



Forwarding Service Requested

Customer Service

Website: sanfordhealthplan.com
Phone: (800) 499-3416

J31F 2,529
MANTHEI,DIANE J
1906 23RD AVE S
GRAND FORKS ND 58201

EXPLANATION OF BENEFITS

Keep this statement for your records.

THIS IS NOT A BILL.

This explanation of benefits (EOB) shows services you recently received for the date range below, including what Sanford Health Plan paid your health care providers and your share of the costs for these services.

Member Name: Diane J Manthei
Member ID Number: 50007317001
Statement Date: 09/27/21
Page Number: Page 1 of 3

Summary of claims included on this statement is from 09/20/2021 - 09/27/2021

Amount billed	\$1,173.25	This is the total amount billed to Sanford Health Plan by your provider(s).
Plan discount	\$359.00	Amount saved by using an in-network or participating provider (if applicable). Sanford Health Plan negotiates lower rates with these providers to help save money.
Amount not covered	\$0.00	This is the portion of your bill that is not covered by your benefit plan. You may or may not need to pay this amount. See the Claim Details section for more information.
What Sanford Health Plan paid	\$651.40	Sanford Health Plan paid a total of \$651.40 to your provider(s) for your health care.
What I may owe	\$162.85	This is the amount you owe after plan discounts and what Sanford Health Plan paid. This includes services for care that may not be covered by the plan.
You saved	30.6%	You saved \$359.00 off your care (total amount billed) by using your Sanford Health Plan coverage and network providers. For up-to-date information on your deductible, coinsurance and out-of-pocket maximums, log into to your secure member portal at sanfordhealthplan.com/memberlogin .

IMPORTANT MESSAGES

To learn more about your benefits, please look in your Plan Documents. For questions or concerns about the claim(s)/service(s) listed, contact Customer Service at the number above.

If you disagree with how Sanford Health Plan paid your benefits, see the attached Appeal Rights and Form for important information on how to ask the Plan to review your case. Submit the attached Appeal Form, contact Customer Service or log in to your Member Portal at sanfordhealth.com/memberlogin to file an appeal.

Plan Benefit Year: 01/01/2021 through 12/31/2021

PPO Individual Deductible	
\$500.00	\$0.00
Used	Remaining
PPO Individual Coinsurance	
\$470.41	\$529.59
Used	Remaining
PPO Family Deductible	
\$1000.00	\$500.00
Used	Remaining
PPO Family Coinsurance	
\$818.31	\$1181.69
Used	Remaining
BASIC Individual Deductible	
\$500.00	\$0.00
Used	Remaining
BASIC Individual Coinsurance	
\$470.41	\$1029.59
Used	Remaining
BASIC Family Deductible	
\$1000.00	\$500.00
Used	Remaining
BASIC Family Coinsurance	
\$818.31	\$2181.69
Used	Remaining

Login into your mySanfordHealthPlan account at sanfordhealthplan.com/memberlogin to view the most up-to-date cost share information.

THIS IS NOT A BILL

Claim Number: 48496210
Provider / Vendor Name: SANFORD HEALTHCARE ACCESSORIES / SANFORD HEALTHCARE ACCESSORIES LLC

Medical Service Details			Member Benefit		Amount Provider May Bill You					Notes*
Date of Service	Type of Service	Amount Billed	Plan Discount	Amount Paid By Plan	Co-pay	Deductible	Coinsurance	Amount Not Covered		
09/02/21-09/02/21	1	\$915.50	\$245.90	\$535.68	\$0.00	\$0.00	\$133.92	\$0.00		
09/02/21-09/02/21	1	\$257.75	\$113.10	\$115.72	\$0.00	\$0.00	\$28.93	\$0.00		
Claim Total:		\$1,173.25	\$359.00	\$651.40	\$0.00	\$0.00	\$162.85	\$0.00		
							Amount You May Owe:			\$162.85

*Notes
1 Medical Care



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