

Insurance Benefits and Limitations

Date: [Insert Date]

Policyholder Name: [Insert Policyholder Name]

Policy Number: [Insert Policy Number]

Dear [Policyholder Name],

We are writing to provide you with a summary of your insurance benefits and any limitations that may apply to your policy. Please review the following information carefully.

Benefits:

- Coverage for medical expenses up to [amount]
- Prescription drug coverage
- Preventive care services at no additional cost
- Access to a network of healthcare providers

Limitations:

- Pre-existing conditions may not be covered for the first [number] months
- Out-of-network services may incur higher out-of-pocket expenses
- Annual coverage limits of [amount] apply
- Certain services may require prior authorization

If you have any questions regarding your benefits or limitations, please do not hesitate to contact our customer service department at [customer service number] or [email address].

Thank you for choosing [Insurance Company Name]. We appreciate your trust in us to provide for your insurance needs.

Sincerely,

[Your Name]

[Your Title]

[Insurance Company Name]