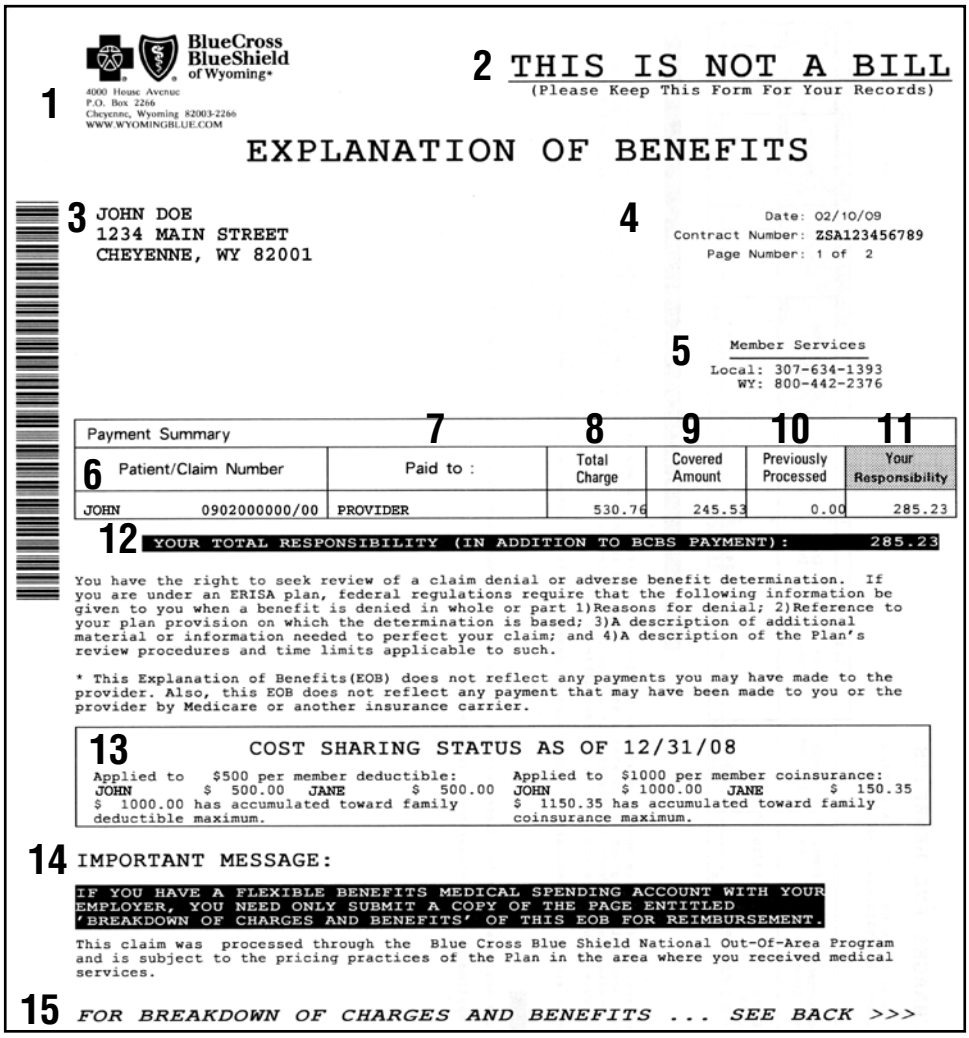
# How to Read Your Explanation of Benefits

This form has been designed to help explain how health care claims are processed. The major features of the Explanation of Benefits (EOB) include:




1. **Address** – The mailing and web site address for Blue Cross Blue Shield of Wyoming.
2. **This Is Not A Bill** – A reminder that this EOB is designed to provide information regarding the processing of claims and is not a bill.
3. **Patient's Name and Address** – The name and address of the patient as shown on our records.
4. **Date** – Date the EOB is printed.
   **Contract Number** – The patient's Blue Cross Blue Shield of Wyoming identification number.
   **Page Number** – Identifies the number of EOB pages for the claim(s) reported.
5. **Member Services Phone Numbers** – The numbers you should call with any questions you may have regarding the processing of claims or information displayed on this EOB.
6. **Patient/Claim Number** – The name of the patient who received the service and the claim number designated for the purposes of identification.
7. **Paid To** – The name of the individual or provider that was paid for the service.
8. **Total Charge** – The total charge billed by the provider of service.
9. **Covered Amount** – The portion of the claim that has been paid by this plan and/or discounted by the provider.
10. **Previously Processed** – Any amount previously processed by this plan, Medicare or another insurance company.
11. **Your Responsibility** – The portion of the claim that you are responsible to pay to your provider.
12. **Your Responsibility to the Provider** – The total amount for all claims noted on this EOB that you are responsible to pay your provider(s).
13. **Year to Date Cost Sharing Status** – The total deductible, coinsurance, and/or copayment as described in sections 26, 27 and 28 in the *Breakdown of Charges and Benefits* section of your EOB that you and/or your family members have accumulated year to date. These totals may reflect claims in process for which you have not yet received an EOB. Only family members who had claims will be listed.
14. **Important Message** – This space has been reserved for general messages that may apply to you.
15. **For Breakdown of Charges and Benefits** – A reminder that a detailed breakdown of how your claims were processed begins on the reverse side of your EOB.

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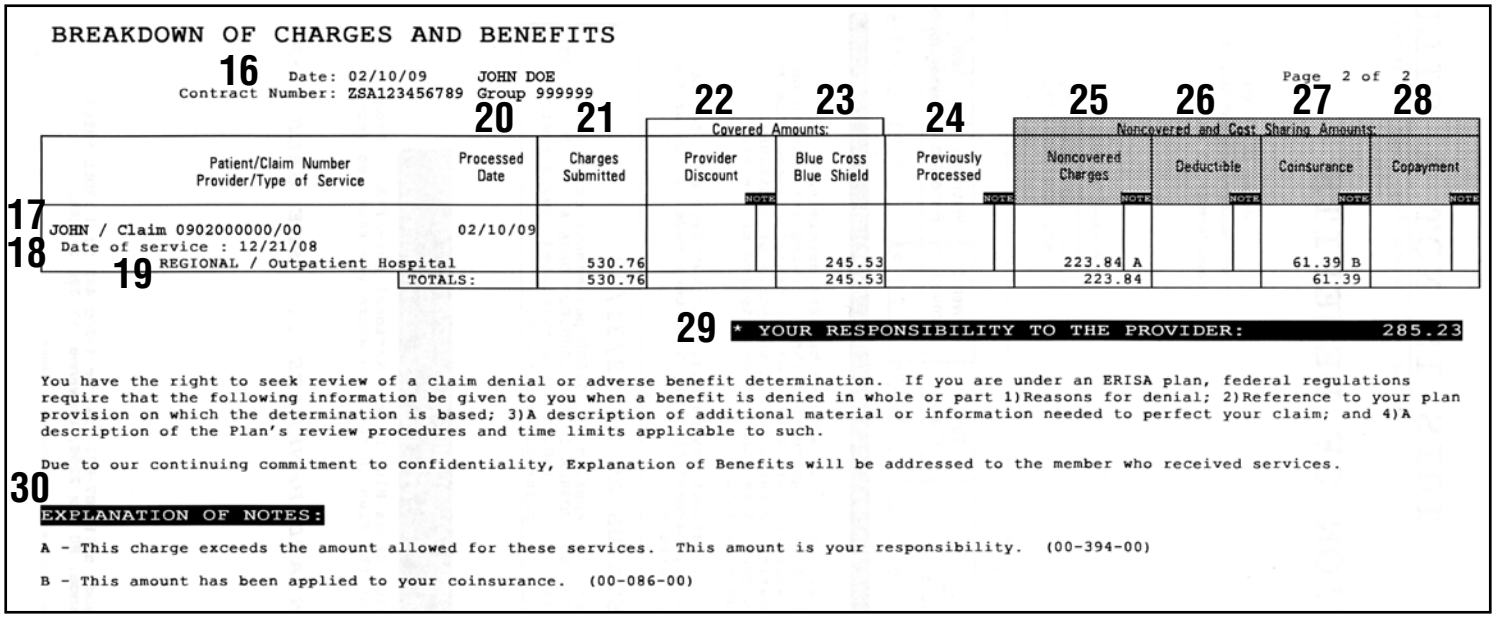
**More helpful information on the reverse side**



BREAKDOWN OF CHARGES AND BENEFITS

16 Date: 02/10/09 JOHN DOE
Contract Number: ZSA123456789 Group 999999

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| 17 Patient/Claim Number / 19 Provider/Type of Service | 20 Processed Date | 21 Charges Submitted | 22 Covered Amounts: Provider Discount | 23 Covered Amounts: Blue Cross Blue Shield | 24 Previously Processed | 25 Noncovered and Cost Sharing Amounts: Noncovered Charges | 26 Noncovered and Cost Sharing Amounts: Deductible | 27 Noncovered and Cost Sharing Amounts: Coinsurance | 28 Noncovered and Cost Sharing Amounts: Copayment |
|---|---|---|---|---|---|---|---|---|---|
| JOHN / Claim 0902000000/00 | 02/10/09 | | | | | | | | |
| 18 Date of service : 12/21/08 | | | | | | | | | |
| REGIONAL / Outpatient Hospital | | 530.76 | | 245.53 | | 223.84 A | | 61.39 B | |
| TOTALS: | | 530.76 | | 245.53 | | 223.84 | | 61.39 | |

29 * YOUR RESPONSIBILITY TO THE PROVIDER: 285.23

You have the right to seek review of a claim denial or adverse benefit determination. If you are under an ERISA plan, federal regulations require that the following information be given to you when a benefit is denied in whole or part 1)Reasons for denial; 2)Reference to your plan provision on which the determination is based; 3)A description of additional material or information needed to perfect your claim; and 4)A description of the Plan's review procedures and time limits applicable to such.

Due to our continuing commitment to confidentiality, Explanation of Benefits will be addressed to the member who received services.

30 EXPLANATION OF NOTES:

A - This charge exceeds the amount allowed for these services. This amount is your responsibility. (00-394-00)

B - This amount has been applied to your coinsurance. (00-086-00)

16. **Date** – Date the EOB was printed.
**Patient's Name** – Person receiving the services.
**Contract Number** – The patient's Blue Cross Blue Shield of Wyoming identification number.
**Group Number** – The patient's health insurance plan group number.
17. **Patient/Claim Number** – The name of the patient who received the service and the claim number designated for the purpose of identification.
18. **Date of Service** – The date the service was performed.
19. **Provider/Type of Service** – The name of the provider that performed the service and the type of service that was performed.
20. **Processed Date** – The date that claim processing was completed.
21. **Charges Submitted** – The charge billed by your provider for each service performed.
22. **Provider Discount** – The portion of the charge that may have been discounted by your provider.
23. **Blue Cross Blue Shield** – The amount the patient's coverage paid toward each service.
24. **Previously Processed** – Any amount previously processed by this plan, Medicare or another insurance company.
25. **Noncovered Charges** – The charges that are not covered according to the terms set forth in your benefit plan.
26. **Deductible** –Before the plan pays benefits in certain categories, you must first pay a portion of the covered charges. The amount you pay is called a deductible.
27. **Coinsurance** – A percentage of the cost of care that you pay based on your benefit plan. Coinsurance is applied after deductible amounts, if applicable.
28. **Copayment** – Specified dollar amount that you pay for certain services based on your benefit plan.
29. **Your Responsibility to the Provider** – The total amount that you are responsible to pay to your provider(s) from sections 25, 26, 27 and 28.
30. **Explanation of Notes** – Explanations or descriptions corresponding to the amount(s) noted in sections 22, 24, 25, 26, 27 and 28 shown on the *Breakdown of Charges and Benefits*.

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Please call our Member Services department with any questions you may have about your EOB. Call toll-free 1-800-442-2376, Monday–Friday, 8AM–5PM, Mountain Time.