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.

22 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.

WYOMING

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:** the amounts recently applied to the patient's individual benefits are described in the ***Plan Benefits Summary.*** The amounts recently applied to the family (or overall) benefits are described in the ***Program Benefits Summary.*** *The summaries may include amounts shown on the EOB, and/or amounts from other EOBs, and/or amounts from claims still being processed.*
22. *Amounts shown in the Benefits Summaries may include amounts that are not shown on this particular EOB. The summaries may include amounts from other EOBs or amounts from claims still being processed.*