SANFORD
HEALTH PLAN
PO BOX 91110
SIOUX FALLS SD 57109-1110

20211018B03
J49E
8509 24115



**Forwarding Service Requested**

**Customer Service**

Website: Sanfordhealthplan.com
Phone: (800) 752-5863

J49E 17,057

TESCHER,DARLA
1106 N 33RD ST
BISMARCK ND 58501

# 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:** Darla Tescher
**Member ID Number:** 50023579601
**Statement Date:** 10/18/21
**Page Number:** Page 1 of 4

## Summary of claims included on this statement is from 10/06/2021 - 10/18/2021

| | | |
|---|---|---|
| **Amount billed** | **$941.00** | This is the total amount billed to Sanford Health Plan by your provider(s). |
| **Plan discount** | **$0.00** | 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** | **$941.00** | 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** | **$0.00** | Sanford Health Plan paid a **total of $0** to your provider(s) for your health care. |
| **What I may owe** | **$941.00** | 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** | **0.0%** | You saved $0 off your care (total amount billed) by using your Sanford Health Plan coverage and network providers.<br>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.**

Please see detailed claim information on the following page(s).

SANFORD HEALTH PLAN

**Darla Tescher CLAIM DETAILS**

**THIS IS NOT A BILL**

**Claim Number:** 48861597

**Provider / Vendor Name:** KLEMIN, PETER L / SANFORD BISMARCK

| | Medical Service Details | | Member Benefit | | Amount Provider May Bill You | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date of Service | Type of Service | Amount Billed | Plan Discount | Amount Paid By Plan | Co-pay | Deductible | Coinsurance | Amount Not Covered | Notes* |
| 10/04/21-10/04/21 | 1 | $35.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $35.00 | PNC NDP2 |
| 10/04/21-10/04/21 | 1 | $194.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $194.00 | PNC NDP2 |
| 10/04/21-10/04/21 | 1 | $58.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $58.00 | PNC NDP2 |
| **Claim Total:** | | **$287.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$287.00** | |
| | | | | | | **Amount You May Owe:** | | **$287.00** | |

| *Notes | |
|---|---|
| 1 | Medical Care |
| NDP2 | SHP SECONDARY PAYOR NDPERS |
| PNC | SERVICE NOT COVERED DUE TO PLAN LIMIT, EXCLUSION, OR AUTHORIZATION REQUIREMENT |

SANFORD HEALTH PLAN

## Darla Tescher CLAIM DETAILS

## THIS IS NOT A BILL

**Claim Number:** 48896446

**Provider / Vendor Name:** RODACKER, MARK W / SANFORD BISMARCK

| | Medical Service Details | | Member Benefit | | Amount Provider May Bill You | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date of Service | Type of Service | Amount Billed | Plan Discount | Amount Paid By Plan | Co-pay | Deductible | Coinsurance | Amount Not Covered | Notes* |
| 10/05/21-10/05/21 | 5 | $325.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $325.00 | PNC NDP2 |
| **Claim Total:** | | **$325.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$325.00** | |
| | | | | | | **Amount You May Owe:** | | **$325.00** | |

***Notes**

| | |
|---|---|
| NDP2 | SHP SECONDARY PAYOR NDPERS |
| PNC | SERVICE NOT COVERED DUE TO PLAN LIMIT, EXCLUSION, OR AUTHORIZATION REQUIREMENT |
| 5 | Diagnostic Laboratory |

## Darla Tescher CLAIM DETAILS

## THIS IS NOT A BILL

**Claim Number:** 48913799

**Provider / Vendor Name:** KLEMIN, PETER L / SANFORD BISMARCK

| | Medical Service Details | | Member Benefit | | Amount Provider May Bill You | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Date of Service | Type of Service | Amount Billed | Plan Discount | Amount Paid By Plan | Co-pay | Deductible | Coinsurance | Amount Not Covered | Notes* |
| 10/05/21-10/05/21 | 2 | $329.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $329.00 | PNC NDP2 |
| **Claim Total:** | | **$329.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$0.00** | **$329.00** | |
| | | | | | | **Amount You May Owe:** | | **$329.00** | |

SANFORD HEALTH PLAN

| *Notes | |
|---|---|
| PNC | SERVICE NOT COVERED DUE TO PLAN LIMIT, EXCLUSION, OR AUTHORIZATION REQUIREMENT |
| NDP2 | SHP SECONDARY PAYOR NDPERS |
| 2 | Surgery |