



Forwarding Service Requested

Customer Service

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

MERTZ, JULIE L
2520 HOOVER AVE
BISMARCK ND 58501

J49E

17,675

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: Julie L Mertz
Member ID Number: 50007059402
Statement Date: 10/18/21
Page Number: Page 1 of 4

Summary of claims included on this statement is from 10/11/2021 - 10/18/2021

Amount billed	\$287.75	This is the total amount billed to Sanford Health Plan by your provider(s).
Plan discount	\$10.26	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	\$63.04	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	\$164.45	Sanford Health Plan paid a total of \$164.45 to your provider(s) for your health care.
What I may owe	\$113.04	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	3.6%	You saved \$10.26 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.

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



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

PPO Individual Deductible	
	\$500.00 \$0.00
	Used Remaining
PPO Individual Coinsurance	
	\$1000.00 \$0.00
	Used Remaining
PPO Family Deductible	
	\$1065.12 \$434.88
	Used Remaining
PPO Family Coinsurance	
	\$2000.00 \$0.00
	Used Remaining
BASIC Individual Deductible	
	\$500.00 \$0.00
	Used Remaining
BASIC Individual Coinsurance	
	\$1000.00 \$500.00
	Used Remaining
BASIC Family Deductible	
	\$1065.12 \$434.88
	Used Remaining
BASIC Family Coinsurance	
	\$2000.00 \$1000.00
	Used Remaining

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



Julie L Mertz CLAIM DETAILS

THIS IS NOT A BILL

Claim Number: 48948367
Provider / Vendor Name: AXTMAN, KEVIN / BONE AND JOINT CENTER

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		
10/05/21-10/05/21	1	\$64.52	\$2.12	\$37.40	\$25.00	\$0.00	\$0.00	\$0.00		
10/05/21-10/05/21	1	\$64.52	\$2.84	\$61.68	\$0.00	\$0.00	\$0.00	\$0.00		
Claim Total:		\$129.04	\$4.96	\$99.08	\$25.00	\$0.00	\$0.00	\$0.00		
						Amount You May Owe:				\$25.00

*Notes
1 Medical Care

Julie L Mertz CLAIM DETAILS

THIS IS NOT A BILL

Claim Number: 49010492
Provider / Vendor Name: AXTMAN, KEVIN / BONE AND JOINT CENTER

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		
10/08/21-10/08/21	1	\$64.52	\$2.12	\$37.40	\$25.00	\$0.00	\$0.00	\$0.00		
10/08/21-10/08/21	1	\$63.04	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$63.04		PNC
10/08/21-10/08/21	1	\$31.15	\$3.18	\$27.97	\$0.00	\$0.00	\$0.00	\$0.00		
Claim Total:		\$158.71	\$5.30	\$65.37	\$25.00	\$0.00	\$0.00	\$63.04		
						Amount You May Owe:				\$88.04

*Notes	
1	Medical Care SERVICE NOT COVERED DUE TO PLAN LIMIT, EXCLUSION, OR AUTHORIZATION REQUIREMENT