**[Insurance Company Name]**
[Company Address]
[City, State, Zip Code]
[Phone Number]

**Date:** [Current Date]

**RE: EXPLANATION OF BENEFITS (EOB)**

**Member Name:** [Member Full Name]
**Member ID:** [ID Number]
**Claim Number:** [Claim Number]
**Provider:** [Healthcare Provider Name]
**Date of Service:** [Service Date]

Dear [Member Name],

This letter provides a summary of the claim processed for the services listed above. This is not a bill. It is an explanation of how your benefits were applied and the final payout breakdown.

| Service Description | Amount Billed | Plan Discount | Covered Amount | Deductible/Copay | Insurance Paid |
|---|---|---|---|---|---|
| [Service Type] | $[0.00] | -$[0.00] | $[0.00] | -$[0.00] | **$[0.00]** |

**Summary of Responsibility:**

- **Total Amount Paid to Provider:** $[0.00]
- **Total Member Responsibility:** $[0.00]

**Notes/Reason Codes:**
[Enter code descriptions here, e.g., "Service covered under standard medical plan."]

If you have questions regarding this statement or wish to appeal this determination, please contact our Member Services department at [Phone Number] or visit our website at [Website URL].

Sincerely,

[Claims Department Name]
[Insurance Company Name]