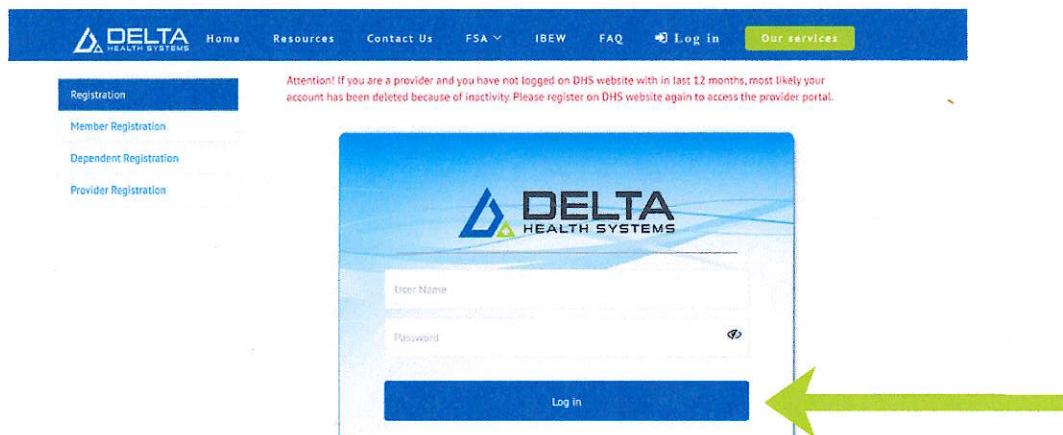


## How to View an EOB

### Easy Access Instructions

1. Go to [www.deltahealthsystems.com](http://www.deltahealthsystems.com)
2. Select **Member** on the top tool bar, then select Click Here to Login or Register
 

Covered employees: register as a "Member"  
 Covered dependents age 18 or older: register as a "Dependent"
3. To register, complete the required fields and click Submit.

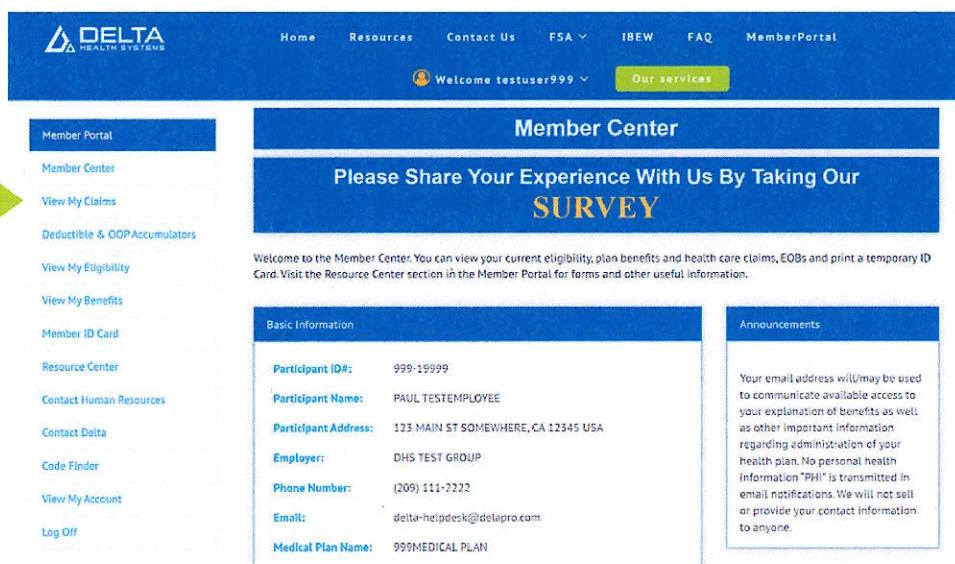


4. When you return to [www.deltahealthsystems.com](http://www.deltahealthsystems.com), select Member and enter your **User Name** and **Password**.

**Important:** Registration information is case sensitive.

### How to View EOBs

1. In the Member Center, click **View My Claims**.



2. Find the claim you want to view and in the Status column, click on Processed.

View My Benefits  
Member ID Card  
Resource Center  
Contact Human Resources  
Contact Delta  
Code Finder  
View My Account  
Log Off

**Health & Wellness Tools**  
TeamCare Health Coaching  
Mayo Clinic  
FSA Store  
Delta HealthCare Behavioral Health

**Claims Search**

Participant ID: 999-19999  
Select Participant: TEST-EMPLOYEE-PAUL  
Select Claim Status: All  
Select Claim Type: All  
Select Date of Service Year: All  
Search

**Claims Search Result**

View an EOB about a particular processed claim (click on the Processed status link at the end of the row in the summary table. Where 'IN' means In Network and 'ON' means Out of Network.)  
Please click here to view your Deductible and Out of Pocket totals. [Export Claims to Excel](#)

Claim Number	Claim Type	Date of Service	Provider Name	Billed	Plan Pays	Patient Pays	Status
99999073009	M	1/25/2025	JAMES F LEE MD	\$ 300.50	\$ 0.00	\$ 240.20	Processed as IN
99999073009	M	1/24/2025	JAMES F LEE MD	\$ 300.50	\$ 0.00	\$ 240.20	Processed as IN

A message will pop up asking if you want to open or save the file. Click Open and a PDF of your EOB will open which you can print or save to your computer.

Forwarding Service Requested

Paul Testcase  
1234 W. Oak Street  
Stockton, CA 95203

**Explanation of Benefits**  
RETAIN FOR TAX PURPOSES  
THIS IS NOT A BILL

Customer Service  
DELTA HEALTH SYSTEMS  
ADMINISTRATIVE SERVICES  
CUSTOMER SERVICE PHONE #  
800-691-2443

Paid Date: 11/26/2025  
Check #: 123456

If you disagree with the payment of this claim or have information that could change our decision, please contact Delta Health Systems within 180 days.

Log into [deltahealthsystems.com](#) to select an option to discontinue paper EOBs. Select View My Claims to suppress paper and begin receiving your electronic EOBs.

Claim #: Patient: Check #: 123456 Provider #: 2a

Check #: 123456 Group ID #: 2a

Dates of Service	Type of Service	Amount Billed	Net Cost/Billed	Discount/Billed	Disposition	Disbursed Amount	Deductible Amount	Copy Amount	Covered Amount	% Paid	Plan Payment
01-Nov-2025	Health Plan Payment	\$100.00	\$91.00	\$10.00	\$100.00	\$100.00	\$10.00	\$10.00	\$100.00	100%	\$100.00
01-Nov-2025	Health Plan Payment	\$100.00	\$91.00	\$10.00	\$100.00	\$100.00	\$10.00	\$10.00	\$100.00	100%	\$100.00
01-Nov-2025	Health Plan Payment	\$100.00	\$91.00	\$10.00	\$100.00	\$100.00	\$10.00	\$10.00	\$100.00	100%	\$100.00
01-Nov-2025	Health Plan Payment	\$100.00	\$91.00	\$10.00	\$100.00	\$100.00	\$10.00	\$10.00	\$100.00	100%	\$100.00
<b>Claim Totals: C.O.B \$0.00</b>		\$100.00	\$91.00	\$10.00		\$100.00	\$10.00	\$10.00	\$100.00	100%	\$100.00

## Forgot Your User ID or Password?

Select **Member** on the home page, select [click here](#) to login or register and then click on [Forgot Your Password](#). After answering a series of security questions, your password will be reset and set to the email address you used when you originally registered.

### Access to Covered Dependent Information

Due to privacy laws, online access to your covered dependents' information varies based on their age:

**Up to Age 18:** Dependents' healthcare information is available only to the covered employee.

**Age 18 and Over:** To view their claims and eligibility, dependents must register. Once registered, your dependent has the option to e-sign an authorization release form allowing you as the covered employee to view their personal healthcare information.

*Note: The Health Insurance Probability and Accountability Act (HIPPA) regulates privacy for health insurance plans; access requirements may be modified from time to time based on legal requirements.*

# UNDERSTANDING YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT

An Explanation of Benefits (EOB) statement will be sent to you after you receive services. Your EOB **verifies** that a claim was received, **documents** how a claim was processed, **outlines** the reason(s) why a claim was denied, and **summarizes** the amount paid by the plan, what portion the patient is responsible for paying, if any, and the amount the provider will need to either write off if the services were provided in-network or attempt to collect if the services were provided out-of-network.

## SAMPLE EOB

See the back of this sheet for detailed descriptions of each of the numbered fields in blue circles below.

## **SAMPLE** Explanation of Benefits

**RETAIN FOR TAX PURPOSES  
THIS IS NOT A BILL**

JOHN SMITH  
100 MAIN STREET  
LAFAYETTE CA 94549

## Customer Service

DELTA HEALTH SYSTEMS  
ADMINISTRATION SERVICES  
CUSTOMER SERVICE PHONE#  
(800) 291-0726

**Sent to:** JOHN SMITH

If you disagree with the payment of this claim or have information that could change our decision, please contact Delta Health Systems within 60 days.

For the Service Period: 12/24/2021 through 01/13/2022

3	4	5	6	7	8	9	10	11	12
Claim #: 11111-222222		Relationship: Self			Provider: HOMETOWN CLINIC				
					Patient: JOHN SMITH				
Dates of Service	Type of Service	Billed Amount	Allowed Amount	Reason Code	Deductible Amount	Copay Amount	% Paid	Plan Payment	Patient Responsibility
01/13	Office Care	\$125.00	\$96.31	1	\$0.00	\$0.00	80%	\$77.05	\$19.26
13	C.O.B.	\$0.00	\$125.00	96.31	\$0.00	\$0.00		\$77.05	\$19.26
					15	Paid Amount: \$77.05			

**Total Amount Billed**

**\$125.00**

This is the total amount billed for the dates of service of 12/24/2021 thru 01/13/2022.

**Total Amount Paid By Plan**

\$77,05

This is the amount the plan paid in total for services rendered from 12/24/2021 thru 01/13/2022. Please see the "Claim Summary" section of this document for more information.

### Your Financial Responsibility

\$19.26

This is the amount the provider(s) of service *may* bill you after your health plan benefits are paid. Typically a plan participant may be billed by the provider of service because they have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. Amounts shown here do not reflect any payments made at the point of service. A breakdown of your total financial responsibility is shown in the claim detail for each member.

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#### Formation of Calcium Hydroxide

#### ANSWER



# UNDERSTANDING YOUR EXPLANATION OF BENEFITS (EOB) STATEMENT CONTINUED...

## EOB INFORMATION

Below are descriptions of the fields that correspond to the sample EOB on the front of this card:

- 1. Group ID Number:** (Also referred to as the HEALTHCARE ID on your ID Card.) This unique number identifies you and your health plan without using any personal information. When contacting Delta Health Systems regarding questions about your EOB, be sure to have this number available to access claim information with ease.
- 2. Claim Number:** A number that is generated for each benefit claim made under the health plan. When contacting Delta Health Systems regarding questions about your EOB, be sure to have this number available to access claim information with ease.
- 3. Date(s) of Service:** The date care or treatment was received.
- 4. Type of Service:** Indicates the types of services that were received (i.e., lab work, office visit, etc.).
- 5. Billed Amount:** The amount your provider billed for the services he/she provided.
- 6. Allowed Amount:** The amount your plan has agreed to pay for the services received.
- 7. Reason Code:** This code corresponds to how a claim was processed; a detailed explanation of the code will be provided in the Explanations of Claims Handling section (Number 16 on the Sample EOB).
- 8. Deductible Amount:** This box will show the amount of the claim that has been applied toward satisfying the deductible, if any.
- 9. Copay Amount:** The amount of your copay for certain benefits (i.e., office visit, ER, chiropractic, etc.).
- 10. %:** Indicates the percentage the plan will pay of the Allowed Amount (Number 6 on the Sample EOB). The percentage will vary depending on the plan you have selected and whether care was received from an in-network or out-of-network provider.
- 11. Plan Payment:** The dollar amount the plan will issue to the appropriate party.
- 12. Patient Responsibility:** The amount you are responsible for paying to the provider.
- 13. C.O.B. Amount (Coordination of Benefits):** The amount paid by "other insurance", if any.
- 14. Patient's Responsibility:** This section contains the total amount that the patient is responsible for.
- 15. Paid Amount:** This will be the actual payment amount made to the provider or participant.
- 16. Explanation of Claims Handling:** This section includes any additional notes or information as to what was covered or not covered.
- 17. Your Right to Appeal:** This is the procedure and information needed to file a formal review for any denied claim.

