Just4Me Ultra (Gold) Family Dental + Vision: CareSource

Coverage Period: 01/01/14 – 12/31/14

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.caresource.com/just4me or by calling 1-800-479-9502.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,000. Does not apply to copays, pharmacy drugs and services listed below as no charge.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of– pocket limit on my expenses?	Yes. $6,000.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of– pocket limit?	Premium, balance-billed charges, copayments, health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.caresource.com/just4me or call 1-800-479-9502.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No, provided the specialist is in-network.	You can see the **specialist** you choose without permission from this plan.

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.caresource.com/just4me or call 1-800-479-9502 to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
Released on April 23, 2013
(corrected)

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Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	Not covered.	Copayment waived when the only charge is for allergy injections/serum, diagnostic or therapy services. Twelve-visit limit for spinal manipulation. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply.
	Specialist visit	$75/visit	Not covered.	
	Other practitioner office visit	$25/visit for nurse/physician assistant; 10% coinsurance for therapy services	Not covered.	
	Preventive care/screening/immunization	No charge	Not covered.	Services must meet requirements as determined by federal and state law.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered.	No coverage for services not medically necessary
	Imaging (CT/PET scans, MRIs)	$125/procedure	Not covered.	

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If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caresource.com/just4me	Generic drugs	$15 retail; $48 mail per prescription	Not covered.	There is no deductible for pharmacy items. Retail provides a 30-day supply. Mail order provides a 90-day supply.
	Preferred brand drugs	$75 retail; $188 mail per prescription	Not covered.	
	Non-preferred brand drugs	$100 retail; $250 mail per prescription	Not covered.	
	Specialty drugs	25% coinsurance (retail and mail)	Not covered.	There is no deductible for pharmacy items. $150 maximum coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered.	Condition must be medically necessary
	Physician/surgeon fees	10% coinsurance	Not covered.	Condition must be medically necessary
If you need immediate medical attention	Emergency room services	$250/visit	Not covered.	Waived if you are admitted directly from the Emergency Department.
	Emergency medical transportation	10% coinsurance	Not covered.	Your network provider must obtain prior authorization for all inpatient stays, partial hospitalization programs, and intensive outpatient services.
	Urgent care	$50 copay/visit	Not covered.	Routine or preventive care not covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/stay	Not covered.	Except in an emergency, you must call your PCP before going to a hospital
	Physician/surgeon fee	10% coinsurance	Not covered.	Condition must be medically necessary

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	Not covered.	Your network provider must obtain prior authorization from us for all inpatient stays, partial hospitalization programs and intensive outpatient services.
	Mental/Behavioral health inpatient services	$250/stay	Not covered.	
	Substance use disorder outpatient services	10% coinsurance	Not covered.	
	Substance use disorder inpatient services	10% coinsurance	Not covered.	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	Not covered.	Births outside your service area are not covered if you are more than 37 weeks pregnant.
	Delivery and all inpatient services	10% coinsurance	Not covered.	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered.	Any combination of benefits for home health care services is limited to one hundred (100) visits per calendar year
	Rehabilitation services	Benefits reflect those stated for each covered service category.	Not covered.	Depending on the type of therapy, there is a limit of 12-36 visits per calendar year.
	Habilitation services	Benefits reflect those stated for each covered service category.	Not covered.	Speech and language therapy and/or occupational therapy, 20 visits per benefit year. Mental/behavioral health outpatient services, 30 visits per benefit year.
	Skilled nursing care	$100/visit	Not covered.	Any combination of benefits for skilled nursing facility / inpatient rehabilitation facility services limited to 90 days per calendar year.
	Durable medical equipment	10% coinsurance	Not covered.	Must be medically necessary
	Hospice service	10% coinsurance	Not covered.	Benefit for a terminal illness, for up to six months
If your child needs dental or eye care	Eye exam	No charge for routine eye exam	Not covered.	Limit of one routine eye exam per year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Glasses	10% coinsurance		One set of prescription glasses (lenses and frames) or purchase of contacts per year at no cost. Contact lenses limited to a single purchase of up to a 3-month supply of daily disposables, or a 6-month supply of nondaily disposables, once per person in any 12-month period. Replacement is limited to once in any 12 month period.
	Dental check-up	Not covered.	Not covered.	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Child dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S
- Weight loss programs.

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

Optional dental + vision coverage

Limitations and Exceptions

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Services	Your Cost	
If you visit a dental provider	$25 (adult basic/visit) $75 (adult major/visit	Out-of-network not covered. Two (2) routine visits are allowed each year. Basic dental benefits (such as X-rays and fillings) are covered up to $300 per year. Major dental benefits (such as impactions and dentures) are separately covered up to $300 per year.
If you visit a vision provider	Vision copayment waived for preventive exam. Eyeglass copayment: $25	Out-of-network not covered. Lenses, frames, up to $150 per year

Your Rights to Continue Coverage:

Federal and state laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

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For more information on your rights to continue coverage, contact the insurer at 1-800-479-9502. You may also contact your state insurance department at 800-686-1526.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 800-686-1526.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,890
- **Patient pays** $1,650

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,5000
Copays	$0
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,650**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,290
Copays	$210
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,580**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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