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

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.

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

SANFORD HEALTH PLAN

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

PPO Individual Deductible

$500.00 Used | **$0.00** Remaining

PPO Individual Coinsurance

$470.41 Used | **$529.59** Remaining

PPO Family Deductible

$1000.00 Used | **$500.00** Remaining

PPO Family Coinsurance

$818.31 Used | **$1181.69** Remaining

BASIC Individual Deductible

$500.00 Used | **$0.00** Remaining

BASIC Individual Coinsurance

$470.41 Used | **$1029.59** Remaining

BASIC Family Deductible

$1000.00 Used | **$500.00** Remaining

BASIC Family Coinsurance

$818.31 Used | **$2181.69** Remaining

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

Diane J Manthei CLAIM DETAILS

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				
Date of Service	Type of Service	Amount Billed	Plan Discount	Amount Paid By Plan	Co-pay	Deductible	Coinsurance	Amount Not Covered	Notes*
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

THIS PAGE INTENTIONALLY LEFT BLANK