Explanation of Benefits (EOB) Statement

Member:
Jane Doe
Member ID: 1234567890
Plan: Standard Health Plan
Date of Service: 2024-05-10
Provider:
Dr. John Smith
ABC Medical Clinic
Claim Number: CLM-456789

Claim Details

Date	Service Description	Provider Charges	Allowed Amount	Not Covered	Deductible	Coinsurance / Copay	Plan Payment	Your Responsibility
2024-05-10	Office Visit	$120.00	$100.00	$0.00	$25.00	$15.00	$60.00	$40.00
2024-05-10	Lab Test	$80.00	$60.00	$0.00	$0.00	$10.00	$50.00	$10.00

Total Provider Charges: $200.00
Total Plan Payment: $110.00
Total You May Owe: $50.00

Notes

- This is not a bill. Do not pay your provider based on this statement.
- Your responsibility may include any deductible, coinsurance, copayments, or non-covered charges.

If you have questions about this statement, contact our Member Services at (800) 555-1234 or visit our website.