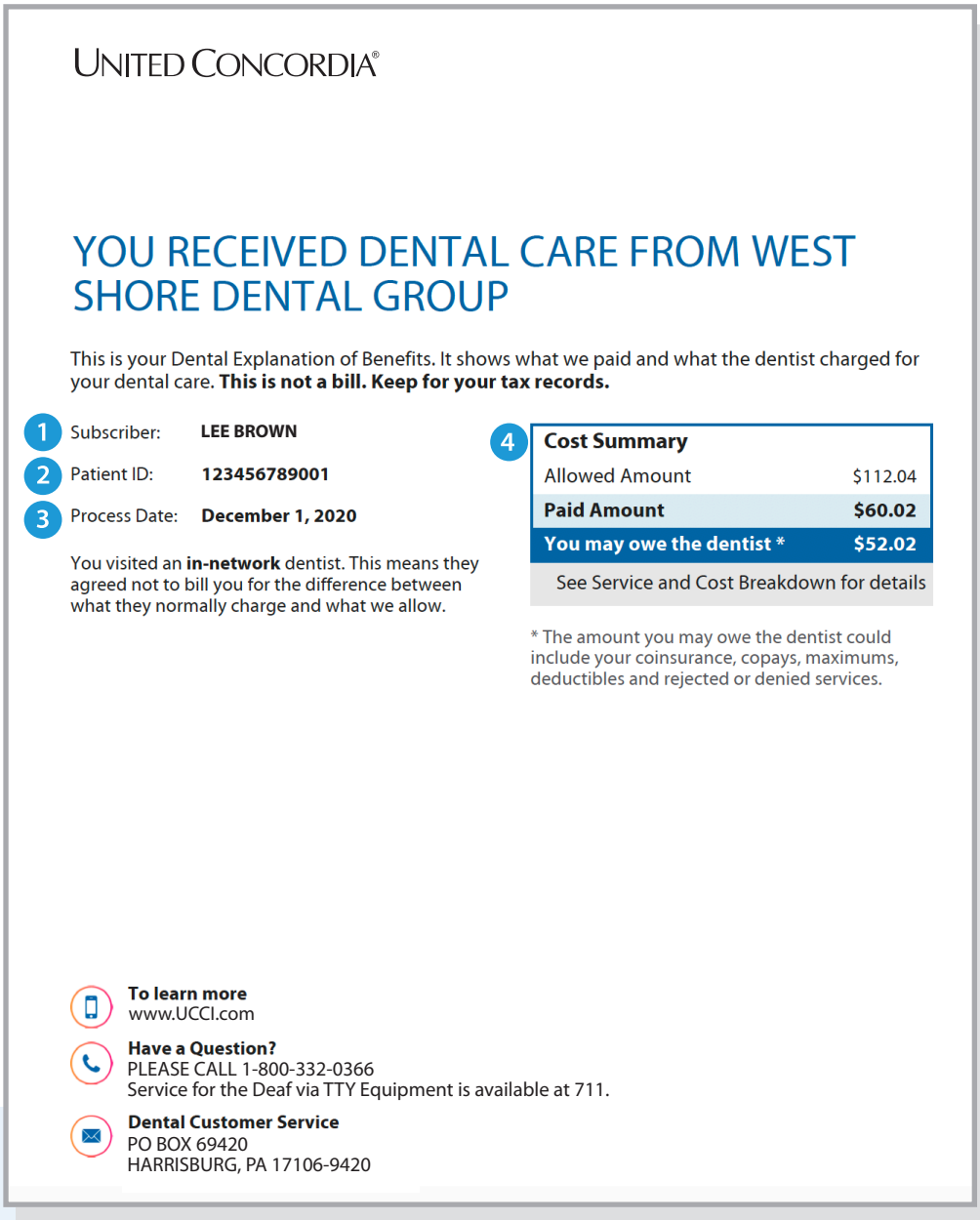
United Concordia dental℠

A Guide to Understanding Your Explanation of Benefits (EOB)



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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: **LEE BROWN**

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.UCCI.com

Have a Question?
PLEASE CALL 1-800-332-0366
Service for the Deaf via TTY Equipment is available at 711.

Dental Customer Service
PO BOX 69420
HARRISBURG, PA 17106-9420

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

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Service and Cost Breakdown

Patient: **LEE BROWN** Patient ID: **123456789001** Claim Number: **12345678900**

Service	Charges (5)	Allowed Amount (6)	Amount Over Allowed (7)	Other Insurance Paid (8)	Deductible (9)	Copay (10)	Co-insurance (11)	Not Covered (12)	Paid Amount (13)	Amount You Owe (14)	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.

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 towards 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, copays or deductibles

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. Each person covered by the plan may also have a deductible.
16. The amount you've already paid towards 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 towards dental care in a year
20. The amount your plan has already paid towards dental care
21. How much your plan will continue to pay
22. The total amount your plan will pay in a year

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Plan Features this Year		16	17	18
15 **Deductible**		**Applied**	**Remaining**	**Total**
Individual Deductible	FULL NAME	$50.00	$.00	$50.00
Deductible	FAMILY	$50.00	$100.00	$150.00
19 **Maximum**		**Applied**	**Remaining**	**Total**
Individual Program Dollar Maximum	FULL NAME	$60.02	$1,439.98	$1,500.00
		20	21	22

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.

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)。