How to Read Your Medical Explanation of Benefits (EOB)

An EOB is not a bill. It explains how your benefits have been applied to your health care services and details what you may owe after your health insurance claim has been processed. If you have questions about your EOB, we're here to help. Call Member Services at 1-800-442-2376, Monday through Friday, 8 a.m. to 5 p.m., TTY: 711, TDD: 1-800-696-4710. Get your medical EOBs electronically from your account on *YourWyoBlue.com*.

Explanation of Health Care Benefits

Claim Information

1 Subscriber Name SAMUEL SAMPLE

2 Patient Name SAMUEL SAMPLE

THIS IS NOT A BILL. This is an explanation of the claim processed based on your plan benefits in effect when the service was performed. Please keep this form for your tax records.

3 Claim Number: 12345678910 6 Patient ID: 01234567890 7 Patient Control Number: 1234567890123 8 Group Number: 12345678

4 Group Name: ABC CORP.

5 Provider: MEDICAL CENTER

9 Dates of Service/ Description	10 Charges	11 Provider Responsibility Amount	12 Allowed Amount	13 Patient Non-covered Amount	14 Amount Pd by Other Ins	15 Deductible Amount	16 Co-pay Amount	17 Co-Insurance Amount	18 Paid Amount	19 Amount You Owe	20 Notes ID
05/12/2015 - 05/12/2015 OFFICE VISIT	100.00	57.25	42.75	.00	.00	.00	40.00	.00	2.75	40.00	
05/12/2015 - 05/12/2015 BIOPSY	200.00	169.03	30.97	.00	.00	30.97	.00	.00	.00	30.97	X5018
05/12/2015 - 05/12/2015 THERAPEUTIC INJECTION	200.00	125.38	74.62	.00	.00	74.62	.00	.00	.00	74.62	X5018
05/12/2015 - 05/12/2015 PHYSICAL MEDICINE	17.00	17.00	.00	.00	.00	.00	.00	.00	.00	.00	H5031
TOTAL	517.00	368.66	148.34	.00	.00	105.59	40.00	.00	2.75	145.59	

Note:

H5031 This is an add-on Procedure Code and must be submitted with a primary procedure. The member ID, relationship and date of service must match those submitted with the primary procedure charge and the performing provider must be associated with the billing provider.

X5018 The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

21 Plan (or Program) Benefits Summary

Patient: SAMPLE SAMUEL

Benefit Period: 01/01/2019 - 12/31/2019
You have satisfied $517.61 of your $1,000.00 individual in network deductible.

$517.61 has been applied to your $2,500.00 individual in network out-of-pocket limit.

Please refer to your benefit booklet for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

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1. **Subscriber Name:** the policyholder
2. **Patient Name:** the member on your plan who received the services
3. **Claim Number:** the number assigned to the claim for identification purposes
4. **Group Name:** the name of your employer group, if applicable
5. **Provider:** the facility or professional providing the services, such as a hospital or a doctor
6. **Patient ID:** your member identification number
7. **Patient Control Number:** this is a provider-assigned number used to track the claim
8. **Group Number:** the number assigned to your health plan
9. **Dates of Service/Description:** the date(s) and a brief description of the services
10. **Charges:** the amount the provider charged for the services
11. **Provider Responsibility Amount:** the provider is responsible for this difference between the charged amount and the amount allowed by BCBSWY. A BCBSWY network provider will not bill you for this amount. However, you may be responsible for this amount if you received services from an out of network provider.
12. **Allowed Amount:** the amount BCBSWY allows for covered services
13. **Patient Non-Covered Amount:** the charges for services not covered by your health plan will be your responsibility
14. **Amount Pd by Other Ins:** the amount paid by other health insurance you may have
15. **Deductible Amount:** the amount shown will be applied toward your deductible. The deductible is the amount you pay for covered services before BCBSWY begins to pay.
16. **Co-pay Amount:** the fixed amount you pay for covered services like office visits or emergency room visits
17. **Co-Insurance Amount:** reflects a percentage of the cost you pay for covered services after you have met your deductible
18. **Paid Amount:** the total amount BCBSWY will pay for covered services
19. **Amount You Owe:** the total amount you will owe, including any deductible, coinsurance or copay amounts
20. **Notes ID:** these codes correspond to additional information provided under "**Note:**"
21. **Plan (or Program) Benefits Summary:** Expenses you pay for services, like deductibles and out-of-pocket limits, are added together and shown in the ***Plan Benefits Summary*** for the patient and the ***Program Benefits Summary*** for the whole family (if applicable). The summaries include amounts from all claims being processed during the benefit period, including those which will show on future EOBs that are still being prepared.

Note: *If you receive an EOB with blocked out information, it is due to the services being done by an out of network provider and payment is being made to the subscriber. If no payment is being made, then the EOB will be sent directly to the patient and not the subscriber. Please login to your YourWyoBlue.com account to see claims details for more information or call Member Services at 800-442-2376 to request an unmasked EOB if the dependent is under 18.*

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How to Read Your Dental Explanation of Benefits (EOB)

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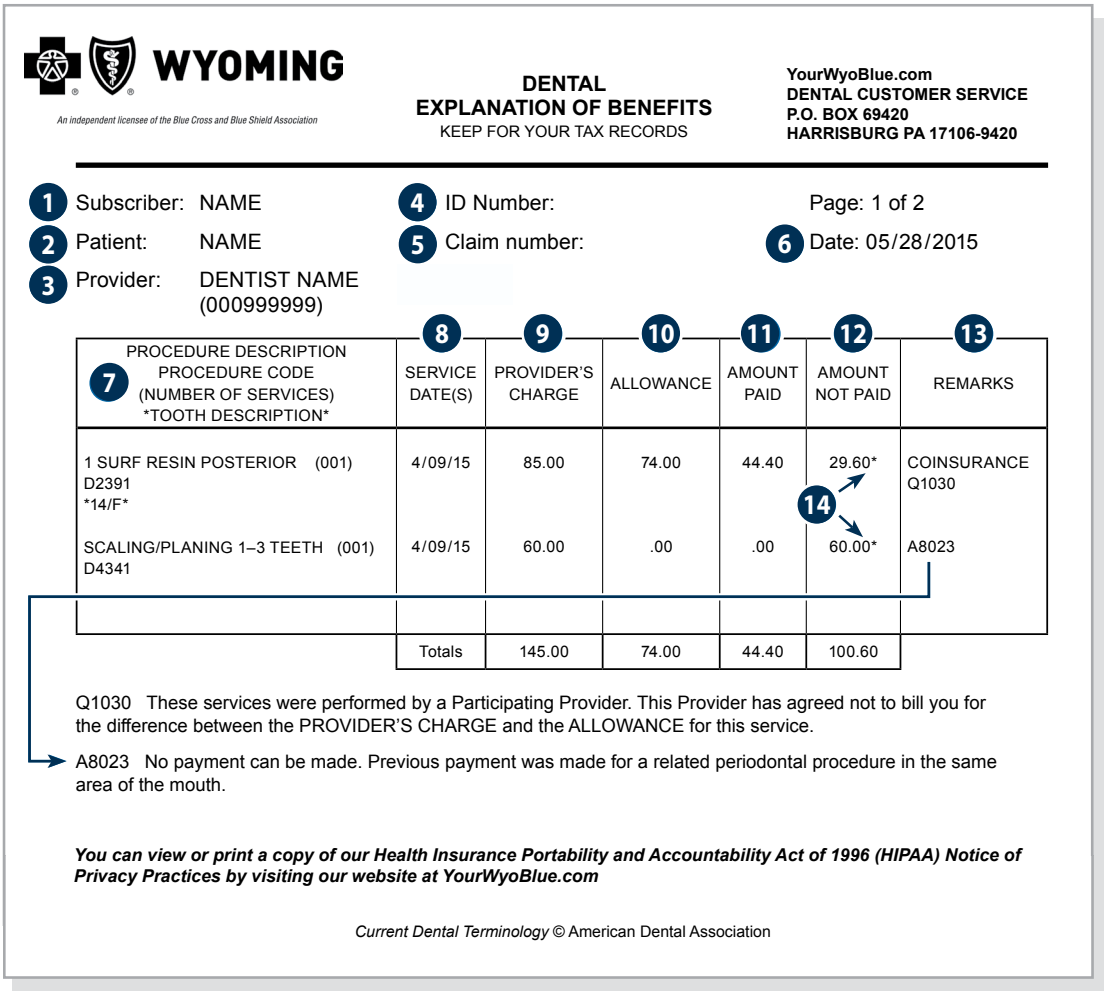
1. **Subscriber:** the policyholder
2. **Patient:** the member on your plan who received the services
3. **Provider:** the facility or professional providing the services
4. **ID Number:** your member identification number
5. **Claim Number:** the number assigned to the claim for identification purposes
6. **Date:** the date the EOB was printed
7. **Procedure Details:** a brief description of services and procedure codes
8. **Service Date(s):** the date(s) of the services
9. **Provider's Charge:** the amount the provider charged for the services
10. **Allowance:** the amount BCBSWY allows for covered services. A BCBSWY network provider will not bill you for the difference between the provider's charge and the allowance. If you received services from an out of network provider, you may be responsible for the difference.
11. **Amount Paid:** the amount BCBSWY will pay for covered services



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DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

YourWyoBlue.com
DENTAL CUSTOMER SERVICE
P.O. BOX 69420
HARRISBURG PA 17106-9420

1 Subscriber: NAME
2 Patient: NAME
3 Provider: DENTIST NAME (000999999)
4 ID Number:
5 Claim number:
Page: 1 of 2
6 Date: 05/28/2015

7 PROCEDURE DESCRIPTION PROCEDURE CODE (NUMBER OF SERVICES) *TOOTH DESCRIPTION*	8 SERVICE DATE(S)	9 PROVIDER'S CHARGE	10 ALLOWANCE	11 AMOUNT PAID	12 AMOUNT NOT PAID	13 REMARKS
1 SURF RESIN POSTERIOR (001) D2391 *14/F*	4/09/15	85.00	74.00	44.40	29.60*	COINSURANCE Q1030
SCALING/PLANING 1–3 TEETH (001) D4341	4/09/15	60.00	.00	.00	60.00*	A8023
	Totals	145.00	74.00	44.40	100.60	

14

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.

A8023 No payment can be made. Previous payment was made for a related periodontal procedure in the same area of the mouth.

You can view or print a copy of our Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices by visiting our website at YourWyoBlue.com

Current Dental Terminology © American Dental Association

12. **Amount Not Paid:** the amount not paid by BCBSWY
13. **Remarks:** message or code providing additional explanation
14. *** (asterisk):** amounts you will owe (including any deductible, coinsurance or copay amounts) are marked with an * in the "**Amount Not Paid**" column

15. Out-of-pocket costs that may apply to covered services:

Deductible: the amount you pay for covered services before BCBSWY begins to pay.

Coinsurance: a percentage of the cost you pay for covered services after you have met your deductible

Copay: the fixed amount you pay for covered services

16. Patient Summary: a summary of the patient's benefits for the benefit period, including what has been applied to the patient's out-of-pocket costs and maximum.

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DENTAL
EXPLANATION OF BENEFITS
KEEP FOR YOUR TAX RECORDS

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DENTAL CUSTOMER SERVICE
P.O. BOX 69420
HARRISBURG PA 17106-9420

1 Subscriber: NAME
2 Patient: NAME
3 Provider: DENTIST NAME (000999999)
4 ID Number:
5 Claim number:
Page: 2 of 2
6 Date: 05/28/2015

14 * Depending on the terms of your coverage, you may be held responsible to the provider for the amounts in the AMOUNT NOT PAID column. These amounts are indicated with an (*) asterisk.

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.

16 PATIENT SUMMARY FOR:

Patient Name: NAME Identification Number:

Benefit Period: 09/01/14 – 08/31/15

For this benefit period, $163.40 has been applied to your $1,500.00 individual program dollar maximum.

Important Information about Your Explanation of Health Care Benefits (EOB)

Notice of Appeal Rights

If you are not satisfied with the explanation, you may file a written appeal.

- You must file your appeal within 180 days following receipt of notice of an Adverse Benefit Determination (ABO). If not included with this EOB, your benefit booklet contains information about the appeal timelines and a complete description of the appeal process.
- Send your appeal to Dental Customer Service, P.O. Box 69420, Harrisburg, PA 17106-9420.
- You may review the claim file, present evidence and testimony, and submit written comments, records and other information related to your claim. We will consider all submissions in making our decision.
- You have the right to ask for any relevant documents, records or other information used to process your claim. If your claim has been denied because it was determined to be investigative or not medically necessary, you may ask for the scientific or clinical judgement used for your claim. Information will be provided to you free of charge.
- We will notify you of our decision within 45 days of receiving your appeal.

Further Appeals. You may be eligible for a further external review of your appeal and a filing fee may be required. In certain cases, our determination letter may include information about how to request further review. You may also find information in your benefit booklet or contact us about an external review.