



Reading an Explanation of Benefits (EOB) Online

How to Read It Online Why It's Not a Bill and How to Spot Errors

————— **An Extended Guide · No. 1761** —————

Tech Made Simple. Service Made Personal.

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SUMMARY

The 60-Second Version

If you read one page first, make it this one. An Explanation of Benefits (EOB for short) is a summary your insurer sends after you get care. The most important thing to know is right on it: "This is not a bill." It is a receipt and an explanation, not a request for money.

- It shows what the provider billed, what Medicare or your plan approved and paid, and the most you might owe.
- With Original Medicare you get a Medicare Summary Notice; with a Medicare Advantage or drug plan you get an EOB from the plan.
- You can see your claims online, usually within a day — no need to wait for the paper copy.
- Always wait for the provider's actual bill and match it against the EOB before you pay a penny.

WATCH OUT

This is information, not medical or financial advice. I help you find, open, and read these documents on your computer or phone. Questions about what a charge means, what you truly owe, or your health belong with your plan, your doctor's billing office, or 1-800-MEDICARE.

THE BASICS

1. What an EOB Actually Is

A receipt for your care, not a demand for payment.

Every time you see a doctor, have a test, or pick up a covered service, the provider sends a charge to Medicare or to your health plan. The plan looks at it, pays its part, and figures out your part. Then it sends you a summary of all that — the Explanation of Benefits. It's a record of what happened with the money, nothing more.

Think of it the way you'd think of a receipt from the pharmacy that shows what insurance covered. It tells you the story of the charge: here's what the doctor asked for, here's what was allowed, here's what got paid, and here's the piece that may land on your side. No action is required the moment it arrives.

GOOD TO KNOW

"Explanation of Benefits" is just a fancy way of saying "here's what your coverage did for this visit." Different plans format it differently, but every one is telling you the same four things.

THE BIG ONE

2. "This Is Not a Bill"

The single most important sentence on the page.

If you remember only one thing from this whole guide, remember this: an EOB is not a bill. Those exact words — or something very close — are printed right on it, usually near the top. It is not asking you to send money. It is not overdue. You do not owe anything just because it arrived.

This trips up good, careful people all the time. They see a large "billed" number, assume it's due, and either panic or rush to pay it. Neither is necessary. The EOB comes first, as an explanation. If you actually owe something, a separate bill will come later from the doctor's office or hospital — and that one will clearly say "amount due" or "please pay."

WATCH OUT

Never pay money straight off an EOB. If a document tells you what Medicare or your plan paid, it's an explanation. If it says "amount due," "please remit," or has a payment stub, that's the actual bill. Pay only the second kind — and only after you've matched it to the EOB.

WHICH ONE

3. MSN or EOB — Which You Get

It depends on how you get your Medicare.

There are two cousins here, and which one lands in your mailbox depends on your coverage. If you have Original Medicare (Part A and Part B, the red-white-and-blue card), you get a Medicare Summary Notice, or MSN. If you have a Medicare Advantage plan or a stand-alone drug plan, you don't get an MSN — your private plan sends you its own Explanation of Benefits instead.

- Original Medicare: a Medicare Summary Notice from Medicare itself, covering your Part A and Part B services.

- Medicare Advantage (Part C): an EOB from the insurance company that runs your plan.
- Part D drug plan: a separate EOB listing your prescriptions and where you are in the year's drug costs.

GOOD TO KNOW

They're built for the same job and read almost the same way, so don't worry about the name. Throughout this guide, when I say "EOB," the advice applies to your Medicare Summary Notice too.

ANATOMY

4. The Columns, One by One

Four numbers tell the whole story.

Once you know the four main columns, every EOB in the world reads the same. The labels vary a little from plan to plan, but the ideas don't. Here they are in the order they usually appear, left to right.

- Billed (or "amount charged"): the full price the provider asked for. Almost always the biggest, scariest number.
- Approved (or "allowed" or "Medicare-approved"): the amount Medicare or your plan agrees the service is worth.
- Paid by plan (or "Medicare paid"): what your coverage actually sent to the provider.
- Your share (or "you may owe," "patient responsibility"): the piece that may fall to you — and the only number worth watching.

Read them as a sentence: "The doctor charged this, Medicare allowed that, paid this much, and my share may be that last little bit." The first three are the plan's business. The last one is yours.

BIG NUMBER

5. Why the Billed Amount Isn't What You Owe

The sticker price almost nobody actually pays.

The billed amount is the number that makes people gasp. A routine visit might show a charge that looks wildly high. Take a breath — that's the provider's list price, not your bill. Medicare and insurance plans negotiate set rates, and the billed amount is almost always much more than anyone ever pays.

It's a bit like the sticker on a car window. Nobody expects to pay it. It's a starting point, and the "approved" column right next to it is the figure that actually matters. The gap between the two is simply written off — you are not responsible for it, and you never will be.

TIP

When a big billed number startles you, slide your eye one column to the right. The approved amount is the real-world number, and your share is smaller still. The scary number is mostly for show.

THE REAL ONE

6. The Approved Amount

The number that actually counts.

The approved amount — you may see it as "allowed," "eligible," or "Medicare-approved" — is the heart of the whole document. It's the agreed-upon value of the service. Everything else is figured from it: the plan pays its percentage of this number, and your share is a slice of this number, not the billed one.

This is why the billed amount can be ignored. If a service is billed high but approved low, your share is based on the low, approved figure. For a service Medicare covers, the provider has agreed to accept the approved amount as full payment — which protects you from the difference.

GOOD TO KNOW

Providers who "accept assignment" agree to Medicare's approved amount. Most do. If a provider doesn't, there can be a small extra charge — your doctor's office can tell you whether they accept assignment.

WHO PAID

7. What Medicare or Your Plan Paid

The coverage doing its job.

The "paid" column shows the money your coverage sent to the provider on your behalf. For a typical Part B service, that's about eighty percent of the approved amount after your yearly deductible is met. Seeing a healthy number here is a good thing — it's exactly what you pay premiums for, working as intended.

You don't need to check this figure against anything or do math on it. It's informational. The only reason to glance at it is reassurance: it shows your coverage recognized the service and paid its part. A zero here, paired with a "denied" note, is the one case worth a closer look — more on that later.

YOUR PART

8. Your Share — The Only Number to Watch

Deductible, coinsurance, and copays.

The last column is the one with your name on it. It's labeled something like "your share," "you may owe," or "patient responsibility." This is the piece the provider may bill you for. It's built from up to three things, and it helps to know which is which.

- Deductible: the amount you pay out of pocket each year before coverage starts paying its share.
- Coinsurance: your percentage of the approved amount — for Part B that's usually the twenty percent after the deductible.
- Copay: a flat amount for a visit or service, more common in Medicare Advantage plans.

TIP

Even this number is a "may owe," not a "do owe." If you have a Medigap supplement, Medicaid, or other coverage, that often picks up this share. Wait for the real bill to see what's truly left for you.

THE RESET

9. The Deductible and the Yearly Reset

Why January looks different from December.

Here's something that confuses a lot of people early in the year. The Part B deductible — a few hundred dollars, and the figure nudges up most years, so confirm the current one on Medicare.gov — resets every January first. Until you've met it, your EOBs may show a bigger "your share" than you're used to, because you're paying toward that deductible.

Once the deductible is met for the year, your share drops to the usual coinsurance — generally the twenty percent for Part B services. So a January EOB that looks pricier than a September one isn't an error. It's just the calendar turning over. The EOB often shows how much of the deductible you've met so far.

GOOD TO KNOW

The exact deductible and premium amounts change year to year. The EOB will reflect whatever this year's figures are; you don't have to memorize them. Medicare.gov always lists the current numbers.

DON'T RUSH

10. Match It to the Bill Before You Pay

The habit that prevents overpaying.

This is the single best habit to build. When the provider's actual bill arrives — days or weeks after the EOB — don't just pay it. Set it next to the EOB for that same date and service, and check that the "amount due" on the bill matches the "your share" on the EOB. They should agree.

- 1 Find the EOB for the same date and service as the bill.
- 2 Compare the bill's "amount due" to the EOB's "your share."
- 3 If they match, the bill is fair to pay.
- 4 If the bill is higher, call the provider's billing office before paying and ask them to explain the difference.

WATCH OUT

A bill that's larger than your EOB share can mean the provider billed you before the claim finished, or billed you for the write-off amount you don't owe. Don't pay the gap until it's explained. This one habit saves people real money.

TIMING

11. Wait for the Real Bill

The order things arrive, and why.

The sequence matters, so let's lay it out. First you get care. Then the provider sends the claim to Medicare or your plan. The plan processes it and sends you the EOB — the explanation. Only after all that does the provider send you a bill for your share, if there is one.

Because the EOB usually arrives first, it's tempting to treat it as the bill and pay right away. Resist that. Sometimes the EOB shows a share but the provider never bills you, because a supplement covered it. Sometimes the final bill is smaller than the EOB suggested. Waiting

costs you nothing and protects you from paying twice or paying too much.

TIP

Start a simple folder — paper or a shoebox is fine. EOBs go in front, bills behind. When a bill comes, pull its matching EOB and compare. It's the whole system, and it takes about a minute per bill.

ONLINE

12. Finding It in Your Medicare Account

Your claims, usually within a day of the visit.

You don't have to wait for the mail. If you have Original Medicare, you can set up a free account at Medicare.gov and see your claims there — often within twenty-four hours of a visit, long before the paper Summary Notice arrives. It's the fastest way to check that a claim went through.

- 1 Go to Medicare.gov and sign in to your account (or create one with your Medicare number).
- 2 Look for "Claims" or "Your claims" in the menu.
- 3 Click a claim to see the billed, approved, and paid amounts and your share.
- 4 You can usually view or download the full Medicare Summary Notice as a PDF from there too.

GOOD TO KNOW

This is the same account some people remember as "MyMedicare." It's now just your Medicare.gov account — same login works across Medicare's site. If you're stuck on the sign-in, that's exactly the kind of thing I can sit down and sort out with you.

PLAN PORTAL

13. Finding It in Your Plan's Website

For Medicare Advantage and drug plans.

If you're on a Medicare Advantage or stand-alone drug plan, your EOBs live on your plan's own website or app, not on Medicare.gov. The web address and the member login are usually printed on the back of your plan card, along with a member-services phone number.

- Find your plan's website from the back of your member card, not from a search engine ad.
- Register once with your member ID, then sign in to see claims and EOBs.
- Look for a section called "Claims," "Explanation of Benefits," or "Statements."
- Most plans let you download each EOB as a PDF to save or print.

WATCH OUT

Labels differ from plan to plan, so don't be thrown if yours calls it something slightly different. If you can't find the claims section, the member-services number on your card will walk you right to it.

PAPER OR SCREEN

14. Paper Copies vs Electronic

You can have it either way — or both.

You get to choose how these reach you. By default, Original Medicare mails a paper Summary Notice, and plans mail paper EOBs. But you can switch to electronic versions, where you get an email letting you know a new statement is ready to view online. Some people like the tidy inbox; others want the paper in hand.

- Electronic Medicare Summary Notices (eMSNs) arrive by email notice each month you have a claim — no waiting four months.
- Going paperless cuts clutter, but make sure you'll actually check the email.
- You can switch back to paper anytime if the screen isn't for you.
- Either way, the information is identical — only the delivery changes.

GOOD TO KNOW

There's no wrong choice here. If you rarely check email, paper is safer so nothing slips by. If your inbox is part of your routine, electronic is faster. Pick the one that fits how you already live.

HOW OFTEN

15. How Often an EOB Shows Up

It's tied to your claims, not the calendar.

People sometimes worry when they don't get one for a while, or get one unexpectedly. Here's the rhythm. With Original Medicare, the paper Summary Notice comes every few months — Medicare currently sends it about every four months — but only for periods when you actually had claims. No visits, no notice.

Medicare Advantage and drug plans usually send an EOB monthly, again only for months with activity. So a quiet month with no EOB is perfectly normal — it just means nothing was billed. And remember, online you can see individual claims much sooner than any of these mailed summaries.

WALK-THROUGH

16. Reading One Line, Start to Finish

Let's follow a single visit across the page.

Say you had an ordinary office visit. On the EOB you'll find a row for that date. Reading left to right: the service date, a short description ("office visit" or similar), the billed amount, the approved amount, what the plan paid, and your share. One row, one visit, the whole story.

Your eye only needs to do two things. First, confirm the date and description sound like something that actually happened to you. Second, note the "your share" figure so you know what to expect when the bill comes. Everything in between is the plan's accounting, and you can let it be.

TIP

If a row lists several little line items for one visit — a visit charge, a lab, a supply — that's normal. Add up only the "your share" column across those lines to see your total for the day.

DENIED

17. When a Service Says "Denied" or "Not Covered"

What it means — and that you can push back.

Sometimes a line shows the plan paid nothing, with a note like "denied" or "not covered," and a reason code. Don't panic. It can mean something small — a missing referral, a service billed under the wrong code, or paperwork that needs a second pass. It doesn't automatically mean you owe the whole amount.

- Read the reason note; the EOB explains codes somewhere on the document, often on the back or a later page.
- Call the provider's billing office first — many denials are a fixable billing mistake on their end.
- If it's a true coverage decision you disagree with, you have the right to appeal, and the EOB tells you how.
- Don't pay a denied charge in a hurry; sort out the reason first.

GOOD TO KNOW

Every EOB and Summary Notice includes instructions for filing an appeal, usually with a deadline. If a denial looks wrong, that appeal process exists precisely for you to use it.

ERRORS

18. Spotting a Service You Never Got

The reason it's worth a two-minute read.

Here's the real payoff for reading your EOB: you are the only person who knows what actually happened to you. The plan sees codes; you remember the day. So the one check that matters most is simply this — does every line describe care you really received, on a date you were really there?

- A visit on a date you were home, not at any office.
- A test or procedure you never had.
- A provider's name you don't recognize at all.
- The same service billed twice for one visit.
- Equipment or supplies that never arrived at your door.

Most of the time everything checks out, and a genuine mistake is usually just a billing slip the office can fix. But now and then a line you don't recognize is the first sign of something worth reporting — which is the next chapter.

FRAUD

19. Red Flags and How to Report Fraud

Your EOB is a fraud-catching tool.

Medicare fraud often shows up first as a charge on an EOB for something that never happened — a service, a test, or especially medical equipment billed in your name by someone who got hold of your Medicare number. Reading your EOBs is how ordinary people catch it. You don't need to be an expert; you just need to notice what doesn't belong.

- 1 First, call the provider's billing office — honest mistakes are common and quickly fixed.
- 2 If the service truly never happened or they can't explain it, call 1-800-MEDICARE (1-800-633-4227).
- 3 You can also contact your Senior Medicare Patrol (SMP), a free program that helps with suspected fraud.
- 4 Keep notes: dates, who you spoke with, and the questioned charge.

WATCH OUT

Never give your Medicare number to anyone who calls, emails, or comes to the door offering "free" tests, braces, or equipment. Legitimate care comes through your own doctor. Guard that number like a credit card — a charge you don't recognize may be why it matters.

WHO TO CALL

20. Call the Plan, or the Doctor's Office?

A simple rule for who handles what.

When something on an EOB puzzles you, the hardest part is often just knowing who to phone. Here's the rule of thumb that sorts most questions in a second. If your question is about the coverage decision — what was approved, denied, or how much the plan paid — call the plan. If it's about the charge itself or a bill you received, call the provider's billing office.

- Plan or Medicare: "Why was this denied?" "How much of my deductible is met?" "Is this covered?"
- Provider's billing office: "Your bill is more than my EOB share." "I never got this service." "Can I get an itemized bill?"
- Either one, for fraud: start with the provider, then 1-800-MEDICARE if it isn't resolved.

TIP

The plan's number is on the back of your card; the billing number is on the provider's bill or statement. Jot down the date and the name of whoever you speak with — it saves headaches if you have to call back.

RECORDS

21. Filing and Keeping Your EOBs

A little order now saves a scramble later.

EOBs are worth keeping, at least for a while. They are your proof of what was billed and paid if a bill is ever wrong, if you need to appeal, or if you're tracking medical costs for taxes. You don't need a filing cabinet — a simple, consistent spot does the trick.

- Keep each EOB at least until its matching bill is paid and settled.
- Hold onto them longer — a year or more — if there's an open appeal or a dispute.
- Online, you can leave them in your Medicare or plan account and download any you want to save.
- A labeled folder by year is plenty of organization for most people.

GOOD TO KNOW

If you go paperless, your statements stay available to view and download in your account, so you don't have to print them. But downloading a copy of anything tied to a dispute is a smart, belt-and-suspenders move.

QUESTIONS

22. Common Worries, Answered

The things people actually ask me.

"I got an EOB but no bill — did I miss paying something?" No. The EOB comes first. If you owe anything, a separate bill will follow. No bill often means a supplement covered your share.

"The billed amount is huge. Am I in trouble?" No. That's the sticker price. Look at "your share" — that's the only figure that could ever reach you.

"I don't recognize a charge." Call the provider's billing office first. If they can't explain it and the service never happened, call 1-800-MEDICARE.

"Do I have to read every one?" A two-minute glance at the dates and services is enough. You're just checking that it all really happened and noting your share.

FOR THE HELPER

23. A Note for the Family Helper

If you check these for a parent.

If you're the one keeping an eye on a parent's statements, EOBs are one of the kindest things you can watch. They are where unfamiliar charges and scams surface first. A few minutes a month can catch a problem early and give everyone peace of mind.

- To see a parent's Medicare claims online, you'll need their permission on file; Medicare has an Authorized Representative form for this.
- For a plan's website, ask about adding you as an authorized contact.
- Set a monthly routine — the first of the month, say — to glance at new claims together.
- Teach the "this is not a bill" rule so your parent doesn't pay an EOB by mistake.

GOOD TO KNOW

The account and the records belong to your parent, so access runs through their permission. There's a companion guide in this series on getting proxy access to a parent's patient portal — ask me for it.

MYTHS

24. A Few Myths, Cleared Up

What an EOB is — and isn't.

"An EOB is a bill." It isn't. It says so right on it. The bill, if any, comes separately and later.

"I owe the billed amount." No. You might owe the much smaller "your share" — and sometimes not even that.

"Ignoring it is fine." A quick read is worth it. It's how you catch errors and fraud before they grow.

"Online claims aren't official." They're the same information as the mailed notice, just faster. You can download the official statement anytime.

A DAY

25. A Two-Minute Check, Step by Step

What checking online actually looks like.

Let me show you how easy an online check really is, so it stops feeling like a chore. You sit down with your coffee, open your Medicare or plan account, and click "Claims." You see a list, newest on top. A new line appears for last week's doctor visit.

- 1 Sign in and open the claims list.
- 2 Glance at the newest claim: right date, right kind of visit? Good.
- 3 Note the "your share" figure so the bill won't surprise you.
- 4 Close the browser. That's it — you're done until the bill comes.

WATCH OUT

Do this once a month and you'll never be caught off guard by a bill again. If signing in is the part that trips you up, that's a perfect thing for us to set up together one time, so it's easy ever after.

DRUG PLANS

26. Your Part D Drug EOB

The one that tracks your year in medicines.

If you have a Part D drug plan, you get a separate EOB just for prescriptions, usually once a month. It reads a little differently because it also tracks where you are in the year's drug coverage stages — how much you and the plan have spent so far, which affects what you pay at the pharmacy.

- It lists each prescription filled, what the plan paid, and what you paid.
- It shows your running totals for the year — handy for seeing a coverage stage approaching.
- Check that every drug listed is one you actually filled.
- Your pharmacy charge at the counter should line up with what this shows.

GOOD TO KNOW

Drug coverage rules and the yearly out-of-pocket limit change year to year. Your drug EOB reflects the current rules automatically, so you don't have to track the numbers yourself — just confirm the drugs are yours.

THE CODES

27. What the Codes and Descriptions Mean

You don't have to decode them.

EOBs are sprinkled with codes — short numbers or letters next to each service and each payment decision. They can look like a foreign language, but you are not expected to translate them. They're shorthand the billing world uses, and the EOB spells out what the important ones mean, usually in a notes section.

The plain-English service description next to the code is what matters to you. "Office visit," "lab test," "X-ray" — if that sounds like your day, you're fine. If a code comes with a note like "denied" or "needs more information," that's your cue to read the note or make a phone call.

TIP

If a description is too vague to tell whether it matches your care, call the provider's billing office and ask them to explain that line in plain words. It's your statement — you're allowed to understand every line of it.

GUARD IT

28. Protecting Your Medicare Number

The best defense against the charges you'd rather not see.

Most of the strange charges people find on an EOB trace back to a Medicare number that got into the wrong hands. The number is the key to billing in your name, so protecting it is the front line. Reading your EOBs is the back line that catches anything that slips through.

- Treat your Medicare number like a credit card — share it only with your own doctors and trusted providers.
- Nobody from "Medicare" calls to offer free gear or verify your number. Hang up on anyone who does.
- Be wary of "free" screenings or braces that ask for your number at a health fair or by phone.
- If you think your number is compromised, call 1-800-MEDICARE.

WATCH OUT

A genuine-looking charge for equipment you never ordered is a classic sign your number was misused. The sooner you spot and report it, the easier it is to put right. That's the whole reason the two-minute read is worth it.

NUMBERS & HEALTH

29. If a Charge Involves Your Health

Where my help ends and your doctor's begins.

Sometimes an EOB raises a question that isn't really about the paperwork at all — it's about your care. You might see a test listed and wonder what it was for, or notice a service and want to know what it means for your health. Those are good questions, but they're not mine to answer.

I can help you find the document, open it, read the columns, match it to a bill, and figure out who to call about a charge. What a test was for, whether you needed it, or what a result means — that's a conversation for your doctor or nurse, who know your whole story.

WATCH OUT

This guide is information about reading a document, not medical or financial advice. For what a charge means for your care, ask your doctor. For what you truly owe, ask the billing office or 1-800-MEDICARE. For an emergency, always call 911.

SET IT UP

30. Setting Up Your Online Account

A one-time job that pays off all year.

If you've never logged in to see your claims online, setting up the account is a one-time task, and then it's yours forever. For Original Medicare, you'll do this at Medicare.gov; for a plan, at the website on your card. The hardest part is usually just creating a username and password you'll remember.

- 1 Go to the official site — Medicare.gov, or the address printed on your card.
- 2 Choose "Create account" and enter your Medicare or member number.
- 3 Pick a username and a strong password, and write them somewhere safe.
- 4 Sign in and find "Claims" to confirm you can see your statements.

TIP

Keep your login written in a safe spot at home, not a sticky note on the monitor. If passwords are the part that drives you up a wall, that's one of the most common things folks ask me to help untangle — you're far from alone.

YOUR RIGHTS

31. Your Rights Around the Bill

You're allowed to ask, question, and appeal.

It's easy to feel that a statement full of codes is the final word. It isn't. You have real rights here, and using them is normal and expected — the appeal instructions printed on every EOB are proof the system assumes you'll speak up when something's off.

- You can ask any provider for an itemized bill that lists each charge in plain terms.
- You can appeal a denied claim; the EOB tells you how and by when.
- You can question a charge without paying it first while it's being sorted out.
- You can get free, unbiased help from your State Health Insurance Assistance Program (SHIP).

GOOD TO KNOW

SHIP counselors offer free one-on-one Medicare help, including making sense of an EOB or a denial. You can find your local SHIP through [Medicare.gov](https://www.Medicare.gov) or by calling 1-800-MEDICARE.

SAVE MONEY

32. How Reading EOBs Saves You Money

The quiet payoff of a two-minute habit.

Let's be honest about why this is worth your time. Reading your EOBs isn't busywork — it's how you keep from paying money you don't owe. People overpay in small, avoidable ways all the time, and almost every one of them is catchable on the EOB.

- You avoid paying a bill that's higher than your real share.
- You catch a service billed twice before you pay for both.
- You notice a charge a supplement should have covered.
- You stop a fraudulent charge from quietly repeating month after month.

None of it takes special knowledge. It takes a folder, a two-minute glance, and the one habit of matching the bill to the EOB before you pay. Do that, and the statement that used

to worry you becomes one of your best money-savers.

YOU'RE NOT ALONE

33. You Don't Have to Do This Alone

A friendly, patient person is one call away.

I hope this guide made your Explanation of Benefits feel a little less daunting and a lot more doable. Keep it in a drawer with your other home papers, come back to a page whenever you need it, and don't worry about memorizing anything. Nobody expects you to.

When you'd rather have a hand, that's exactly what I do. I come to your home, work at your pace, and never make you feel rushed or silly for asking. A first visit is a flat ninety-nine dollars, and for the parts that don't need me on-site I can often help right on your screen for less. Every visit comes with a 30-day, come-back-free guarantee.

I'm a patient tech helper — not a doctor, nurse, or your insurance company — so I stick to the technology: the apps, the logins, the cameras, the gadgets and getting them talking to each other. Anything about your health, your medicines, or what a number means, I'll always point you back to your doctor or nurse.

GOOD TO KNOW

When you call, I answer — or Sophie, my friendly AI helper, takes a message so nothing gets lost. Sophie isn't a runaround; she's just making sure I call you back.

TIP

Call or text me at (330) 200-8042, or visit BillsHomeTech.com. Serving Atwater and all of Portage County, with 30+ years of patient, plain-English tech help. If you're ever not 100% happy with a visit, I'll make it right or refund it. That's a promise. — Bill

CHEAT SHEET

Everyday Cheat Sheet

Keep this by your mail pile or your computer.

- An EOB is NOT a bill. It says so on it. Don't pay money off an EOB.
- Four columns: billed, approved, plan paid, your share. Only "your share" can reach you.
- Ignore the big "billed" number — it's the sticker price nobody pays.

- Wait for the real bill, then match its "amount due" to the EOB's "your share" before paying.
- See claims fast online: Medicare.gov, or your plan's site on the back of your card.
- A service you never got? Call the billing office first, then 1-800-MEDICARE if it's not resolved.
- Never give your Medicare number to anyone who calls offering "free" gear. Guard it like a credit card.

AT A GLANCE

A Picture to Follow Along

How a Visit Becomes an EOB

The EOB comes first — the bill, if any, comes later.

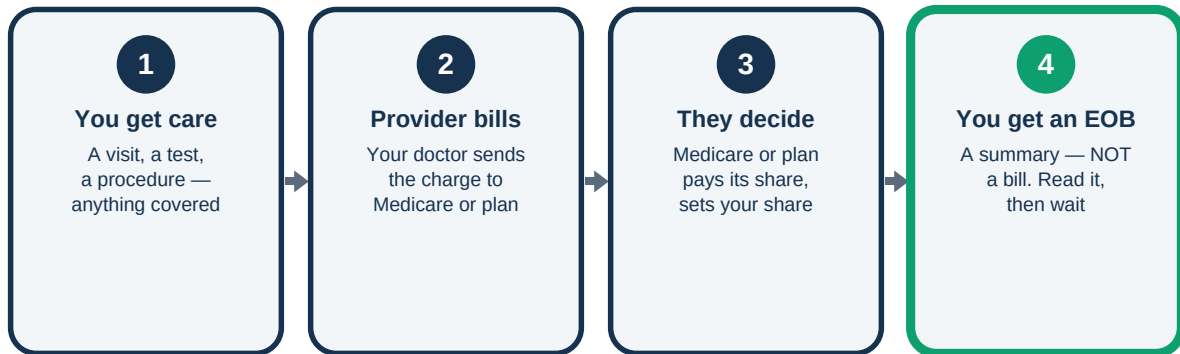


Illustration - a schematic, not to scale. Your setup may differ.

AT A GLANCE

A Second Look

The Four Columns, Plain

Only the last one ever costs you anything.

	What it means	You pay it?
Billed amount	Provider's sticker price	No
Approved amount	What Medicare allows	No
Plan paid	What Medicare/plan	No
Your share	Deductible + coinsurance	Maybe — see bill

Illustration - a schematic, not to scale. Your setup may differ.

BEFORE YOU GO

A Note From Bill

A quick note from Bill. I write these guides to make home tech a little less frustrating, and I do my best to keep every step accurate and up to date. Still, every home, device, and setup is a bit different, so I can't promise a guide will match yours exactly or fix your particular problem. These guides are for general information only — they're not professional, legal, or financial advice, and they don't replace your device's own manual or the manufacturer's instructions. Please go slow, use your own good judgment, and use everything here at your own risk. If a step involves electrical wiring, a gas appliance, a water heater, plumbing, or climbing a ladder — or if anything just doesn't feel safe — please stop and call a licensed professional (or give me a call at 330-200-8042). Bill's Home Tech and Bill Davis can't be responsible for any damage, data loss, or injury that results.



HOW I CAN HELP

Your Visit — and My Promise

In-home visit — \$99 flat for your first visit. No contracts and no surprise charges, and a 30-day follow-up is included.

Remote Support — \$49 for a screen-share session. I only connect with your permission, you watch the whole time, and you can end anytime. If I can't fix it over the screen-share, I refund the \$49 — and if it turns out you need me in person, that \$49 goes toward your visit. It's included free for Support Plan members (\$39/mo).

GOOD TO KNOW

My promise — If you're not 100% satisfied with your visit, I'll come back at no charge, or refund the full \$99. No questions, no awkwardness. That's how I'd want to be treated.

Call or text **(330) 200-8042** · Book a visit: **billshometech.com/book** · **bill@billshometech.com**

This free guide is for general information only — not professional advice, and no substitute for your device's own manual. Any prices or outside products mentioned can change; please confirm current details before you buy. Please use your own good judgment and follow it at your own risk — for anything involving electricity, gas, water, or heights, stop and call a licensed professional. Bill's Home Tech and Bill Davis can't be responsible for any damage, data loss, or injury that results. © 2026 Bill's Home Tech, LLC.