

HOW TO READ YOUR DENTAL EXPLANATION OF BENEFITS

You can access this form in the member section on our website at www.odscompanies.com.

- The patient who had services performed.
- This is the claim number for the services performed.
- The provider who performed services.
- The date the service was provided.
- The type of service performed.
- The code that describes the service performed.
- This is the amount charged.
- This is the amount (if any) that is being denied.
- This shows any charges which have been applied to your plan's deductible. The deductible is subtracted from covered charges and is the responsibility of the patient.
- This shows the amount you saved by using an ODS/Delta participating provider. You are not responsible for these provider discounts.

| 4. | 5. | 6. | 7. | 8. | 9. | 10. | 11. | 12. | 13. | 15. | 16. |
|---|-------------------|----------------|---------------|--------------------|----------------|-------------------|---------------------------|--------|---------------|------------------------|----------|
| FOR SERVICES FROM TO | TYPE OF SERVICE | PROCEDURE CODE | TOTAL CHARGES | DISALLOWED CHARGES | DEDUCTIBLE (-) | PROVIDER DISCOUNT | REMAINING COVERED CHARGES | CO-PAY | TOTAL BENEFIT | PATIENT RESPONSIBILITY | COMMENTS |
| 1. PATIENT: JUAN CLIENTE 2. CLAIM: D5555521-00 3. PROVIDER: SAM SANDER DMD 14. PAYEE: \$AM SANDER DMD | | | | | | | | | | | |
| 0501 050105 | EXAM: INITIAL | D0150 | 50.00 | .00 | .00 | .00 | 50.00 | .00 | 50.00 | .00 | |
| 0501 050105 | PROPHY: ADULT | D1110 | 60.00 | .00 | .00 | .00 | 60.00 | .00 | 60.00 | .00 | |
| 0501 050105 | XRAY : FM SERIES | D0274 | 40.00 | .00 | .00 | .00 | 40.00 | .00 | 40.00 | .00 | |
| | TOTALS | | 150.00 | .00 | .00 | .00 | 150.00 | .00 | 150.00 | .00 | |
| 1. PATIENT: JUAN CLIENTE 2. CLAIM: D5555524-00 3. PROVIDER: SAM SANDER DMD 14. PAYEE: \$AM SANDER DMD | | | | | | | | | | | |
| 0101 010106 | AMAL: 2 SRF PERM | D2150 | 100.00 | .00 | 25.00 | 25.00 | 50.00 | 10.00 | 40.00 | 35.00 | R8 |
| | TOTALS | | 100.00 | .00 | 25.00 | 25.00 | 50.00 | 10.00 | 40.00 | 35.00 | |
| 1. PATIENT: JOSE CLIENTE 2. CLAIM: D5555526-00 3. PROVIDER: SAM SANDER DMD 14. PAYEE: \$AM SANDER DMD | | | | | | | | | | | |
| 0101 010106 | EXAM: INITIAL | D0150 | 50.00 | .00 | .00 | .00 | 50.00 | .00 | 50.00 | .00 | |
| 0101 010106 | PROPHY:ADULT | D1110 | 60.00 | .00 | .00 | .00 | 60.00 | .00 | 60.00 | .00 | |
| 0101 010106 | XRAY: 4 BITEWINGS | D0274 | 40.00 | .00 | .00 | .00 | 40.00 | .00 | 40.00 | .00 | |
| 0101 010106 | FLUORIDE: ADULT | D1204 | 20.00 | .00 | .00 | .00 | 20.00 | .00 | 20.00 | .00 | |
| | TOTALS | | 170.00 | .00 | .00 | .00 | 170.00 | .00 | 170.00 | .00 | |
| 1. PATIENT: MARIA CLIENTE 2. CLAIM: D5555525-00 3. PROVIDER: SAM SANDER DMD 14. PAYEE: \$AM SANDER DMD | | | | | | | | | | | |
| 0101 010106 | AMAL: 2 SRF PERM | D2150 | 100.00 | .00 | 25.00 | 25.00 | 50.00 | 10.00 | 40.00 | 35.00 | R8 |
| | TOTALS | | 100.00 | .00 | 25.00 | 25.00 | 50.00 | 10.00 | 40.00 | 35.00 | |

COMMENTS:
 *** PAYMENT FOR THESE SERVICES IS DETERMINED BASED ON THE SPECIFIC TERMS OF YOUR DENTAL PLAN OR DELTA'S AGREEMENTS WITH DELTA NETWORK DENTISTS.
 R8 THE CHARGE EXCEEDS THE AMOUNT ALLOWED.

| 17. | 17. | 17. | 17. |
|---------------|--|--|-----|
| JUAN CLIENTE | HAS MET \$.00 OF THE \$ 25.00 PATIENT DEDUCTIBLE FOR THE 2005 BENEFIT YEAR. | HAS MET \$ 150.00 OF THE \$ 1,000.00 MAXIMUM FOR THE 2005 BENEFIT YEAR. | |
| | HAS MET \$ 25.00 OF THE \$ 25.00 PATIENT DEDUCTIBLE FOR THE 2006 BENEFIT YEAR. | HAS MET \$ 40.00 OF THE \$ 1,000.00 MAXIMUM FOR THE 2006 BENEFIT YEAR. | |
| JOSE CLIENTE | HAS MET \$.00 OF THE \$ 25.00 PATIENT DEDUCTIBLE FOR THE 2006 BENEFIT YEAR. | HAS MET \$ 170.00 OF THE \$ 1,000.00 MAXIMUM FOR THE 2006 BENEFIT YEAR. | |
| MARIA CLIENTE | HAS MET \$ 25.00 OF THE \$ 25.00 PATIENT DEDUCTIBLE FOR THE 2005 BENEFIT YEAR | HAS MET \$ 40.00 OF THE \$ 1,000.00 MAXIMUM FOR THE 2006 BENEFIT YEAR.THE FAMILY | |
| THE FAMILY | HAS MET \$ 0.00 OF THE \$ 75.00 FAMILY DEDUCTIBLE FOR THE 2005 BENEFIT YEAR. | HAS MET \$ 50.00 OF THE \$ 75.00 FAMILY DEDUCTIBLE FOR THE 2006 BENEFIT YEAR. | |

THIS IS NOT A BILLING. PLEASE SAVE THIS COPY FOR YOUR RECORDS.

Patient deductible for benefit year.

Maximum met for the benefit year.

Family deductible for the benefit year.

This is not a billing. Please save this copy for your records.

- A covered charge is the amount allowed after disallowed charges, the deductible and provider discount are subtracted.
- The co-pay is the difference between the covered charge and the amount paid. This amount is the patient's responsibility.
- This shows the amount of benefit which has been paid by Oregon Dental Service.
- The "Payee" identifies to whom Oregon Dental Service has made the benefit payment.
- This shows the amount to be paid by the patient to the provider.
- Explanations of codes in this column are listed at the bottom of the page under comments. *Additional explanation codes listed on reverse side.*
- If there is a deductible, this section will identify the amount applied toward the annual deductible to-date and this section will also show the annual maximum met.

Dental Explanation Codes and Comments

| EXPLANATION CODES | COMMENTS |
|-------------------|--|
| >4 | MEMBER NO LONGER ELIGIBLE. PLEASE CHECK ID CARD. |
| D04 | UNABLE TO DETERMINE BENEFITS. CLINICAL INFORMATION FROM PROVIDER WAS NOT RECEIVED TO SUBSTANTIATE NECESSITY. |
| D18 | TOOTH COLORED (COMPOSITE) FILLINGS ON BACK TEETH ARE NOT A BENEFIT. ALLOWANCE HAS BEEN MADE FOR A SILVER (AMALGAM) FILLING. |
| D23 | PORCELAIN CROWNS, IF POSTERIOR TO THE UPPER FIRST MOLAR AND LOWER SECOND BICUSPID, ARE OPTIONAL. BENEFIT IS FOR A FULL GOLD CROWN. |
| D29 | PAYMENT IS PROVIDED FOR CAST RESTORATIONS, PORCELAIN CROWNS AND/OR A PROSTHETIC DEVICE ONCE IN A FIVE YEAR PERIOD. |
| D30 | SPECIALIZED TECHNIQUES, PRECISION ATTACHMENTS, IMPLANTS AND COPINGS ARE NOT COVERED. |
| D40 | AN ALTERNATIVE BENEFIT HAS BEEN PROVIDED BASED ON THE CONTRACT LIMITATION. |
| D62 | PAYMENT IS NOT PROVIDED FOR ORTHODONTIC SERVICES, INCLUDING DIAGNOSIS AND TOOTH GUIDANCE APPLIANCES. |
| D76 | IF PRIMARY INSURANCE DID NOT PAY THE AMOUNT AS SHOWN, PLEASE SUBMIT A COPY OF THEIR EXPLANATION OF BENEFITS FOR REVIEW AND/OR AN ADJUSTMENT. |
| D81 | THE MAXIMUM BENEFIT ALLOWANCE UNDER THE NON-DUPLICATION PROVISION IS OUR NORMAL BENEFIT LESS THE AMOUNT PAYABLE UNDER THE PRIMARY PLAN. |
| D88 | BASED ON CONSULTANT REVIEW, NECESSITY NOT ESTABLISHED. TREATMENT IS CONSIDERED PART OF THE RESTORATION. |
| D89 | BASED ON CONSULTANT REVIEW, BENEFIT IS LIMITED. |

| EXPLANATION CODES | COMMENTS |
|-------------------|---|
| D92 | PORCELAIN/RESIN ONLAYS ON POSTERIOR TEETH ARE OPTIONAL. BENEFIT IS PROVIDED FOR METALLIC ONLAY. |
| L25 | MAXIMUM BENEFIT HAS BEEN MET FOR THIS BENEFIT YEAR. |
| L35 | ORTHODONTIC LIFETIME MAXIMUM HAS BEEN MET. |
| Q1 | THIS CLAIM HAS PREVIOUSLY BEEN PROCESSED. PLEASE CHECK YOUR RECORDS. |
| R0 | THIS SERVICE IS NOT COVERED. |
| R1 | THE FEE CHARGED EXCEEDS THE MAXIMUM ALLOWANCE. |
| R5 | THE MAXIMUM ALLOWED FOR SERVICES OF THIS TYPE HAS BEEN REACHED. |
| R6 | THE CHARGE EXCEEDS THE DELTA AMOUNT ALLOWED. |
| R8 | THE CHARGE EXCEEDS THE AMOUNT ALLOWED. |
| S5 | TIMELY-FILING NOT MET. CLAIM SUBMITTED AFTER CONTRACT TIME LIMIT. |
| S6 | DEPENDENT IS OVER MAXIMUM AGE. |
| W1 | PROVIDER DISCOUNT HAS BEEN APPLIED. |
| W6 | THE CHARGE EXCEEDS THE AMOUNT ALLOWED. |
| 48B | INFORMATION REQUESTED FROM THE MEMBER ABOUT OTHER INSURANCE COVERAGE HAS NOT BEEN RECEIVED. |
| 74 | PLEASE SUBMIT A COPY OF THE PRIMARY CARRIER'S EXPLANATION OF BENEFITS. YOUR CLAIM WILL BE REVIEWED/ADJUSTED WHEN WE RECEIVE THIS INFORMATION. |

If you can not find a specific explanation code listed above, or have further questions, please call the Dental Customer Service line at 503-265-5680 (Portland area) or toll-free 1-877-277-7280.