



Key to Following Your Explanation of Benefits

- 1 Contact DAKOTACARE's Customer Service Department should you have any questions regarding your Explanation of Benefits.
- 2 This section lists the Member's name, identification number for whom services were performed and claim number. Please have your identification number and claim number available when contacting Customer Service.
- 3 The total payment being made by your plan, date that payment will be sent and to whom payment is being sent. Payments will be sent directly to participating providers. In certain situations, payment may be sent directly to the Member if services were rendered by a non-participating provider.
- 4 Indicates the amount that you may owe to the provider of service. This does not account for any payments that you may have already paid to the provider of service.
- 5 Name of the hospital, physician or other health care facility who provided the service.
- 6 The date that services were provided and a brief description of services rendered.
- 7 The amount billed by your provider for each service.
- 8 The amount you saved due to contractual agreements between DAKOTACARE and the provider. You have no obligation to pay this amount.
- 9 Amount paid by other insurance company (ex: your primary insurance company, homeowners insurance, auto insurance).
- 10 The amount which will be paid by your plan.
- 11 Any amounts that are not covered by your plan.
- 12 Reason code number used to process your claim. Please refer to section eighteen (18) for description of reason code used.
- 13 A specified dollar amount that the Member is required to pay for certain health services.
- 14 A specified dollar amount of covered services that must be incurred by a Member during a Benefit Year before benefits become payable under the health plan.
- 15 A specified dollar amount expressed as a percentage of the allowance for covered services. (Ex: your coinsurance responsibility may be 20 percent if you are enrolled in a 80/20 plan or 10 percent if you are enrolled in a 90/10 plan).
- 16 The amount that DAKOTACARE has determined to be your financial responsibility for the claim. This amount includes your copayment, deductible, coinsurance and non-covered charges.
- 17 Information pertaining to how your claim was processed.
- 18 Explains how claim payment was determined, including specific reason for non-covered charges.
- 19 Summary of your deductible and coinsurance limits for the Benefit Year. Also includes amounts that you have met to date and the amounts remaining. These amounts are reflective of the date that a claim was processed. Should multiple claims be processed on the same date, your deductible and coinsurance amounts may not change on your Plan Summary.



2600 West 49th Street
P.O. Box 7406
Sioux Falls, SD 57117-7406
www.dakotacare.com

For Customer Service:
(605) 334-4000
or 1-800-325-5598

EXPLANATION OF BENEFITS

Please retain this statement for your personal records.
Date Processed: 05/12/2007
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2 Member ID / Name: 123456789.1 Jane Doe
Group ID / Name: DD10000-001 Greenhead Landscaping
Claim Number: 0411880289

|||||
Jane Doe
4321 Skyline Drive
Hometown, SD 57000-4123

3 Payment Summary

Plan Will Pay: Hope Hospital
Payment Date: 05/25/2007
Payment Amount: \$57.03

4 You Owe Provider \$40.55

5 Provider of Service:
Hope Hospital

Date and Type of Service	Submitted Amount	*Plan Savings	Other Insurance Paid	Plan Pays	Member Responsibility					Total Member Responsibility
					Not Covered By Plan	Reason Code	Copayment	Deductible	Coinsurance	
04/15/2007 Professional Service	85.00	12.97		57.03			15.00			15.00
Laboratory	20.00	9.95						10.05		10.05
Durable Medical Equipment	10.00							10.00		10.00
04/16/2007 Miscellaneous	5.50				5.50	118				5.50
Column Totals	120.50	22.92	0.00	57.03	5.50		15.00	20.05	0.00	40.55

(* Plan Savings - You have no obligation to pay this amount since the provider has contractually agreed to accept the reduction.)

17 Notes:

This is a sample Explanation of Benefits.

18 Reason Code Descriptions:

118 - Services and supplies listed as excluded or not specifically listed as covered under the plan are not covered.

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Plan Summary For 01/01/07 - 12/31/07 as of date processed.

Individual	Annual Limit	Year to Date	Remainder	Family	Annual Limit	Year to Date	Remainder
Deductible	\$250.00	\$104.51	\$145.49	Deductible	\$500.00	\$104.51	\$395.49
Coinsurance	\$1,000.00	\$0.00	\$1,000.00	Coinsurance	\$2,000.00	\$0.00	\$2,000.00

Neither the submission of this Explanation of Benefits nor any other DAKOTACARE materials you may receive shall guarantee that you or your dependents shall be entitled to receive plan benefits. DAKOTACARE has made the determination of eligibility for plan benefits based upon information it deemed accurate at the time this Explanation of Benefits was prepared. If claims payment is made as a result of a mistake of fact or law, DAKOTACARE reserves the right to initiate a claim for recovery of benefits paid or to offset plan benefits from future claims payments.

THIS IS NOT A BILL