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

20211118B04
J3B9
8509 24115

Forwarding Service Requested

Customer Service

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

8,327

URBANEC,JAYCEE R
4104 E VALLEY DR
BISMARCK ND 58503

SANFORD HEALTH PLAN

SANFORD
HEALTH PLAN

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: Jaycee R Urbanec
Member ID Number: 20030517901
Statement Date: 11/18/21
Page Number: Page 2 of 4

Summary of claims included on this statement is from 11/08/2021 - 11/18/2021

Amount billed	**$1,085.00**	This is the total amount billed to Sanford Health Plan by your provider(s).
Plan discount	**$505.16**	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	**$200.50**	Sanford Health Plan paid a **total of $200.50** to your provider(s) for your health care.
What I may owe	**$379.34**	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	**46.6%**	You saved $505.16 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).

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SANFORD HEALTH PLAN

Jaycee R Urbanec CLAIM DETAILS

THIS IS NOT A BILL

Claim Number: 49519672

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*
11/05/21-11/05/21	5	$97.00	$64.75	$0.00	$0.00	$32.25	$0.00	$0.00	
11/05/21-11/05/21	2	$22.00	$15.50	$6.50	$0.00	$0.00	$0.00	$0.00	
Claim Total:		$119.00	$80.25	$6.50	$0.00	$32.25	$0.00	$0.00	
						Amount You May Owe:		$32.25	

*Notes	
5	Diagnostic Laboratory
2	Surgery

Jaycee R Urbanec CLAIM DETAILS

THIS IS NOT A BILL

Claim Number: 49549282

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*
11/04/21-11/04/21	1	$318.00	$124.00	$194.00	$0.00	$0.00	$0.00	$0.00	
Claim Total:		$318.00	$124.00	$194.00	$0.00	$0.00	$0.00	$0.00	
						Amount You May Owe:		$0.00	

SANFORD HEALTH PLAN

*Notes	
1	Medical Care

Jaycee R Urbanec CLAIM DETAILS

THIS IS NOT A BILL

Claim Number: 49549721

Provider / Vendor Name: ARNDORFER, BROOKE A / 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*
10/26/21-10/26/21	1	$5.00	$3.65	$0.00	$0.00	$1.35	$0.00	$0.00	
10/26/21-10/26/21	1	$194.00	$80.74	$0.00	$0.00	$113.26	$0.00	$0.00	
10/26/21-10/26/21	2	$313.00	$122.25	$0.00	$0.00	$190.75	$0.00	$0.00	
10/26/21-10/26/21	2	$136.00	$94.27	$0.00	$0.00	$41.73	$0.00	$0.00	EXRM
Claim Total:		**$648.00**	**$300.91**	**$0.00**	**$0.00**	**$347.09**	**$0.00**	**$0.00**	
						Amount You May Owe:		**$347.09**	

*Notes	
1	Medical Care
2	Surgery
EXRM	BENEFITS REDUCED 50% - MULTIPLE SURGICAL PROCEDURE

How to Read your Explanation of Benefits (EOB)

Sanford Health Plan wants to help you understand your health care coverage. An Explanation of Benefits (EOB) is not a bill; it explains how your benefits have been applied. It also shows what Sanford Health Plan paid for your care and what amount you may be responsible for. Review your EOB carefully along with any bills you receive to make sure both statements match.

B Claim Number: 1234567

D Provider/Vendor Name: DOCTOR NAME / FACILITY NAME/PLACE OF SERVICE

	Medical Service Details		Member Benefit		Amount Provider May Bill You				
A Date of Service	**C** Type of Service	**E** Amount Billed	**F** Plan Discount	**G** Amount Paid by Plan	**H** Copay	**I** Deductible	**J** Coinsurance	**K** Amount Not Covered	**L** Notes*
XX/XX/XXXX – XX/XX/XXXX	<type of service>	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	<claim notes>
	Claim Total:	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	
						Amount You May Owe		$XXXXX.XX	

L

*Notes
<claim notes>

A **Date of Service:** The date(s) you received care.

B **Claim Number:** Reference number Sanford Health Plan assigned to the submitted claim.

C **Type of Service:** Type of medical service received.

D **Provider/Vendor Name:** The provider or facility you received the service from.

E **Amount Billed:** Amount the provider or facility billed for the service.

F **Plan Discount:** 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.

G **Amount Paid by Plan:** The maximum amount Sanford Health Plan allows a provider or facility to charge for the service(s).

H **Copay:** A set amount you pay for certain services, such as an office visit.

I **Deductible:** The amount of covered expense that must be paid by the member before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, Sanford Health Plan won't pay for covered benefits until you've paid $1,500 for services that are subject to the deductible, which may include labs, imaging, procedures and hospitalizations.

J **Coinsurance:** The percentage of the payment that you are responsible for, once the deducible has been met. Co-insurance amount is calculated on the amount paid by the plan. For example, if you have a $100.00 service after you've met your deductible and your coinsurance is 80/20, the Plan will pay for 80 percent ($80) and you will pay 20 percent ($20).

K **Amount Not Covered:** Any amount that may not be covered by your benefit plan.

L **Notes:** Important information; these numbers and/or codes explain more about how claim was processed.

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