Florida Blue
Your Health Solutions Partner

Understanding your dental Explanation of Benefits

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

YOU RECEIVED DENTAL CARE FROM SMILEY FACE DENTAL GROUP.

This is your Dental Explanation of Benefits. It shows what we paid and what the dentist charged for your dental care. **This is not a bill. Keep for your tax records.**

1 Subscriber: **FULL NAME**

2 Patient ID: **123456789001**

3 Process Date: **January 31, 2025**

You visited an **out-of-network** dentist. This means you will be required to pay the difference between what the dentist charged and what we paid.

4

Cost Summary	
Charges	$278.00
Paid Amount	$71.20
You may owe the dentist *	$206.80

See Service and Cost Breakdown for details

*The amount you may owe the dentist could include your coinsurance, copays, maximums, deductibles and rejected or denied services.

To learn more
WWW.FLORIDABLUEDENTAL.COM

Have a Question?
PLEASE CALL 1-888-223-4892
Business Hours: 8am-8pm E.T.
Service for the Deaf via TTY Equipment is available at 711.

DENTAL CUSTOMER SERVICE
PO BOX 69437
HARRISBURG, PA 17106 -9437

1105-S (0125)

1. The person or employee who originally enrolled in this dental plan
2. Your member ID number
3. The date we processed your claim
4. A quick view of how much we paid and what you may owe

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Service and Cost Breakdown

Patient: JANE DOE **Patient ID: 123456789001** **Claim Number: 12345678900**

Service	5 Charges	6 Allowed Amount	7 Amount Over Allowed	8 Other Insurance Paid	9 Deductible	10 Copay	11 Co-insurance	12 Not Covered	13 Paid Amount	14 Amount You Owe	Notes
RECEMENT CROWN 01/15/2025	$125.00	$60.11	$64.89 Q1030	$0.00	$50.00	$0.00	$2.02	$0.00	$8.09	$52.02	
LIMITED ORAL EVALUATION 01/15/2025	$102.00	$51.93	$50.07 Q1030	$0.00	$0.00	$0.00	$0.00	$0.00	$51.93	$0.00	
Total	$227.00	$112.04	$114.96	$0.00	$50.00	$0.00	$2.02	$0.00	$60.02	$52.02	

Notes / Not covered

COINSURANCE - A specified percentage of the allowance which is your responsibility.
Depending on your plan benefits, you may owe $206.80.
The Provider has been paid the amount shown in the AMOUNT PAID column.
Q1050 - This amount is the difference between the PROVIDER'S CHARGE and the amount allowed by your coverage.

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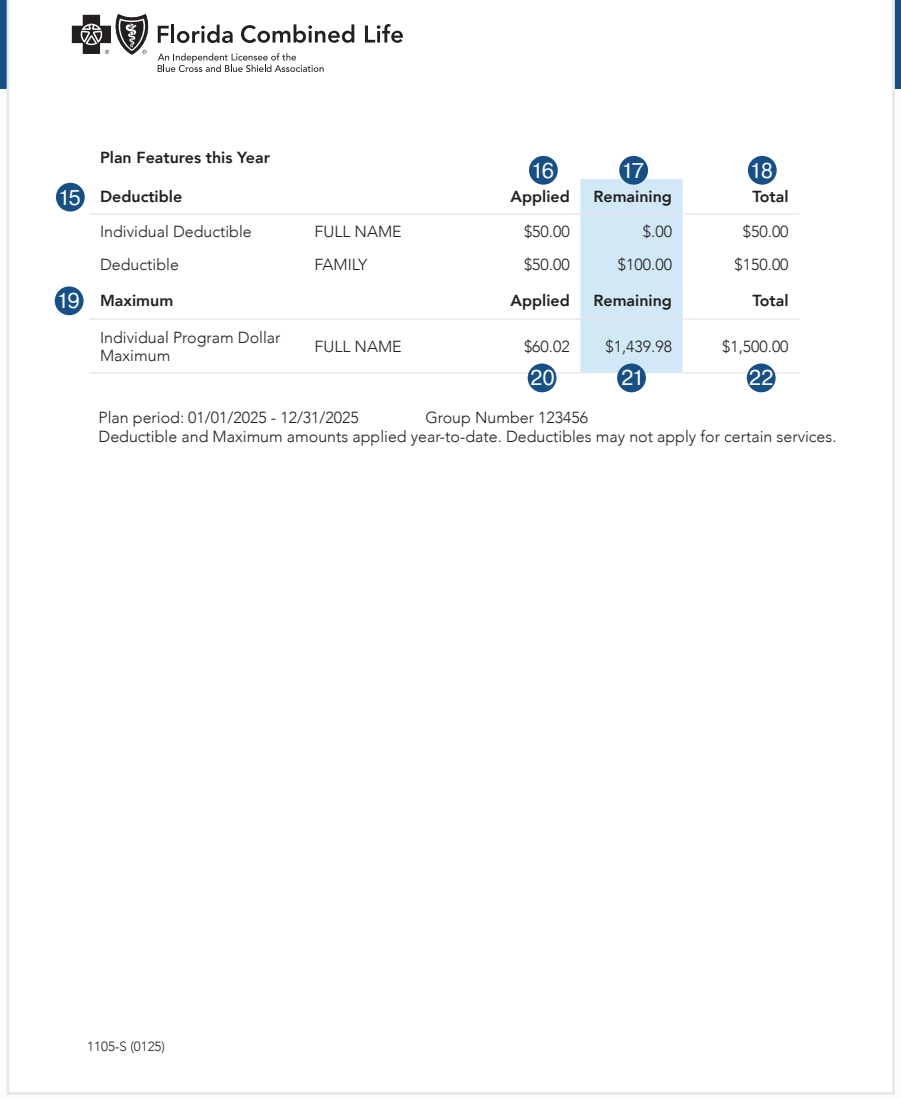
5. The full charge for these services
6. The discounted amount in-network dentists accept as payment
7. The difference between the full charge and the discounted amount
8. How much another insurance plan paid, if you have one
9. The amount you owe toward your annual deductible
10. A set amount you pay each time you get a covered service
11. A percentage of the allowed amount that you pay
12. The amount not covered by your dental plan
13. How much your dental plan paid
14. The amount you may owe the dentist, which could include your coinsurance, copays, or deductibles



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Plan Features this Year

15 Deductible		16 Applied	17 Remaining	18 Total
Individual Deductible	FULL NAME	$50.00	$.00	$50.00
Deductible	FAMILY	$50.00	$100.00	$150.00
19 Maximum		**Applied**	**Remaining**	**Total**
Individual Program Dollar Maximum	FULL NAME	$60.02	$1,439.98	$1,500.00
		20	21	22

Plan period: 01/01/2025 - 12/31/2025 Group Number 123456
Deductible and Maximum amounts applied year-to-date. Deductibles may not apply for certain services.

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15 The amount you must pay each year before your dental plan begins to share in the cost of services; you may have a deductible for the family, and each person covered by the plan may also have a deductible

16 The amount you've already paid toward your yearly deductible

17 How much of the deductible is left to pay

18 Your total deductible amount for the year

19 The most your plan will pay toward dental care in a year

20 The amount your plan has already paid toward dental care

21 How much your plan will continue to pay

22 The total amount your plan will pay in a year