Understanding Your Explanation of Benefits (EOB)



We're dedicated to helping you manage your healthcare in the best way possible. To help you get the most from your healthcare coverage while keeping your out-of-pocket costs down, it's important to understand your benefit plan. Understanding your Explanation of Benefits (EOB) will help.

Your Explanation of Benefits

Your EOB details recent claims and how they were paid. It also explains why claims were denied. An EOB is not a bill.

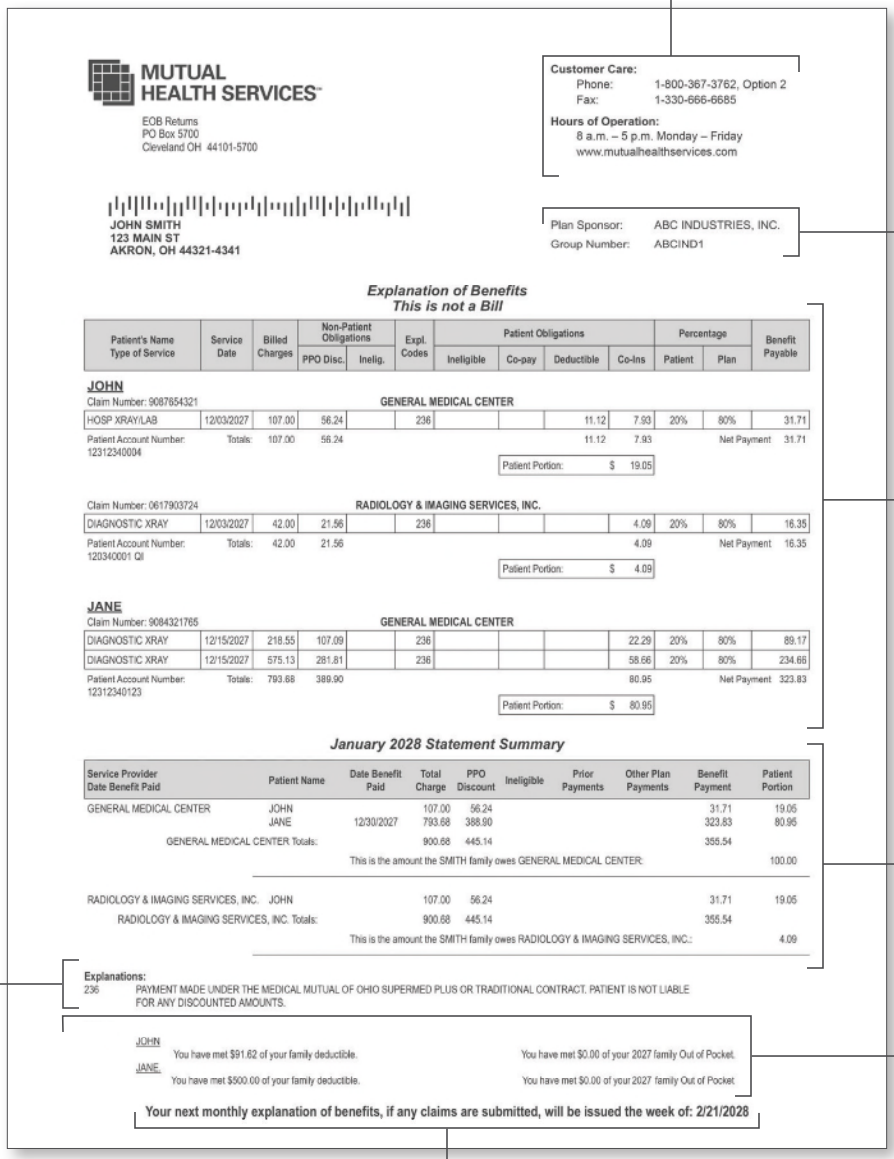
Here's what you'll find on your EOB:

- How to contact our Customer Care team when you have questions or need help.
- Your group number is included on your EOB. You'll be asked for this number any time you call Customer Care for help.
- Claim details for every claim we've processed for you or a covered dependent during the specified month. You may also find notes with more details about your benefits.
- A summary of charges, payments, and any amounts owed for claims processed during the month.
- How much you and any covered dependents have contributed toward your annual deductible(s) and out-of-pocket maximum(s).

You will find a sample EOB on the back page of this handout. If you need more information or have questions, call Customer Care at the number on your EOB.

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MUTUAL HEALTH SERVICES℠



MUTUAL HEALTH SERVICES™

EOB Returns
PO Box 5700
Cleveland OH 44101-5700

Customer Care:
Phone: 1-800-367-3762, Option 2
Fax: 1-330-666-6685

Hours of Operation:
8 a.m. – 5 p.m. Monday – Friday
www.mutualhealthservices.com

JOHN SMITH
123 MAIN ST
AKRON, OH 44321-4341

Plan Sponsor: ABC INDUSTRIES, INC.
Group Number: ABCIND1

Explanation of Benefits
This is not a Bill

Patient's Name / Type of Service	Service Date	Billed Charges	Non-Patient Obligations: PPO Disc.	Non-Patient Obligations: Inelig.	Expl. Codes	Patient Obligations: Ineligible	Patient Obligations: Co-pay	Patient Obligations: Deductible	Patient Obligations: Co-Ins	Percentage: Patient	Percentage: Plan	Benefit Payable
JOHN												
Claim Number: 9087654321					GENERAL MEDICAL CENTER							
HOSP XRAY/LAB	12/03/2027	107.00	56.24		236			11.12	7.93	20%	80%	31.71
Patient Account Number: 12312340004	Totals:	107.00	56.24					11.12	7.93		Net Payment	31.71
								Patient Portion:	$ 19.05			
Claim Number: 0617903724					RADIOLOGY & IMAGING SERVICES, INC.							
DIAGNOSTIC XRAY	12/03/2027	42.00	21.56		236				4.09	20%	80%	16.35
Patient Account Number: 120340001 QI	Totals:	42.00	21.56						4.09		Net Payment	16.35
								Patient Portion:	$ 4.09			
JANE												
Claim Number: 9084321765					GENERAL MEDICAL CENTER							
DIAGNOSTIC XRAY	12/15/2027	218.55	107.09		236				22.29	20%	80%	89.17
DIAGNOSTIC XRAY	12/15/2027	575.13	281.81		236				58.66	20%	80%	234.66
Patient Account Number: 12312340123	Totals:	793.68	389.90						80.95		Net Payment	323.83
								Patient Portion:	$ 80.95			

January 2028 Statement Summary

Service Provider / Date Benefit Paid	Patient Name	Date Benefit Paid	Total Charge	PPO Discount	Ineligible	Prior Payments	Other Plan Payments	Benefit Payment	Patient Portion
GENERAL MEDICAL CENTER	JOHN		107.00	56.24				31.71	19.05
	JANE	12/30/2027	793.68	388.90				323.83	80.95
GENERAL MEDICAL CENTER Totals:			900.68	445.14				355.54	
This is the amount the SMITH family owes GENERAL MEDICAL CENTER:									100.00
RADIOLOGY & IMAGING SERVICES, INC.	JOHN		107.00	56.24				31.71	19.05
RADIOLOGY & IMAGING SERVICES, INC. Totals:			900.68	445.14				355.54	
This is the amount the SMITH family owes RADIOLOGY & IMAGING SERVICES, INC.:									4.09

Explanations:
236 PAYMENT MADE UNDER THE MEDICAL MUTUAL OF OHIO SUPERMED PLUS OR TRADITIONAL CONTRACT. PATIENT IS NOT LIABLE FOR ANY DISCOUNTED AMOUNTS.

JOHN — You have met $91.62 of your family deductible. — You have met $0.00 of your 2027 family Out of Pocket.
JANE — You have met $500.00 of your family deductible. — You have met $0.00 of your 2027 family Out of Pocket.

Your next monthly explanation of benefits, if any claims are submitted, will be issued the week of: 2/21/2028

Customer Care Information
Website, address and phone numbers where you can send questions and get answers.

Plan Sponsor
The name of your employer group, which is important for claims questions.

Claim Details
1. Claimant
   The person who received service(s).
2. Claim Number
3. List of Services Billed
   How your claim was processed.
4. Billed Charges
   The dollar amount your healthcare provider billed for services given.
5. Non-patient Obligations
   The amount your benefit plan pays for this service. You are not responsible for paying this amount.
6. Patient Obligations
   The amount your plan pays for this service. You are responsible for paying this amount.
7. Percentage
   The coinsurance percentages for your plan and the patient.
8. Benefits Payable
   The amount your plan paid.
9. Patient Portion
   The amount you have to pay.

Monthly Statement Summary
Includes the total family charges, payments and total family amount owed for claims processed during the month.

Deductible and Coinsurance Balances
The deductible and out-of-pocket amounts you and your dependents have met for the plan year. Some totals might be combined amounts based on the benefit plan.

Next Monthly EOB Statement Date
Applicable only if any claims are submitted.

Explanation Codes
Additional benefit information.