UNDERSTANDING YOUR EXPLANATION OF BENEFITS

DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

WWW.ARKANSASBLUECROSS.COM
DENTAL CUSTOMER SERVICE
P.O. BOX 69437
HARRISBURG PA 17106-9437

(2) Subscriber: (5) ID Number: Page: 1 of 2
(3) Patient: (6) Claim Number: (7) Date:
(4) Provider:

PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES) *TOOTH DESCRIPTION* (8)	(9) SERVICE DATE(S)	(10) PROVIDER'S CHARGE	(11) ALLOWANCE	(12) AMOUNT PAID	(13) AMOUNT NOT PAID	(14) REMARKS
PROPHYLAXIS ADULT (001) D1110	06/29/15	84.00	55.00	26.25	20.00 8.75 29.00	DEDUCTIBLE COINSURANCE Q1050
PERIODIC EVALUATION (001) D0120	06/29/15	47.00	31.00	23.25	(15) 7.75 16.00	COINSURANCE Q1050
BITEWINGS FOUR FILMS (001) D0274	06/29/15	58.00	39.00	29.25	9.75 19.00	COINSURANCE Q1050
	TOTALS	189.00	125.00	78.75	110.25	

Q1050 This amount is the difference between the PROVIDER'S CHARGE and the amount allowed by your coverage.

You can request a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices by calling 1-800-238-8379.
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

(16) Name
Street
City, State, Zip

(17) **HAVE A QUESTION?**
PLEASE CALL **1-888-223-4999**
Business Hours: 8am-8pm E.T.
Service for the Deaf via TDD Equipment is available at 1-800-345-3837.

THIS IS NOT A BILL

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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.

1. Your dental insurance carrier, Arkansas Blue Cross Blue Shield
2. Name of the person who is the policyholder
3. Name of the person who received the services
4. Name of the provider billing for services (including provider number)
5. Arkansas Blue Cross Blue Shield'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. The amount the provider billed for each service
11. Maximum amount on which Arkansas Blue Cross Blue Shield will base payment for dental benefits covered under the policy
12. The amount paid by Arkansas Blue Cross Blue Shield's Dental plan
13. Portion of the bill that is 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 asterick (*)
16. Policyholder's name and mailing address
17. Arkansas Blue Cross Blue Shield's toll-free customer service number

Arkansas
BlueCross BlueShield
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Subscriber: 5 ID Number: Page: 2 of 2

2 Patient: 6 Claim Number: Date:

3 Provider: 7

4 DEDUCTIBLE - The initial portion of payment applicable to certain services for which you are responsible.

15 COINSURANCE - A specified percentage of the allowance which is your responsibility.

The Provider has been paid the amount shown in the AMOUNT PAID column.

18

19 PATIENT SUMMARY FOR:

Patient Name: Identification Number:

Benefit Period: 01/01/15 - 12/31/15 Coverage: Dental Group Number:

For this benefit period, you have satisfied $20.00 of your $20.00 individual deductible.

20 For this benefit period, $78.75 has been applied to your $1,000.00 individual program dollar maximum.

Important information about your appeal rights.

You have the right to appeal a full or partial denial of benefits or payment on a claim for services you have received. Your appeal must be in writing and we must receive it within 180 days following your receipt of this explanation of benefits. We will conduct a full and fair review and provide a written notice of our decision within 60 days of receipt of your appeal. Your request for appeal should be sent to:

Dental Claims Administrator
P.O. Box 69437
Harrisburg, PA 17106-9437

You also have the right to request and receive, free of charge, the following information about the processing of your claim:

1. The specific rule, guideline, protocol or other similar criterion used, if any, in making the benefit or payment decision; and/or
2. An explanation of the scientific or clinical factors relied upon if the claim was denied in whole or in part based on the lack of medical necessity or the experimental or investigational nature of a service.

If you are a participant or beneficiary in an employee welfare benefit plan subject to the Employee Retirement Income Security Act (ERISA), you may have the right to file a civil action under Section 502 (a) of ERISA if your claim is denied after all appeal steps required by your plan have been completed. You should contact your employer or consult with an attorney if you are not sure whether you have the right to sue under ERISA.

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18. **Deductible** – charges the insured must pay each Benefit Year / Contract Year before Arkansas Blue Cross Blue Shield's dental benefits reimbursement begins
19. **Coinsurance** – a percentage of the allowance that is your responsibility. Example: if a filling is covered at 60% of the allowance, you are responsible for the other 40%
20. **Patient Summary** – a summary of the patient's Benefit Year/Contract Year, including what has been applied to the patient's maximum and/or deductible
21. **Appeal Rights** – you, or a representative designated by you in writing, have the right to appeal an adverse benefit determination

Arkansas BlueCross BlueShield
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Arkansas Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association and is licensed to offer health plans in all 75 counties of Arkansas.
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