

How to Read your Explanation of Benefits



Florida Combined Life

An Independent Licensee of the
Blue Cross and Blue Shield Association

This is only an illustration of how a claim may be processed and actual provider payments and member cost sharing is determined by your policy.

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**DENTAL
EXPLANATION OF BENEFITS**
KEEP FOR YOUR TAX RECORDS

WWW.FLORIDABLUEDEXPLANATION.COM
DENTAL CUSTOMER SERVICE
PO BOX 69437
HARRISBURG PA 17106-9437

2 Subscriber: _____

3 Patient: _____

4 Provider: _____

5 ID Number: _____

6 Claim Number: _____

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7 Date: _____

PROCEDURE DESCRIPTION (NUMBER OF SERVICES) *TOOTH DESCRIPTION*	9	10	11	12	13	14
	SERVICE DATE(S)	PROVIDER'S CHARGE	ALLOWANCE	AMOUNT PAID	AMOUNT NOT PAID	REMARKS
PORCELAIN CERAMIC CROWN D2740 *10*	(001) 02/29/16	900.00	888.00	427.50	33.00* 427.50* 12.00	DEDUCTIBLE COINSURANCE Q1030
CORE BUILDUP D2950 *10*	(001) 02/29/16	150.00	150.00	120.00	30.00*	COINSURANCE
TOTALS		1050.00	1038.00	547.50	502.50	

Q1030 These services were performed by a Participating Provider. This Provider has agreed not to bill you for the difference between the PROVIDER'S CHARGE and the ALLOWANCE for this service.

You can request a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices by calling 1-800-772-8244.

If you are covered by more than one health benefit plan, you should file all your claims with each plan.

Dental Claims Administrator
PO Box 69438
Harrisburg, PA 17106-9438

HAVE A QUESTION?
PLEASE CALL **1-888-223-4892**
Business Hours: 8am-8pm E.T.
Service for the Deaf via TDD Equipment
is available at 1-800-345-3837.

17 THIS IS NOT A BILL

16 Name _____
Street _____
City, State, Zip _____

1. Your dental insurance carrier, Florida Combined Life Insurance Company, Inc. (FCL)
2. The name of the person who is the policyholder
3. The name of the person who received the services
4. The name of the provider billing for the services (including provider number)
5. FCL's unique customer ID for the member
6. Number assigned to the claim
7. Date Explanation of Benefits (EOB) was printed
8. Description of services performed along with their procedure codes
9. Date each service was performed
10. Amount the provider billed for each service
11. Maximum amount on which FCL will base payment for dental benefits covered under the policy.
12. Amount paid by FCL's dental plan
13. Portion of the bill not covered by your plan (this can include coinsurance, deductible, copayment amounts or amounts not covered by your plan)
14. Indicates an additional message explaining billing (a footnoted explanation indicates the reason)
15. Depending on your plan, you may be responsible for paying the provider the total in the "amount not paid" column, marked with an asterisk (*)
16. Policyholder's name and mailing address
17. FCL's toll-free customer service number

