## Right of Appeal

If you have questions about your claim, please contact Mutual of Omaha's Customer Service department at 1-800-775-1000. Because most questions about benefits can be answered informally, we encourage you first to try resolving any problem by talking with us. Of course, you have the right to file an appeal requesting that we formally review our claim decision, without making an informal inquiry.

To file an appeal, you must send a written request within 180 days from the date you receive this form to: Mutual of Omaha Insurance Company, Attention: Reevaluation Committee,111 Shuman Boulevard, Naperville, IL 60563. If you have any additional documents, records, or other information in support of your appeal, or if you want to submit written comments, you have the opportunity to do so. They should accompany your written request. Be sure to include the patient name, insured's name, and the insured's identification number on all documents.

You also have the right to an expedited appeal in certain circumstances. Call our customer services number at 1-800-775-1000 to get more information or to request full copy of our Claims Appeals Procedures, or you can find these procedures on our website at: https://www.mutualofomaha.com/dental-insurance

Mutual of Omaha will provide a written decision on your appeal within 30 days.

If You have any questions regarding an appeal or grievance concerning the dental care services that You have been provided which have not been satisfactorily addressed by this Policy, You may contact the Office of the Managed Care Ombudsman for assistance as follows:

Office of the Managed Care Ombudsman Bureau of Insurance, P.O. Box 1157, Richmond, Virginia 23218

Toll free phone 1-877-310-6560, select option 1 Fax (804) 371-9944; ombudsman@scc.virginia.gov

Dental policies are administered, at least in part, by TruAssure Insurance Company.

# Understanding Your Explanation of Benefits (EOB)

After a trip to the dentist's office, you'll likely receive an EOB outlining what your dentist charged for procedures performed, what is covered by your dental plan and what you owe the dentist (if you owe anything). **THIS IS NOT A BILL. It's simply FYI.**

**A** This section contains member and patient identification information, dentist name and the claim number.

**B** **Amount Submitted** is the amount your dentist billed for services performed.

**C** **Allowed Amount** is the amount charged by your dentist that is eligible for payment by you or your dental plan.

**D** **Network Savings** is the amount saved when using a network dentist.

**E** **Coverage Percentage** is the percentage of the allowed amount that is covered by your dental plan.

**F** **Deductible Applied** is the amount applied to your annual deductible — the total you owe before your dental plan starts to pay.

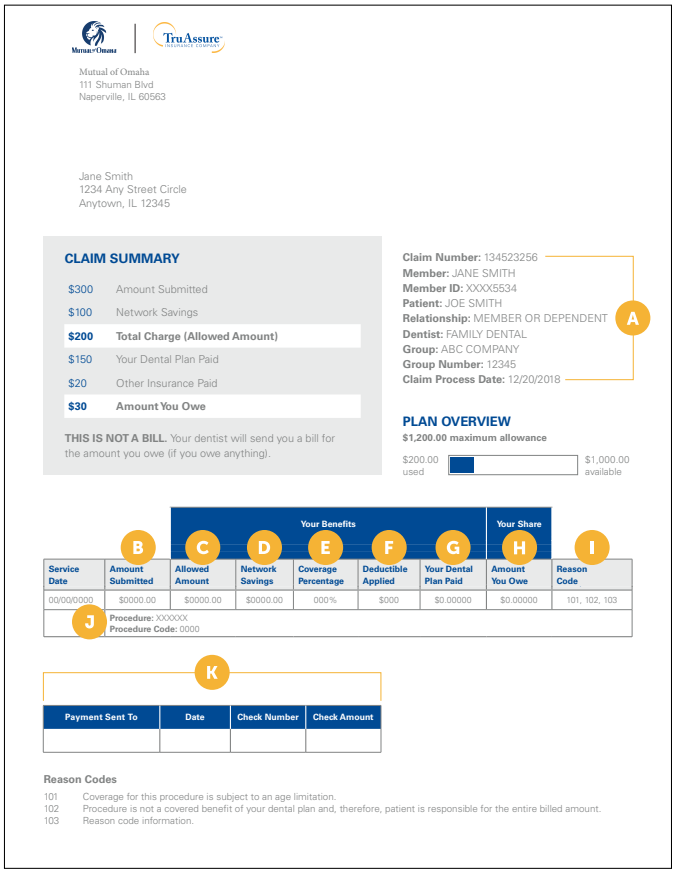
**G** **Your Dental Plan Paid** is the amount covered by your dental plan.

**H** **Amount You Owe** is the portion of the allowed amount that you owe your dentist.

**I** **Reason Codes** explain procedure limitations, non-covered procedures and other reasons why a procedure may not be eligible for payment by your dental plan.

**J** **Procedure Description** and **Procedure Code** explain the services performed on the patient.

**K** This section includes detail about your dental plan's payment.



Mutual of Omaha
111 Shuman Blvd
Naperville, IL 60563

Jane Smith
1234 Any Street Circle
Anytown, IL 12345

**CLAIM SUMMARY**

| | |
|---|---|
| $300 | Amount Submitted |
| $100 | Network Savings |
| **$200** | **Total Charge (Allowed Amount)** |
| $150 | Your Dental Plan Paid |
| $20 | Other Insurance Paid |
| **$30** | **Amount You Owe** |

**THIS IS NOT A BILL.** Your dentist will send you a bill for the amount you owe (if you owe anything).

**Claim Number:** 134523256
**Member:** JANE SMITH
**Member ID:** XXXX5534
**Patient:** JOE SMITH
**Relationship:** MEMBER OR DEPENDENT
**Dentist:** FAMILY DENTAL
**Group:** ABC COMPANY
**Group Number:** 12345
**Claim Process Date:** 12/20/2018

A

**PLAN OVERVIEW**
**$1,200.00 maximum allowance**
$200.00 used — $1,000.00 available

| | | B | C | D | E | F | G | H | I |
|---|---|---|---|---|---|---|---|---|---|
| | | | Your Benefits | | | | | Your Share | |
| Service Date | | Amount Submitted | Allowed Amount | Network Savings | Coverage Percentage | Deductible Applied | Your Dental Plan Paid | Amount You Owe | Reason Code |
| 00/00/0000 | | $0000.00 | $0000.00 | $0000.00 | 000% | $000 | $0.00000 | $0.00000 | 101, 102, 103 |
| J | **Procedure:** XXXXXX<br>**Procedure Code:** 0000 | | | | | | | | |

K

| Payment Sent To | Date | Check Number | Check Amount |
|---|---|---|---|
| | | | |

**Reason Codes**

101 Coverage for this procedure is subject to an age limitation.
102 Procedure is not a covered benefit of your dental plan and, therefore, patient is responsible for the entire billed amount.
103 Reason code information.

If you have any questions, please contact Customer Service at 800-775-1000.