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.

5. **Contract Number** – The patient’s Blue Cross Blue Shield of Wyoming identification number.

6. **Page Number** – Identifies the number of EOB pages for the claim(s) reported.

7. **Patient/Claim Number** – The name of the patient who received the service and the claim number designated for the purposes of identification.

8. **Paid To** – The name of the individual or provider that was paid for the service.

9. **Total Charge** – The total charge billed by the provider of service.

10. **Covered Amount** – The portion of the claim that has been paid by this plan and/or discounted by the provider.

11. **Previously Processed** – Any amount previously processed by this plan, Medicare or another insurance company.

12. **Your Responsibility** – The portion of the claim that you are responsible to pay to your provider.

13. **Your Responsibility to the Provider** – The total amount for all claims noted on this EOB that you are responsible to pay your provider(s).

14. **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.

15. **Important Message** – This space has been reserved for general messages that may apply to you.

16. **For Breakdown of Charges and Benefits... See Back >>**

More helpful information on the reverse side
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.

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.