UnitedHealthcare

P.O. Box 30567
Salt Lake City, UT 84130-0567

EXPLANATION OF DENTAL PLAN REIMBURSEMENT
THIS IS NOT A BILL

Date: 11/15/2017
Subscriber: DEMO, CHRISDEMO

DPS$$$PKG
DEMO, CHRISDEMO
123 MAIN STREET
SOLON OH 44070

PAYMENT HAS BEEN MADE TO YOUR PROVIDER

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PROVIDER OR MBR NAME AND ID NO; PROVIDER NETWORK STATUS; GROUP NO; CLAIM NO ADA CODE DESCRIPTION	DATE OF SERVICE	TOOTH NO	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID	EOB CODE
John Q. Dentist 90144978900; Out of Network 10311140; 163192367000									
ADA CODE D0120 periodic oral evaluation	11/11/16	01 32	38.00	38.00	0.00	0.00	0.00	38.00	
ADA CODE D0431 adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesi	11/11/16	01 32	10.00	10.00	0.00	0.00	0.00	10.00	
ADA CODE D1110 prophylaxis - adult	11/11/16	01 32	71.00	71.00	0.00	0.00	0.00	71.00	
SUB-TOTAL			119.00	119.00	0.00	0.00	0.00	119.00	

Notes:

Plan underwritten by UnitedHealthcare Insurance Company

Please refer to your benefit plan documents for information regarding eligibility, frequency of benefits and claims information.

	AMOUNT CLAIMED	AMOUNT ALLOWED	DEDUCT APPLIED	OTHER INS	PATIENT RESP	AMOUNT PAID
TOTAL	119.00	119.00	0.00	0.00	0.00	119.00

APPEALS PROCEDURE

A review of this benefit determination may be requested by you or your authorized representative by submitting your appeal to us in writing at the following address: **Attention: Appeals, P.O. Box 30569, Salt Lake City, UT 84130-0569.** The request for your review must be made within 180 days from the date you receive this statement. If you request a review of your claim denial, we will complete our review no later than 30 days after we receive your request for review. Your written request for review should include:

- The member's name, identification number, and group policy number
- The actual service for which a no benefit coverage decision was made
- The reasons why you feel benefit coverage should be provided
- Any available medical information to support your reasons for reversing the benefit decision, if applicable

You may have the right to file a civil action under ERISA if all required reviews of your claim have been completed.

The above described appeals process may not apply to government dental benefit programs that are not related to employment, such as Medicare or Medicaid. If this EOB relates to Medicare or Medicaid coverage, please contact the toll-free number on your ID card for information on how to submit a request for review of this benefit determination.

(MB7228)