HF1155/SF1040

MINNESOTA DENTAL ASSOCIATION®

COVERED SERVICES

Some dental benefit plan contracts with participating providers allow the plan to deny payment for services that are normally covered and simultaneously prohibit the dentist from charging the patient their normal fee for the procedure.

Minnesota law currently prohibits dental benefit plans from dictating fees a dentist may charge for services rendered unless such services are covered. Covered services are currently defined as dental care services for which reimbursement is available or would be available but for certain contractual limitations. Dental plans are using the current definition to deny payment (not reimburse) for services while simultaneously declaring that the services are covered. Thus retaining the plan's ability to set the fee a dentist may charge on services in which the dental plan has no financial involvement or burden.

DENTAL PLANS ARE USING THE CURRENT DEFINITION TO DENY PAYMENT (NOT REIMBURSE) FOR SERVICES WHILE SIMULTANEOUSLY DECLARING THAT THE SERVICES ARE COVERED.

The MDA's bill, HF1155 and SF1040, introduced by Representative Reyer and Senator Boldon, would restore the original intent of the law by changing the current definition of a covered service to dental care services that are reimbursed. The intent of this legislation is to remedy an intrusion in the patient provider relationship. The legislation will prohibit third party payers from dictating who, when, and what service a dentist provides particularly when the third party payer does not reimburse and "cover" that service. The broad application of the term "covered" to services that are not reimbursed shifts the burden of paying for services away from the dental plans and to providers. The MDA considers this a fairness issue and is seeking legislation to prohibit dental plans from requiring fee discounts on services not reimbursed.

This bill does not limit a dental plan from including contract provisions such as balance billing, waiting periods, frequency limitations, deductibles, or maximum annual limits, so long as it pertains to services that are reimbursed/covered.

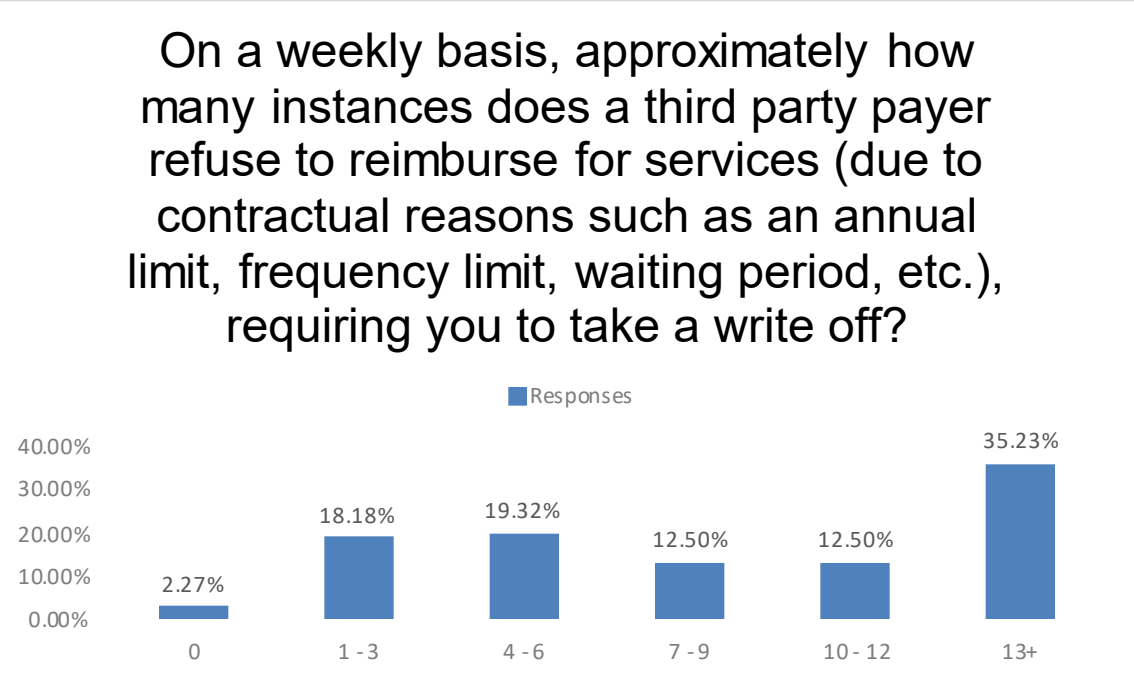
- Third party payers should not dictate fees beyond contracted services that are actually reimbursed!
- Allowing third party payers to dictate fees on services they do not reimburse unfairly shifts the burden on delivering services at the expense of the provider network.
- Practices that are required to provide services at a discounted rate may unfortunately lead to cost shifting onto other patients, including the uninsured.
- Insurance companies do this as a marketing move to improve their competitive position. If they can require dentists to accept capped fees or mandatory write-offs, they can offer discounts that certain competitors in the dental market cannot.
- The current practice is unfair to dentists. A dental benefit company should not dictate dentists' fees for services in which the insurance company has no financial risk or involvement.

CONTACT: For more information, contact Dan Murphy at ***dmurphy@mndental.org*** or 612.767.4255.

[1]*Minn. Stat. §62Q.78 subd. 6*

On a weekly basis, approximately how many instances does a third party payer refuse to reimburse for services (due to contractual reasons such as an annual limit, frequency limit, waiting period, etc.), requiring you to take a write off?

Answer Choices	Responses
0	2.27%
1 - 3	18.18%
4 - 6	19.32%
7 - 9	12.50%
10 - 12	12.50%
13+	35.23%



When a third party payer does not reimburse for a service due to a contractual limit (i.e. annual limit, frequency limit, waiting period, etc.) but never the less identifies the service as "covered", how is your practice impacted?

Responses
We have all the expenses to cover and nothing reimburse.
We typically have to take a write off and can't charge the patient the full fee.
We are required to write off the adjustment.
We have to write the amount off and don't get paid for our time.
Poorly as we lose out on that production.
We don't get reimbursed and the patient doesn't get any benefit from the plan that they or their employer is paying premiums for.
We have to issue a write off, if we are contracted with that payer.
If there is a limitation on exams, flu, bitewings, etc, we still have to provide the best service as possible. We get a lot of referred patients and if they have already had two exams in that year, we have to write off due to their limitations.
We have to submit the insurance, follow up with the patient to pay the amount, and lose money for procedures that patients agree to getting despite knowing that the procedures are not going to be covered. Essentially the patients agree to the treatment, we quote them our full fee, but still have to take a write off due to what is mandated from their insurance company. Not to mention how long many of these claims take to process and deny. We had a situation recently where claims were held up nearly 6 months from one insurance company!
It wastes our time to figure out what is going on.
It confuses the patient, it often serves as a barrier to the patient having the service done (and getting the care they need), and it decreases the reimbursement that we we receive.
Less income and more desire not to continue to work with insurance companies.
Our office, its doctors, and dental therapists, are forced to accept the lack of reimbursement as a loss.

We cannot collect our entire fee for service. That is money we could use to put back into the business to grow, give (already reduced) staff bonuses/raises to help w/ retention, it impacts what supplies we can order, and countless other things.
If a service is not covered but a plan dictates what we can charge, this is a negative impact on revenue and the ability to cover our costs.
Financially it costs us money in write offs and adjustments.
Can't charge the pts, so our office has to write it off.
We give the patients incorrect information and estimates causing us to lose trust with our patients in our ability to gather correct information and write estimates.
I already told the patient we should do the services and then we find I have to write off the whole thing. So I'm doing services for free. They also make me write off the whole cost of frenectomy if I intend to do a separate procedure in the area, claiming that it can be done together. They are two separate procedures for different purposes.
Negatively. The patient feels as though the practice has done something wrong and should be financially liable.
I went out of network in approximately 1987.
We have less money to cover the ever increasing expenses from employee wages to supplies.
We are having to take a write off, even though the patient has maxed benefit.
It cuts into our profits so monetary loss.
We have to write off everything above the allowed amount by the insurance company.
There's a whole lot of staff time trying to figure out what to collect from the patient. Some plans make us take a write off, others don't, so we dont' know how much is planning to be paid and, more importantly, we have trouble figuring out how much will be left in their annual maximum for future services happening before the claim is processed.
Significantly, systems in place to keep to a minimum, but cash paying patient suffers the most.

We are left in a dilemma where we forced to choose to treat the patient but get ZERO reimbursement or consider getting into the business implications with the patient and suggest waiting for treatment until it is covered. If the insurance companies want dentists to treat patients needs but don't want to reimburse but also want to dictate that we can't charge the patient maybe they can pay our employees and lease obligations.
It is hard as the patients do not know and we can not always catch them and not preform. The Doctor gets more upset about the write offs.
It impacts the practice and patients negatively.
We lose money and are required to write it off. Patients look at the EOB's.
We still have to write off the negotiated amount, and we are not getting the insurance payment- so we are not getting the full fee.
It does cause a financial hardship as we are still required to take the write-off.
We are dropping insurances that do this.
We have to take the write off as that is what insurance tells the patient. We loose thousands of dollars due to insurance dictation.
Loss of money.
Significant loss of revenue.
Harder to cover overhead costs and staffing costs, treatment gets put off until insurance will pay.
They force us to write it off and eat the cost.
We end up writing off a lot of money to the point that sometimes we barely see a profit off of many of these patients. With the costs of everything going up, it is hard to sustain ourselves.
We lose money.
We are required to only collect the contracted rate, which sometimes patients do not want to pay because they thought their insurance was going to cover this. This makes the patient mad at our office when really they should be mad at their insurance. So ... it impact us financially and customer

Payers have indicated that if the MDA's bill succeeds, patients will have higher out of pocket expenses if dentists charge a fee higher than the plan's "discounted rate." How would you respond to this claim?

Responses
We need educate patients on their dental needs. IF insurance is not covering a procedure the patient should contact their HR to help change their dental plan.
Our fees are the same for all patients and we use the [redacted] fees.
Agree - that would be the case.
Dentists typically raise at a certain percentage with the new year, I do not believe dentists would upcharge just because they can.
Our fees are set to reflect the specialized training and education of staff, the cost of supplies, technique, and the average cost of reimbursement for these specialized services.
3rd party payers should not have any say about procedures that they provide no benefit for. They usually 'help' up to a certain annual dollar amount. After that dollar amount their 'help' is over and done with so they shouldn't have any input.
That is true.
It would be great if we didn't have to write as much off or have patients pay more. We always want third-party payers to pay more, so it doesn't have to always be charged out to patients or have it as a write off. We have cases where a patient has been referred, but because they have been somewhere else previously, it should not be on us to have to write more off.
The insurance company plans force their rates and plans on dentists. This lets the insurance companies dictate the patient's treatments rather than allowing the patients and doctors to plan.
Patients are paying insurance companies for benefits and paying a significant amount for these benefits. The insurance companies are profiting excessively every day. Patients pay for certain benefits. Patients understand what is covered with their plan (for the most part). It is not a surprise when we tell them certain things aren't covered and they choose the treatment anyway if they believe it to be beneficial to their health. It is not fair for the dentist to always suffer in this relationship. The discounted rate is meant to apply for what patients are paying for benefits.

Discounted rates are only meant to apply to services that are paid by insurance. If it's not a service that's paid by insurance, and it's needed and wanted by the patient, the patient has the freedom to choose whether they have it done or which dentist they see for it. Fees may be a determining factor when patients choose a dentist.
Insurance companies haven't changed their covered amounts in MANY years. It has never increased in regards to inflation or increased costs. During COVID, when supply costs skyrocketed, they never increased their allowed amounts and their allowed amounts aren't increased on a frequent basis and when it does it is only a few dollars, when the costs of supplies and wages are increasing at record amounts. It will also give the patient a choice whether dental insurance is even a good option for them anymore. Dental insurance companies have turned into a for profit business instead of trying to help the patient retain oral health. Putting limitations on the plans have made them feel like treatment isn't needed if it's not "covered" and have made them delay treatment. It's also put limitations on dentists and the treatment they provide and supplies they buy to do the treatment. It's also made them want to become out of ntwk providers so that also will prevent patients from being seen if we aren't "in-ntwk" for them.
Dental benefit providers need to get with the program - they haven't raised rates to their participants in relationship to how our costs have increased. Dental benefit providers have not increased their annual limits to take into consideration increase in costs - we still see many of our patients with $1000 maximum benefits - by no means covers 2 cleanings and restorative, if necessary. Personally, I have paid the same premium for our family of 4 for dental benefits for over 5 years - no increase at all, which means, dental benefit providers are not covering the costs of the participants nor providing dental clinics fees to cover our costs. If it is not a covered benefit, payers have paid $0 towards the cost of the service, they should not dictate how much a dental provider can charge.
We already set our fee's, after insurance pays we make the insurance adjustment they tell us to. We have no say in what the insurance company fee schedule is.
If it is a covered benefit, that a discounted rate is what the provider has agreed to charge. If it is NOT a covered benefit, then a third party should have no say in what is being charged.
Third payers are not true insurances. They just provide “discounts” and probably do not provide benefit to patients that are paying monthly premiums for them.
Plans discounted rates are not based on the realities of our costs.
Patients will pay what is reasonable and appropriate for said procedure.
When does the dentist reach a maximum write off?
Yes, they will have higher out of pocket expenses.

We are already dealing with this issue as insurance never pays what our fees should be. Insurance should not have the right to dictate care or compromise our standard of care.
The fee charged would be are normal fee that all other patients pay on a regular basis.
Perhaps, but we bill the same amount to every pt, so they wouldn't be paying more than anyone else. We just ran an audit and found that our best payer reimburses at a 65% rate. We are having trouble keeping the lights on and paying for quality employees as it is, so adding the what we have to write off just because the patient used more benefit or didn't wait or whatever means they are getting worse care.
We already do.
Yes the fees at the office may be higher, but we know many of the plans for dental are less than $30 premium as they are paying their provider. There is not a enough training for patients as they see dental should be the same as their medical. It is a very confusing insurance for them and they do not understand it. Takes our staff longer to explain their beneifts and our time working the claims to get paid or collect past dues than what they are paying in premiums.
Write offs are excessive with most companies and most companies haven't increased fee reimbursements for years. We as a dental provider have had increased costs in everything but the insurance companies have not reflected that in their reimbursements.
Possibly, but at least the patient has more freedom of choice.
Insurance companies should pay more towards the patients' out-of-pocket expenses. Premiums are only going higher with coverage getting worse. It should be Premiums are getting higher due to better coverage.
Insurance companies have quarterly profits in the billions of dollars. There is absolutely no reason why they should not be paying a fare fee to dentists instead of "discounted rates" and they would still have profits in the billions even if they did not pass the expenses on to the patients.
Yes, there is no doubt that patients would carry a higher burden. A consistency among all insurance companies should be put in place. We understand that the patient does pay for their dental plan. With that being said, some insurance companies PPO plans pay half of what our fees are, at times especially with [redacted] plans slash are fees where we just break even. We are only honoring the existing patients that are on [redacted] or who has to change due to an employer change in carrier.
I dont understand - we would not have to have higher fees if there was not so much write off.

That is probably true. However it would be the same rate as a patient with no dental insurance. Our ordinary and customary fee.
That’s how the free market works. If they don’t like our fees, they can go elsewhere. My staff won’t work for free. Why should I? We’re going out of network because of nonsense like this so because of insurance companies behavior patients will end up paying even more.
Dental insurance isn't like medical insurance! There is always more out of pocket for patients that need extensive comprehensive care that goes over there contractual limits.
We work with our patients directly to make sure that their dental services are affordable for them. Insurance dictating what and when we can charge interferes heavily with doctor patient care and can lead to more expensive dental issues later on costing the patient even more.
They have NO right to dictate what we charge when THEY are paying NOTHING for the services. We can provide a MUCH HIGHER level of service to our patients when we can run a solvent business and invest in the best technology to treat our patients the way they deserve to be treated. The insurance company has no skin in the game when they don't pay, so as dentists, we should not be controlled by third-party payers - especially when it is threatening our ability to stay open. Also - we will not need to charge nearly as much for our services if we don't have to take writeoffs for non-covered services, as we would be able to pull a profit much easier if our fees are not dictated to be as low as they currently are with contracted rates.
We would charge the same price as the agreed contractual rate.
No they won't, dentists will get paid more and more will take insurance.
This is absolutely false. The dental insurance company just doesn't want to pay. The dental insurance company is all about profits and paying their board members lots of money. If there wasn't a 3rd party payer (dental insurance company) dictating fees/reducing fees/flat out not paying fees, then the owner dentist could charge less for their services. Getting rid of the "middle man" (dental insurance company) would greatly reduce the cost of dental health care for every consumer/patient.

Please share any examples of recent situations where a payer has not reimbursed for services (due to annual limits, frequency limits, waiting periods, etc.) yet dictated your fee. What was the situation?

Responses
Patients being seen for perio maintenance or prophy, we write off a portion. Yearly max being met and we still write a portion off.
They do it all the time. The most common example is a limited exam. The patient only gets 2 exams per year but has some urgent issue that needs to be addressed. The limited exam isn't reimbursed due to frequency limitations but our fee for our time and expertise is significantly reduced even though we're helping the patient.
Crown not covered due to frequency, we have to write off difference of dictated fee, then patient owes the dictated fee amount.
They do it for fluoride all the time. Fluoride is rarely covered for adults. We tell adults that if they want the benefits of fluoride, it will be $50. Patients choose to pay the $50, but now more and more insurance companies have the fluoride as a "non covered benefit," but still make us take the $13 write off because the "allowed amount" is $37. The insurance companies also will do this if there is a frequency limitation for restorations, like crowns for example. If the frequency limitation hasn't been met and the patient wants a new crown for whatever reason (usually because they come from another office with a bad or decaying crown that should be replaced), insurance companies will still require us to take the write off and only charge the patient the allowed amount. Often in these cases, we didn't even do the crown in the first place!
Patient had no coverage for a crown for a waiting period, yet I still had to abide by the fee. Why should I take the hit? Patient did end up paying in full at the dictated rate.
Fluoride treatments are recommended every six months for many children, but some insurances only cover it once per year. And those insurances who choose not to cover it still dictate that we can't charge our usual and fair fee.
Patient delayed fillings for 10 mos. We provided treatment. When she was due for radiographs, she had new decay on a different surface and fill was denied (made provider w/off responsibility) due to frequency limit. Also, a different patient didn't brush/floss, had heavy plaque at every appt, drank a lot of pop/had high sugar consumption. Got recurrent decay on a tooth that had been filled w/in 2 yrs- we had to write off the entire filling due to freq limit. Many cases like this one.
Pt comes in for an extra cleaning - their choose as they want to get them cleaned every 4 months. The cleaning was not covered by payors/dental benefit providers but we could only charge the negotiated fee. That is ridiculous - the patient is choosing to come in for an extra cleaning, we should be able to charge accordingly.

Sealants on premolars...kids with high risks should have sealants on premolars as well. If they have caries, they will pay for the restoration at a discounted price, but they will not cover preventative sealants on premolars. Not covered benefits, yet the write off are still there that I have to honor.
An exam was not covered due to frequency and dictated the fee we could charge. We had a patient that had new decay on a tooth were they had a filling done 1 year prior, but were dictated the fee based on when it was last done even though it was different surfaces then before.
Plans not paying for needed root planning due to restrictions that have nothing to do with patient's health. Not covering radiographs when patient has rampant caries after oral cancer care.
A patient wanted to have 30-year-old crowns that needed to be replaced due to recurrent decay. Insurance covered the first crown only, then the rest (6) were discounted to the point that the lab bill for the crowns was almost equivalent to the total charge. We could not proceed with this treatment.
We see this frequently with fluoride, where it is covered for children, but not adults on the plan, therefore a 'covered benefit' and they will dictate we adjust our fee. The other issue is recurrent decay on a tooth within the 24 month limit the benefit company places. It is out of our control that the patient has new decay, however, they will not allow us to charge the patient for a new filling on that tooth and will make us write off the whole thing. THIS is infuriating.
Benefit max reached. or Filling on same tooth within 24 months due to recurring decay. Waiting periods, having to take the write off on a "covered Procedure" due to waiting period.
Patient chose to limit care because of yearly max imposed by contractual contract by insurance. Patient chose to wait for new calendar year to finish fillings with decay present, which ended up needing additional care/treatment because a root canal was now necessary.
The patient was due for a 6 month prophy and exam and is allowed 2 per year but during this benefit year the patient required a root canal which used up the max benefit. If the patient were to proceed with the second prophy and exam the insurance company stated that the patient could only be charged the allowable amount set by the insurance company.
I just had a health partners patient in that was maxed out for the year in benefits. I was still required to give the write off on all of the patients work. Happens all the time.
Perio maintenance and we were required to take a write off even if the patient knew they were exceeding their frequency limits.
Insurance companies dictate the fees on every covered service. So any time there is an issue with a waiting period or annual limits, they always dictate the fee and the reimbursement.
We see this often with exams and xrays. Since we are oral surgery we usually do not get reimbursed but have to take the write off.
This almost always happens in implant cases. It is a major source of write offs.

Patient has filling done 2 years ago and now have a new cavity on that same tooth. Insurance won't pay for a new filling for three years, the dentist would have to do the treatment for free for the patient or make the patient wait for treatment until the insurance will pay which will lead to a larger amount of decay and potentially leading to more extensive and expensive dental care which could involve crowns, root canals, or implants.
Insurance denied partial due to missing tooth clause but then declared a contractual fee less than what the UCR was.
We fabricated a new crown for a new patient. The old crown was placed 4 years ago at a different office. The insurance refused to pay due to frequency, but still reduced our fee due to a contracted rate. We frequently have adult patients that chose to receive fluoride. Their plan states that it is only a covered service for 13 and under. Our office if forced to give these patients the contracted rate discount even though their insurance reimburses nothing.

Please provide any further pertinent information regarding this topic.

Responses
We are extremely frustrated with how payers have all of these frequency limitations. It's hard running our office due to having a lot of referred patients and having us either write it off or having the patients pay. Payers have not updated their reimbursement rates even with inflation and if they have, it's very minimal. We really hope this issue gets resolved.
For [redacted], it didn't used to be the case that we had to take a write off for non-covered services. This changed when [redacted] started getting processed in [redacted]. It's very sad that the insurance companies work hard to degrade what we do every day.
I am getting ready for retirement next year and this is one of the reasons I am tired of my profession
Insurance Companies are dictating treatment and fee's for patients, not the Doctors themselves. This causes higher fee's with less yearly benefits available.
We need to hold these insurance companies accountable for their bad behavior. It makes no sense that they can dictate a payment that they do not pay.
I would like this legislation to pass, but would also like this legislation to assist our patients. I am timid that this will only prevent more patients from declining treatment in the future rather than holding them more accountable to their patient portions due.
If government won't reign in out of control fraud by insurance taking patients premiums then refusing to pay for services, we will go out of network with all of them.
Since the dental insurance company is not willing to pay for services, they expect the dentist to performe forced charity. This is completely wrong and should be illegal. I strongly believe that most every dental professional just wants to help our patients, but dental insurance just gets in the way. There may have been a time in the past that dental insurance was helpful. But those days are clearly gone and dental insurance has turned into a camel (a horse designed by a committee). Thank you for trying to help the dental profession.

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]

Date of Birth: xx/xx/xxxx
Relationship: SUBSCRIBER
Subscriber: [redacted]

Subscriber ID: [redacted]
Patient Acct: [redacted]

Business/Dentist: [redacted]

License No.: [redacted]
Check No.:
Issue Date: [redacted]
Receipt Date:
Claim No.: [redacted]

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers. file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted] PRODUCT: [redacted]											
CLIENT/ID: [redacted]											
SUBCLIENT: [redacted]											
NETWORK: PPO DENTIST											
13/D,O	01/30/23	D2150	146.00	0.00	146.00	0.00			0.00	0.00	P
POLICY CODE: PP21000											
Total			146.00	0.00	146.00	0.00	0.00		0.00	0.00	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

PP21000 - AMALGAM AND COMPOSITE RESIN RESTORATIONS ARE PAYABLE TO THE SAME DENTIST OR DENTAL OFFICE ONCE WITHIN A 24-MONTH PERIOD, REGARDLESS OF THE NUMBER OR COMBINATION OF RESTORATIONS PLACED ON A SURFACE.

***FREQUENCY LIMITATION* - 24 Months**

Patient had #13 MOD placed on 12/30/2[illegible]

Dentist submitted $146 for an amalgam restoration on 1/30/23. The approved maximum fee that the dentist could charge the patient was $0. The amount that the plan would reimburse was $0, due to a 24 month frequency limitation (PP21000). The service would have been reimbursed had the frequency limitation not been in effect. The plan therefore would (1) not reimburse for the service and (2) dictated that the dentist could not charge the patient anything for the service. Essentially, the dentist provided the service for free and had to take the $146 hit.

[redacted]

[redacted]

[redacted]

www.[redacted]/providerservices
FOR INQUIRIES: 844-791-5988

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracting dentists.

ANTI-FRAUD NUMBER 612-224-3277

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

Dentist Copy

EOB_DDS

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

RECEIVED MAR 2 8 2023 BY: .....

Patient Name: [redacted]

Date of Birth:
Relationship:
Subscriber:

Subscriber ID:
Patient Acct:

Business/Dentist: [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

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Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted] PRODUCT: [redacted] PPO PLUS PREMIER CLIENT/ID: [redacted] SUBCLIENT:											
NETWORK: PREMIER DENTIST											
19/0	03/16/23	D2391	229.00	146.00	83.00	0.00			0.00	146.00	P
POLICY CODE: AP13004											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
AP13004 - THE DENTAL PLAN STIPULATES A WAITING PERIOD FOR THIS SERVICE THAT HAS NOT BEEN MET.											
		Total	229.00	146.00	83.00	0.00	0.00		0.00	146.00	

Waiting Period

The dentist submitted $229 on 3/16/23 for resin based composite. The plan did not reimburse anything (payment of $0) due to a waiting period limitation (AP13004). The plan then indicated the maximum that the dentist could charge the patient out of pocket was $146, $83 less of what it cost to perform the procedure.

[redacted]

www.[redacted]providerservices
FOR INQUIRIES: 844-791-5988

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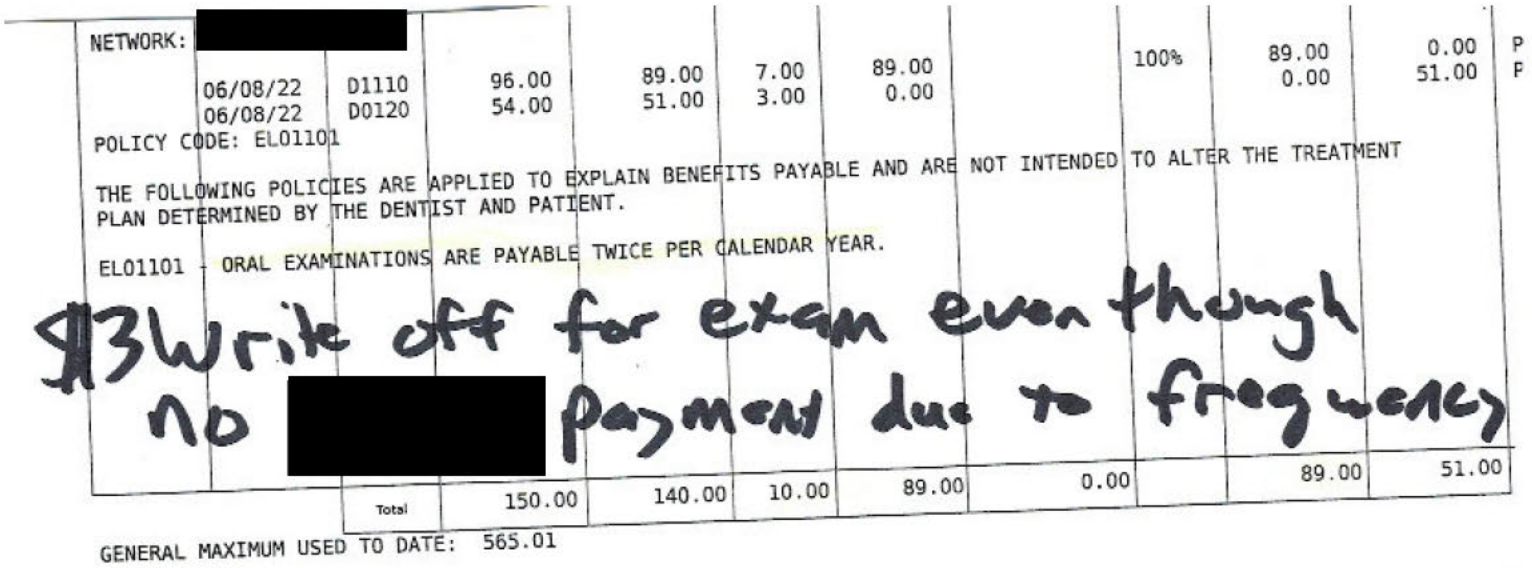
[redacted]

Dentist Copy



NETWORK: [redacted]

06/08/22	D1110	96.00	89.00	7.00	89.00		100%	89.00	0.00	P
06/08/22	D0120	54.00	51.00	3.00	0.00			0.00	51.00	P

POLICY CODE: EL01101

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL01101 - ORAL EXAMINATIONS ARE PAYABLE TWICE PER CALENDAR YEAR.

$3 Write off for exam even though no [redacted] payment due to frequency

Total	150.00	140.00	10.00	89.00	0.00		89.00	51.00

GENERAL MAXIMUM USED TO DATE: 565.01

[redacted]

Patient came in for a third exam in a year- dentist submitted the cost of the procedure ($54). The plan indicated that it would pay $0 because "oral examinations are payable twice per calendar year." The plan then indicated that the maximum allowed amount of reimbursement, had the procedure been reimbursed, would have been $51. This is the amount in which the provider would be allowed to charge the patient for the service out of pocket, despite the plan not paying/reimbursing.

NETWORK: [redacted]

03/0	06/13/22	D2391	182.00	146.00	36.00	146.00		80%	116.80	29.20
14/0	06/13/22	D2391	182.00	146.00	36.00	146.00		80%	116.80	29.20
30/0	06/13/22	D2391	182.00	146.00	36.00	146.00		80%	116.80	29.20
J/0	06/13/22	D2391	182.00	146.00	36.00	0.00			0.00	146.00
POLICY CODE: EL21000										
K/O,B	06/13/22	D2392	252.00	216.00	36.00	216.00		80%	172.80	43.20
	06/13/22	D9230	56.00	56.00	0.00	0.00			0.00	56.00
POLICY CODE: EL00061										
19	06/13/22	D1351	52.00	46.00	6.00	0.00			0.00	46.00
POLICY CODE: EL13029										

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL13029 - SEALANTS AND SEALANT REPAIRS ARE PAYABLE ONCE PER TOOTH PER LIFETIME.

CONTINUED ON NEXT PAGE

		Total								

Sealant write off even though not covered due to frequency [redacted]

Dentist submitted $52 for a sealant on 6/13/22. Plan did not reimburse (payment of $0) due to the service being "payable once per tooth per lifetime" (EL13029). The plan indicated that the maximum reimbursement it allowed (if the service would have been paid/reimbursed) was $46. The patient payment amount (far right column) is $46, meaning the dentist could charge the patient directly for the service but only a maximum of $46. This is a $6 write off the dentist is having to take on a service that the plan does not reimburse.

Pre-treatment Estimate Claim

[redacted] - Dental Office Toolkit

Patient Information

Patient Account Number: [redacted]
Patient Name: [redacted]
Date of Birth: [redacted]
Relationship Code: Subscriber
Subscriber Name: [redacted]

Claim Information

Receipt Date: [redacted]
Process Date: [redacted]
Claim Number: [redacted]
Claim Type: Pre-treatment Estimate
Claim Status: Denied
Other Carrier Payment:

Dentist Information

Dentist Name: [redacted]
License Number: [redacted]
Dentist TIN: [redacted]
Specialty: General Practitioner
Place Of Service: Office
Other Carrier:

Tooth Number	Area of Arch	Surface	Date of Service	Proc Code	Submt'd Amount	Apprv'd Amount	Allowed Amount	Ded	Office Visit	CoPay	Patient Pmt	Plan Pmt	Par Network	Product	Claim Line Status	Payment Number	Pay To	Issued Date
Group Number: 3500 Sub-group Number: 1000																		
				D9985	$92.93	$69.02	$0.00	$0.00	$0.00	100%	$69.02	$0.00	Premier Dentist	[redacted] PPO plus Premier	Denied		Provider	
Policy Code(s): AP99854, AP99856																		
10				D6740	$1,452.00	$1,078.00	$0.00	$0.00	$0.00	0.0%	$1,078.00	$0.00	Premier Dentist	[redacted] PPO plus Premier	Denied		Provider	
Policy Code(s): EL51006																		
11				D6245	$1,452.00	$1,079.00	$0.00	$0.00	$0.00	0.0%	$1,079.00	$0.00	Premier Dentist	[redacted] PPO plus Premier	Denied		Provider	
Policy Code(s): EL51006																		
12				D6245	$1,452.00	$1,079.00	$0.00	$0.00	$0.00	0.0%	$1,079.00	$0.00	Premier Dentist	[redacted] PPO plus Premier	Denied		Provider	
Policy Code(s): EL51006																		
13				D6740	$1,452.00	$1,078.00	$0.00	$0.00	$0.00	0.0%	$1,078.00	$0.00	Premier Dentist	[redacted] PPO plus Premier	Denied		Provider	
Policy Code(s): EL51006																		

Dentist submits for reimbursement for four procedures, each totaling $1,452. The plan did not reimburse (plan payment of $0) due to "fixed and removable prosthetic procedures are benefits once be five-year period" (EL51006- see next page for explanation). The maximum approved amount of reimbursement the plan would have paid if the 5-year period maximum did not apply would have been $1,078, which is $373 less than the cost of the procedure. The patient payment is $1,078, meaning while the plan will not reimburse, it has set the maximum amount the dentist can directly charge the patient as $1,078. For these four procedures, the write off the dentist is taking is $1,492.

Tooth Number	Area of Arch	Surface	Date of Service	Proc Code	Submt'd Amount	Apprv'd Amount	Allowed Amount	Ded	Office Visit	CoPay	Patient Pmt	Plan Pmt	Par Network	Product	Claim Line Status	Payment Number	Pay To	Issued Date
The following policies are applied to explain benefits payable and are not intended to alter the treatment plan determined by the dentist and patient:																		
Policy AP99854: This is the 1.6% MinnesotaCare tax and calculated off the plan payment amount, as required by Minnesota Statute 295.52, subd. 2.																		
Policy AP99856: The MinnesotaCare Tax fee is only payable per plan payment amount when submitted on the same date of service as the benefited underlying procedure.																		
Policy EL51006: Fixed and removable prosthetic procedures are benefits once per five-year period.																		

Total:	$4,383.02	$0.00	
Subscriber Deductible:	$0.00		
	Paid to Subscriber		
Net Amount:		$0.00	
	Paid to Provider		
Gross Amount:		$0.00	
R&D Withhold:		$0.00	
Net Amount:		$0.00	

Click here for your screen sharing code

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provid

PLAN: [redacted]
CLIENT/ID: [redacted]
SUBCLIENT: [redacted]
PRODUCT: [redacted] PPO PLUS PREMIER

NETWORK: PREMIER DENTIST

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
	11/21/23	D9230	85.00	41.00	44.00	41.00		100%	41.00	0.00	P
05/D,O	11/21/23	D2392	285.00	216.00	69.00	216.00		100%	216.00	0.00	P
14/D,O	11/21/23	D2392	285.00	216.00	69.00	216.00		100%	216.00	0.00	P
31/M,O	11/21/23	D2392	285.00	0.00	285.00	0.00			0.00	0.00	P
		Total	940.00	473.00	467.00	473.00	0.00		473.00	0.00	

POLICY CODE: PP2100D

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

PP2100D AMALGAM AND COMPOSITE RESIN RESTORATIONS ARE PAYABLE TO THE SAME DENTIST OR DENTAL OFFICE ONCE WITHIN A 24-MONTH PERIOD, REGARDLESS OF THE NUMBER OR COMBINATION OF RESTORATIONS PLACED ON A SURFACE.

GENERAL MAXIMUM USED TO DATE: 1773.00

Dentist submitted $285 for a resin based composit on 11/21/23. The plan did not pay (payment of $0) due to a 24 month waiting period. The plan dictated the amount the dentist could charge the patient as $0, meaning that the dentist had to write off the entire cost of the procedure ($285).

✓ 473.00
0.00
467.00
$940.00

[redacted]

Payment for these services is determined in accordar with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

If the claim was denied in whole or in part, you may submit a written request for an appeal to:

[redacted]

www.[redacted].org
FOR INQUIRIES: 952-854-0795 or 800-535-6373 (TTY users call 711)

[redacted]

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false informatio submitted to [redacted] you can help us lower th costs by calling our anti-fraud hotline or email us at reportfraud@[redacted] You do not need identify yourself.

Dentist Copy

Page 1 (
09-2

FOR DDS [redacted]

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted]					
CLIENT/ID: [redacted]											
SUBCLIENT: [redacted]											
NETWORK: PREMIER DENTIST											
	12/06/23	D0140	73.00	69.00	4.00	69.00		80%	55.20	13.80	P
	12/06/23	D0220	34.00	28.00	6.00	28.00		80%	22.40	5.60	P
29	12/06/23	D7140	190.00	145.00	45.00	0.00			0.00	145.00	P
POLICY CODE: AP13004											
	12/06/23	D9230	81.00	81.00	0.00	0.00			0.00	81.00	P
POLICY CODE: EL00061											
29	12/06/23	D7953	724.00	724.00	0.00	0.00			0.00	724.00	P
POLICY CODE: AP13004											
	12/06/23	D9985	17.63	16.75	0.88	1.55		100%	1.24	15.51	P
POLICY CODE: AP99854											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
AP13004 - THE DENTAL PLAN STIPULATES A WAITING PERIOD FOR THIS SERVICE THAT HAS NOT BEEN MET.											
CONTINUED ON NEXT PAGE											
		Total									

Dentist submits $190 on 12/6/23 for an extraction. The plan does not reimburse (payment of $0) due to a waiting period limitation, but states that the maximum approved fee and patient payment is $145. That is the maximum the dentist can charge the patient for the service, even though the plan did not pay. The dentist has to write off $45.

Claim information

Payer reference #	[redacted]	Product	[redacted]
Adjudication date	F4		
Status category	[redacted]	Payment amount	0.00
Status date	6 / 98	Payment method	NON
Status code		Check date	[redacted]
		Check #	[redacted]

Payment summary

View claim remit | View full remit

Patient control #	[redacted]	Provider liability	101.96
Patient responsibil...	258.04	Other liability	0.00
Claim payment	0.00	State tax	0.00
Remit date	[redacted]2024	Withhold	0.00

Payment detail

Line control #	Date of service	Adj svc/mod	Submitted svc/mod	Charged amount	Paid amount	Grp cd/ reason cd	Amt	Remark cd
1	12/27/2023 - 12/27/2023	D1110		120.00	0.00	CO / 45 PR / 1	30.00 90.00	
2	12/27/2023 - 12/27/2023	D0274		99.00	0.00	CO / 45 PR / 1	39.60 59.40	
3	12/27/2023 - 12/27/2023	D0120		78.00	0.00	CO / 45 PR / 1	23.05 54.95	
4	12/27/2023 - 12/27/2023	D1206		63.00	0.00	CO / 45 PR / 1	9.31 53.69	

This member chose a plan with a very high deductible. Even though the patient is eligible for each of these services, The dentists gets zero payment from the insurance, and we are required to write off $101.96 (CO/45).

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

[redacted]

Patient Name: [redacted]
Date of Birth:
Relationship:
Associate:
Associate ID:
Patient Acct:

Business/Dent:
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

If you have not signed up for direct deposit, don't delay! Do so now for the fastest, safest way to get payment. Payment will often be in your account within 48 hours. To sign up, log on to Dental Office Toolkit and follow the direct deposit link. If you're not a toolkit user, go to www.toolkitsonline.com to register.

Pay To: C = Custodial Parent
S = Associate
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted] PPO PLUS PREMIER					
CLIENT/ID:											
SUBCLIENT:											
NETWORK: PREMIER DENTIST											
	11/30/23	D1110	110.00	91.00	19.00	0.00			0.00	91.00	P
POLICY CODE: EL00056											
	11/30/23	D0120	65.00	53.00	12.00	53.00		80%	42.40	10.60	P
	11/30/23	D9985	2.80	2.80	0.00	0.00			0.00	2.80	P
POLICY CODE: EL00061											
		Total	177.80	146.80	31.00	53.00	0.00		42.40	104.40	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL00056 - THE ENROLLEE HAS EXCEEDED THE DENTAL PLAN'S TIME/FREQUENCY LIMITATION FOR THIS SERVICE.
EL00061 - THIS PROCEDURE IS NOT A BENEFIT UNDER THE DENTAL PLAN.

GENERAL MAXIMUM USED TO DATE: 1885.40

[redacted]

www.[redacted].com
Questions?
Please contact Customer Service at 501-835-3400 or 800-462-5410

Payment for these services is determined in accordance with the specific terms of the associate's dental plan and/or [redacted] agreements with its contracting dentists.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling 501-835-3400 or 800-462-5410.

Contact us if you would like a written statement about why we did not pay your claim.

Dentist Copy

P3106028008

[redacted]

[redacted]

20231129012

Inquiries: 800-323-1743
www.[redacted]com

Electronic Service Requested

[redacted]

206

1 OF 1

ENV 9071

Explanation of Payment

Claim Numbe[redacted]ent [redacted] ber A Subscriber ID: XXX[redacted]

TH	SURF	Service Date	Proc. Code	Procedure Description	Submit Amt	Fee Adjust	Approved Amt	Allowed Amt	Deduct Applied	% Co-Pay	Patient Payment	Delta Dental Payment	Ref. Code
		11/16/2023	140	LIMIT EVAL	94.00	25.00	69.00	69.00	0.00	100	69.00	0.00	003
		11/16/2023	220	1ST PA XRA	36.00	8.00	28.00	28.00	0.00	100	28.00	0.00	003
				TOTALS	130.00	33.00	97.00	97.00	0.00		97.00	0.00	

Dentist: [redacted]

Network [redacted]

Other Carrier Payment: 0.00
Withhold: .00
Net Amount: 0.00

Reference

003 Maximum benefit of your dental plan has been reached.

Other Information

Payment for these services is determined in accordance with the specific terms of your dental plan and with the terms of [redacted]greements with [redacted]etwork dentists. Procedures requiring professional judgement for benefit determination have been reviewed by a dental consultant.

If you believe this claim was submitted as the result of fraud, contact [redacted]at Phone: 1-888-328-9343 or E-mail: compliance@[redacted]com.

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Nam[redacted]

Date of Birth

Relationship:

Subscriber:

Subscriber ID

Patient Acct

Business/Denti[redacted]

License No.:

Check No.:

Issue Date:

Receipt Date:

Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted]					
CLIENT/ID:											
SUBCLIENT:											
NETWORK: PREMIER DENTIST											
	11/29/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	11/29/23	D0120	65.00	53.00	12.00	53.00		100%	53.00	0.00	P
	11/29/23	D0274	78.00	58.00	20.00	58.00		100%	58.00	0.00	P
	11/29/23	D9985	4.90	4.90	0.00	0.00			0.00	4.90	P
POLICY CODE: EL00061											
		Total	310.90	250.30	60.60	111.00	0.00		111.00	139.30	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
EL00061 - THIS PROCEDURE IS NOT A BENEFIT UNDER THE DENTAL PLAN.

GENERAL MAXIMUM USED TO DATE: 373.50

[redacted]

[redacted]

www[redacted]com
FOR INQUIRIES: 800-524-0149

[redacted]

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracting dentists.

ANTI-FRAUD TOLL FREE NUMBER 800-524-0147
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our toll-free hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

Dentist Copy

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]

Date of Birth:
Relationship:
Subscriber:

Subscriber ID:
Patient Acct:

Business/Dentist: [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

PLAN: [redacted] PRODUCT: [redacted]
CLIENT/ID: [redacted]
SUBCLIENT:

NETWORK: [redacted]

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
15/M,O	11/28/23	D2150	220.00	156.88	63.12	156.88		80%	125.50	31.38	P
19/M,O,D	11/28/23	D2160	269.00	173.84	95.16	173.84		80%	115.96	57.88	P
POLICY CODE: AP15014											
20/D,O	11/28/23	D2150	220.00	156.88	63.12	156.88		80%	0.00	156.88	P
POLICY CODE: AP15014											
	11/28/23	D9985	11.35	7.80	3.55	7.80		100%	0.00	7.80	P
POLICY CODE: AP99854,AP15014											
		Total	720.35	495.40	224.95	495.40	0.00		241.46	253.94	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

AP15014 - THE PATIENT'S BENEFIT PERIOD MAXIMUM HAS BEEN REACHED.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 2000.00

[redacted] [redacted]

www.[redacted].org
FOR INQUIRIES: 800-553-9536

000000000745

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted]'s agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name [redacted]

Date of Birth:
Relationship
Subscriber:

Subscriber ID
Patient Acct:

Business/Dent [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]							PRODUCT: [redacted]				
CLIENT/ID:											
SUBCLIENT:											
NETWORK: [redacted]											
	11/29/23	D0120	65.00	54.06	10.94	0.00			0.00	54.06	P
POLICY CODE: EL01102											
	11/29/23	D4910	163.00	137.80	25.20	137.80		100%	137.80	0.00	P
	11/29/23	D9985	3.65	3.07	0.58	2.20		100%	0.00	3.07	P
POLICY CODE: AP99854,AP15014											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
EL01102 - ORAL EXAMINATIONS (INCLUDING EXAMINATIONS BY A SPECIALIST) ARE PAYABLE TWICE PER CALENDAR YEAR.											
AP15014 - THE PATIENT'S BENEFIT PERIOD MAXIMUM HAS BEEN REACHED.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
	Total		231.65	194.93	36.72	140.00	0.00		137.80	57.13	

GENERAL MAXIMUM USED TO DATE: 2000.00

[redacted]

[redacted]

www.[redacted]org
FOR INQUIRIES: 800-553-9536

000000000745

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted]s agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted]org. You do not need to identify yourself.

Dentist Copy

DELTA DENTAL

Explanation of Benefits
(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Denti [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]											
CLIENT/ID [redacted]											
SUBCLIENT											
NETWORK: PREMIER DENTIST											
	11/28/23	D0120	65.00	53.00	12.00	0.00			0.00	53.00	P
POLICY CODE: EL01010											
	11/28/23	D1110	110.00	91.00	19.00	91.00		100%	91.00	0.00	P
	11/28/23	D9985	2.80	2.30	0.50	1.46		100%	1.46	0.84	P
POLICY CODE: AP99854											
		Total	177.80	146.30	31.50	92.46	0.00		92.46	53.84	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL01010 - ORAL EXAMINATIONS, INCLUDING EMERGENCY EXAMINATIONS AND EXAMINATIONS BY A SPECIALIST, ARE PAYABLE TWICE IN A CALENDAR YEAR.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 549.61

[redacted]

www[redacted].org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

000000000744

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name [redacted]

Date of Birth:
Relationship:
Subscriber:

Subscriber ID:
Patient Acct

Business/Dentist: [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted]					
CLIENT/ID: [redacted]											
SUBCLIENT:											
NETWORK: [redacted]											
02	12/01/23	D2950	321.00	230.00	91.00	0.00			0.00	230.00	P
POLICY CODE: AP13004											
	12/01/23	D9985	5.14	3.68	1.46	0.00		100%	0.00	3.68	P
POLICY CODE: AP99856,AP99854											
Total			326.14	233.68	92.46	0.00	0.00		0.00	233.68	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

AP13004 - THE DENTAL PLAN STIPULATES A WAITING PERIOD FOR THIS SERVICE THAT HAS NOT BEEN MET.
AP99856 - THE MINNESOTACARE TAX FEE IS ONLY PAYABLE PER PLAN PAYMENT AMOUNT WHEN SUBMITTED ON THE SAME DATE OF SERVICE AS THE BENEFITED UNDERLYING PROCEDURE.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

[redacted] [redacted]

www.[redacted]org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted]org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct

Business/Dent [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

PLAN: [redacted] PRODUCT: [redacted]
CLIENT/ID:
SUBCLIENT:

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
NETWORK: PREMIER DENTIST											
	11/29/23	D0120	65.00	53.00	12.00	0.00			0.00	53.00	P
POLICY CODE: EL01010											
	11/29/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	11/29/23	D9985	3.65	3.00	0.65	0.00		100%	0.00	3.00	P
POLICY CODE: AP99856,AP99854											
Total											

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
AP99856 - THE MINNESOTACARE TAX FEE IS ONLY PAYABLE PER PLAN PAYMENT AMOUNT WHEN SUBMITTED ON THE SAME DATE OF SERVICE AS THE BENEFITED UNDERLYING PROCEDURE.
EL01010 - ORAL EXAMINATIONS, INCLUDING EMERGENCY EXAMINATIONS AND EXAMINATIONS BY A SPECIALIST, ARE PAYABLE TWICE IN A CALENDAR YEAR.

CONTINUED ON NEXT PAGE

[redacted]

www.[redacted]/providerservices
FOR INQUIRIES: 844-791-5988

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracting dentists.

ANTI-FRAUD NUMBER 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]

Date of Birth:

Relation

Subscriber:

Subscriber

Patient Acc

Business/Dentist [redacted]

License No.:

Check No.:

Issue Date:

Receipt Date:

Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

PLAN: [redacted]
CLIENT/ID:
SUBCLIENT

PRODUCT: [redacted]

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
NETWORK: PREMIER DENTIST											
	11/10/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	11/10/23	D9985	2.61	2.15	0.46	0.00		100%	0.00	2.15	P
POLICY CODE: AP99856,AP99854											
Total			165.61	136.55	29.06	0.00	0.00		0.00	136.55	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
AP99856 - THE MINNESOTACARE TAX FEE IS ONLY PAYABLE PER PLAN PAYMENT AMOUNT WHEN SUBMITTED ON THE SAME DATE OF SERVICE AS THE BENEFITED UNDERLYING PROCEDURE.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

[redacted]

[redacted]

www.[redacted].org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Nan [redacted]

Date of Bi
Relationship:
Subscriber

Subscriber ID
Patient A

Business/Dentis' [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted] PPO PLUS PREMIER					
CLIENT/ID: [redacted]											
SUBCLIENT:											
NETWORK: PREMIER DENTIST											
20/B	11/27/23	D2391	219.00	146.00	73.00	146.00		50%	0.00	146.00	P
POLICY CODE: AP15014											
21/B	11/27/23	D2391	219.00	146.00	73.00	146.00		50%	0.00	146.00	P
POLICY CODE: AP15014											
	11/27/23	D9985	7.01	4.67	2.34	4.67		100%	0.00	4.67	P
POLICY CODE: AP99854,AP15014											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
AP15014 - THE PATIENT'S BENEFIT PERIOD MAXIMUM HAS BEEN REACHED.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
		Total	445.01	296.67	148.34	296.67	0.00		0.00	296.67	

GENERAL MAXIMUM USED TO DATE: 0.00

[redacted]

[redacted]

www.[redacted].org
FOR INQUIRIES: 651-406-5912 or 800-453-9912

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted]MN.org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

[redacted]

Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentist:
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted]					
CLIENT/ID: [redacted]											
SUBCLIENT:											
NETWORK:	PREMIER DENTIST										
	12/04/23	D0120	65.00	53.00	12.00	53.00		100%	53.00	0.00	P
	12/04/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	12/04/23	D0274	78.00	58.00	20.00	58.00		100%	58.00	0.00	P
	12/04/23	D9985	4.90	4.90	0.00	0.00			0.00	4.90	P
POLICY CODE: EL00061											
		Total	310.90	250.30	60.60	111.00	0.00		111.00	139.30	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
EL00061 - THIS PROCEDURE IS NOT A BENEFIT UNDER THE DENTAL PLAN.

GENERAL MAXIMUM USED TO DATE: 735.50

[redacted]

www.[redacted].com
FOR INQUIRIES: 800-524-0149

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted]'s agreements with its contracting dentists.

ANTI-FRAUD TOLL FREE NUMBER 800-524-0147
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our toll-free hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

Dentist Copy

[redacted]

Explanation of Benefits
(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentist: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted] PRODUCT: [redacted]											
CLIENT/:											
SUBCLIENT											
NETWORK: [redacted]											
	11/28/23	D0140	94.00	69.96	24.04	0.00			0.00	69.96	P
POLICY CODE: EL00070											
	11/28/23	D0220	36.00	27.56	8.44	27.56		100%	27.56	0.00	P
	11/28/23	D9985	2.08	1.56	0.52	0.44		100%	0.44	1.12	P
POLICY CODE: AP99854											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
EL00070 - THIS PROCEDURE IS LIMITED TO ONCE PER CALENDAR YEAR.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
		Total	132.08	99.08	33.00	28.00	0.00		28.00	71.08	

GENERAL MAXIMUM USED TO DATE: 913.51

[redacted]

www.[redacted].org
FOR INQUIRIES: 800-553-9536

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentis: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

PLAN: [redacted] PRODUCT: [redacted]
CLIENT/ID:
SUBCLIENT:

NETWORK: PREMIER DENTIST

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
19	11/27/23	D2740	1323.00	1120.00	203.00	1120.00		50%	0.00	1120.00	P
POLICY CODE: AP15014											
	11/27/23	D9985	21.17	17.92	3.25	17.92		100%	0.00	17.92	P
POLICY CODE: AP99854,AP15014											
		Total	1344.17	1137.92	206.25	1137.92	0.00		0.00	1137.92	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

AP15014 - THE PATIENT'S BENEFIT PERIOD MAXIMUM HAS BEEN REACHED.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 0.00

[redacted]

www.[redacted].org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

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ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Nam [redacted]

Date of Birth:
Relationship:
Subscriber:

Subscriber ID
Patient Acc.

Business/Dentis [redacted]

License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

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Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

PLAN: [redacted] PRODUCT: [redacted] PPO PLUS PREMIER
CLIENT/ID: [redacted]
SUBCLIENT:

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
NETWORK: PREMIER DENTIST											
	11/29/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	11/29/23	D0274	78.00	58.00	20.00	58.00		80%	46.40	11.60	P
	11/29/23	D0120	65.00	53.00	12.00	53.00		80%	42.40	10.60	P
	11/29/23	D9985	4.90	3.93	0.97	1.78		100%	1.42	2.51	P
POLICY CODE: AP99854											
		Total	310.90	249.33	61.57	112.78	0.00		90.22	159.11	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 350.39

[redacted]

[redacted]

www.[redacted]/providerservices
FOR INQUIRIES [redacted]44-791-5988

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracting dentists.

ANTI-FRAUD NUMBER 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline. You do not need to identify yourself. Only ANTI-FRAUD calls can be accepted on this line.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID
Patient Acct:

Business/Dentist: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted] PPO PLUS PREMIER					
CLIENT/ID: [redacted]											
SUBCLIENT:											
NETWORK: PREMIER DENTIST											
	11/28/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11017											
	11/28/23	D9985	2.61	2.15	0.46	0.00		100%	0.00	2.15	P
POLICY CODE: AP99854,AP99856											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.											
AP99856 - THE MINNESOTACARE TAX FEE IS ONLY PAYABLE PER PLAN PAYMENT AMOUNT WHEN SUBMITTED ON THE SAME DATE OF SERVICE AS THE BENEFITED UNDERLYING PROCEDURE.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
		Total	165.61	136.55	29.06	0.00	0.00		0.00	136.55	

[redacted]

[redacted]

www[redacted].org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name [redacted]

Date of Birth:

Relationship:

Subscri

Subscriber ID:

Patient Acct:

Business/Dentis [redacted]

License No.:

Check No.:

Issue Date:

Receipt Date:

Claim #

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted] PPO PLUS PREMIER					
CLIENT/ID [redacted]											
SUBCLIEN											
NETWORK: PREMIER DENTIST											
	11/21/23	D1110	110.00	91.00	19.00	0.00			0.00	91.00	P
POLICY CODE: EL11017											
	11/21/23	D9985	1.76	1.46	0.30	0.00		100%	0.00	1.46	P
POLICY CODE: AP99854,AP99856											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.											
AP99856 - THE MINNESOTACARE TAX FEE IS ONLY PAYABLE PER PLAN PAYMENT AMOUNT WHEN SUBMITTED ON THE SAME DATE OF SERVICE AS THE BENEFITED UNDERLYING PROCEDURE.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
		Total	111.76	92.46	19.30	0.00	0.00		0.00	92.46	

[redacted]

[redacted]

www.[redacted]org

FOR INQUIRIES 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted]org. You do not need to identify yourself.

Dentist Copy

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct.

Business/Dentist: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted] PPO PLUS PREMIER					
CLIENT/ID: [redacted]											
SUBCLIENT:											
NETWORK: PREMIER DENTIST											
	12/04/23	D0120	65.00	53.00	12.00	53.00		100%	53.00	0.00	P
	12/04/23	D4910	163.00	134.40	28.60	0.00			0.00	134.40	P
POLICY CODE: EL11011											
	12/04/23	D0210	159.00	126.00	33.00	126.00		100%	126.00	0.00	P
	12/04/23	D9985	6.20	5.01	1.19	2.86		100%	2.86	2.15	P
POLICY CODE: AP99854											
		Total	393.20	318.41	74.79	181.86	0.00		181.86	136.55	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11011 - PERIODONTAL PROPHYLAXES ARE PAYABLE TWICE PER CALENDAR YEAR.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 443.94

[redacted]

www[redacted]org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted], you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted]org. You do not need to identify yourself.

Dentist Copy

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentist: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
PLAN: [redacted]						PRODUCT: [redacted]					
CLIENT/ID SUBCLIENT: [redacted]											
NETWORK: PREMIER DENTIST											
	11/30/23	D0220	36.00	28.00	8.00	28.00		100%	0.00	28.00	P
POLICY CODE: AP15014											
	11/30/23	D9985	0.58	0.45	0.13	0.45		100%	0.00	0.45	P
POLICY CODE: AP99854,AP15014											
THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.											
A AP15014 - THE PATIENT'S BENEFIT PERIOD MAXIMUM HAS BEEN REACHED.											
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.											
		Total	36.58	28.45	8.13	28.45	0.00		0.00	28.45	

GENERAL MAXIMUM USED TO DATE: 0.00

[redacted]

www[redacted].org
FOR INQUIRIES: 651-994-5436 or 800-465-8953

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
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Dentist Copy

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentist [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

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Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

PLAN: [redacted] PRODUCT: [redacted] PPO PLUS PREMIER
CLIENT/ID [redacted]
SUBCLIENT

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
NETWORK: PREMIER DENTIST											
	12/06/23	D1110	110.00	91.00	19.00	91.00		100%	91.00	0.00	P
	12/06/23	D0120	65.00	53.00	12.00	0.00			0.00	53.00	P
POLICY CODE: EL01010											
	12/06/23	D0274	78.00	58.00	20.00	58.00		100%	58.00	0.00	P
	12/06/23	D9985	4.05	3.23	0.82	2.38		100%	2.38	0.85	P
POLICY CODE: AP99854											
		Total	257.05	205.23	51.82	151.38	0.00		151.38	53.85	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL01010 - ORAL EXAMINATIONS, INCLUDING EMERGENCY EXAMINATIONS AND EXAMINATIONS BY A SPECIALIST, ARE PAYABLE TWICE IN A CALENDAR YEAR.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 357.38

[redacted]

www.[redacted].org
FOR INQUIRIES: 651-406-5901 or 800-448-3815

Payment for these services is determined in accordance with the specific terms of the member's dental plan and/or [redacted] agreements with its contracted dentists.

ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy

09-25-2019

[redacted]

Explanation of Benefits

(THIS IS NOT A BILL)

Patient Name: [redacted]
Date of Birth:
Relationship:
Subscriber:
Subscriber ID:
Patient Acct:

Business/Dentist: [redacted]
License No.:
Check No.:
Issue Date:
Receipt Date:
Claim No.:

Our Dental Office Toolkit offers the ability to search comprehensive claims history, manage transactions for multiple clinics and providers, file claims and pre-treatment estimates, and sign up for EFT and ERA.

Pay To: C = Custodial Parent
S = Subscriber
P = Provider
A = Alternate Provider

PLAN: [redacted] PRODUCT: [redacted] PPO PLUS PREMIER
CLIENT/ID
SUBCLIENT [redacted]

Area/Tooth Code/Surface	Date of Service	Procedure Code	Submitted Amount	Maximum Approved Fee	Contract Dentist Adjustment	Allowed Amount	Deductible / Patient Co-Pay / Office Visits	Co-Pay %	Payment	Patient Payment	Pay To
NETWORK: PREMIER DENTIST											
	12/06/23	D1110	110.00	91.00	19.00	0.00			0.00	91.00	P
POLICY CODE: EL11017											
	12/06/23	D0120	65.00	53.00	12.00	53.00		80%	42.40	10.60	P
	12/06/23	D0274	78.00	58.00	20.00	58.00		80%	46.40	11.60	P
	12/06/23	D9985	4.05	3.23	0.82	1.78		100%	1.42	1.81	P
POLICY CODE: AP99854											
		Total	257.05	205.23	51.82	112.78	0.00		90.22	115.01	

THE FOLLOWING POLICIES ARE APPLIED TO EXPLAIN BENEFITS PAYABLE AND ARE NOT INTENDED TO ALTER THE TREATMENT PLAN DETERMINED BY THE DENTIST AND PATIENT.

EL11017 - PROPHYLAXES (CLEANINGS) ARE PAYABLE TWICE PER CALENDAR YEAR.
AP99854 - THIS IS THE 1.6% MINNESOTACARE TAX AND CALCULATED OFF THE PLAN PAYMENT AMOUNT, AS REQUIRED BY MINNESOTA STATUTE 295.52, SUBD. 2.

GENERAL MAXIMUM USED TO DATE: 2.56

[redacted]

www[redacted].org
FOR INQUIRIES: 651-406-5912 or 800-453-9912

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ANTI-FRAUD HOTLINE 612-224-3277
Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to [redacted] you can help us lower these costs by calling our anti-fraud hotline or email us at reportfraud@[redacted].org. You do not need to identify yourself.

Dentist Copy