CareSource™
Just4Me™

This Statement Period
8/21/2016 to 8/27/2016

1

Member ID
Health Plan:
Payer ID:

THIS IS NOT A BILL

Your personal explanation of benefits statement

Who paid for your family's health care plan this period

2

Total Billed Charges		**$74.42**
Amount CareSource Paid		**$10.42**
Medical costs	$0.00	
Prescription costs	$10.42	
CareSource Discounts		**$20.56**
Amount Your Family Paid		**$43.44**
Medical costs	$43.44	
Prescription costs	$0.00	
Excluded costs	$0.00	

"CareSource discounts" shown in this statement are for costs and charges CareSource negotiated for you with doctors, pharmacists, and hospitals. "Excluded costs" represent the items or partial amounts that are not covered by your plan, which you may be responsible for paying to the doctor or hospital.

Your family's health plan spending this statement period

3

Individual	Medical In-Network	Prescriptions	Total
	$43.44	$0.00	$43.44
Family Total	$43.44	$0.00	**$43.44**

+ Family totals reflected above, but members(s) recieve their own EOB when they have a medical claim

© 2014 CareSource
Questions about your plan or this statement call 1-800-479-9502 or visit CareSource.com/Just4Me
Urgent medical questions call CareSource 24/7 NurseLine at 1-866-206-4240.

CareSource™
Just4Me™

Your personal explanation of benefits statement

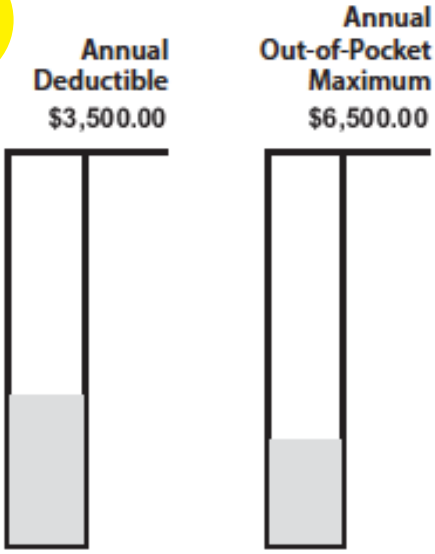
Plan Year-to-Date
1/1/2016 to 8/27/2016

4

Who paid for your family's health care plan this year

5

Total Billed Charges		**$14,195.16**
Amount CareSource Paid		**$2,302.66**
Medical costs	$424.33	
Prescription costs	$1,878.33	
CareSource Discounts		**$10,174.47**
Amount Your Family Paid		**$1,718.03**
Medical costs	$1,443.03	
Prescription costs	$275.00	
Excluded costs	$0.00	



Deductibles and Out-of-Pocket Maximum

What you paid out-of-pocket for your medical and prescription claims

6

	Maximum Amount	In-Network Amount You Spent	Out-of-Network[1] Amount You Spent	Amount Remaining
Annual Deductible	$3,500.00	$1,343.03	$0.00	$2,156.97
Annual Out-of-Pocket Maximum	$6,500.00	$1,718.03	$0.00	$4,781.97

Annual deductible - The amount you pay for health care services or supplies during each one-year period you are covered by our health plan before CareSource Just4Me begins to pay for eligible expenses.

Annual out-of-pocket maximum - The most you are required to pay for covered services during each one-year period you are covered by CareSource Just4Me. Not all expenses you pay count toward this limit.

Coinsurance - The percentage of a health care bill that you pay for certain covered services. When services have a coinsurance amount, you pay the health care Provider that amount, usually at the time of service.

Copayment - A fixed dollar amount that you pay for certain covered services, usually at the time of service. This amount, also called a copay, is a portion of the full bill.

[1]**Out-of-Network** expenses are covered only in the case of emergency care from an out-of-network provider, or urgent care services outside the service area.

© 2014 CareSource

CareSource
Just4Me™

Your personal explanation of benefits statement

Medical Claims (8/21/2016 to 8/27/2016) 7

Medical claims sections within this statement list new medical claims that were processed this period or previously processed claims that have been adjusted this period. The exclusions column represents the items or partial amounts that are not covered by your plan, or amounts from an out-of-network provider which you may be responsible for paying to the doctor or hospital.

Service Date, Claim Number, Provider, Prior Authorization, Description	Amount CareSource Paid				Amount You Paid				Total Amount You Paid
	Total Charge	Plan Discount	Plan Payment	Explanation Code	Plan Exclusions	Copay	Deductible	Co-Insurance	
08/16/2016 PHYSICIAN SERVICES In-Network	$64.00	$20.56	$0.00	PXN	$0.00	$0.00	$43.44	$0.00	$43.44
Statement Period Total:	$64.00	$20.56	$0.00		$0.00	$0.00	$43.44	$0.00	$43.44

Explanation Codes

Code	Description
PXN	Maximum payment issued

Prescription Claims (8/21/2016 to 8/27/2016) 8

Prescription claims within this statement show submitted prescription claims and total costs covered by CareSource for this period. Adjusted claims may be reflected in this statement or may show an amount that is different than what was listed prior to the adjustment. The cost of the prescription displayed is the negotiated rate at the pharmacy at the time of purchase and does not take into account other reimbursements. Negotiated rates on prescription drugs can vary by pharmacy, quantity, strength and/or dosage of the drug.

Prescription Description	Prescription Cost	Amount CareSource Paid	Amount You Paid			Total Amount You Paid
			Copay	Deductible	Other	
08/22/2016 GIANT EAGLE PHARMACY Rx #:	$8.83	$8.83	$0.00	$0.00	$0.00	$0.00
08/22/2016 GIANT EAGLE PHARMACY Rx #:	$1.59	$1.59	$0.00	$0.00	$0.00	$0.00
Statement Period Total:	$10.42	$10.42	$0.00	$0.00	$0.00	$0.00

© 2014 CareSource

CareSource
Just4Me™

Your personal explanation of benefits statement

Total Medical Claims (8/21/2016 to 8/27/2016) 9

Service Date, Claim Number, Provider, Prior Authorization, Description	Amount CareSource Paid				Amount You Paid				Total Amount You Paid
	Total Charge	Plan Discount	Plan Payment	Explanation Code	Plan Exclusions	Copay	Deductible	Co-Insurance	
08/16/2016 PHYSICIAN SERVICES In-Network	$64.00	$20.56	$0.00	PXN	$0.00	$0.00	$43.44	$0.00	$43.44
Statement Period Total:	$64.00	$20.56	$0.00		$0.00	$0.00	$43.44	$0.00	$43.44

Explanation Codes

Code	Description
PXN	Maximum payment issued

Total Prescription Claims (8/21/2016 to 8/27/2016) 10

Prescription Description	Prescription Cost	Amount CareSource Paid	Amount You Paid			Total Amount You Paid
			Copay	Deductible	Other	
08/22/2016 GIANT EAGLE PHARMACY Rx #:	$8.83	$8.83	$0.00	$0.00	$0.00	$0.00
08/22/2016 GIANT EAGLE PHARMACY Rx #:	$1.59	$1.59	$0.00	$0.00	$0.00	$0.00
Statement Period Total:	$10.42	$10.42	$0.00	$0.00	$0.00	$0.00

If you don't know whether to go to your doctor, an urgent care center, or an emergency room, call the CareSource 24/7 NurseLine at 1-866-206-4240 (TTY/TDD 1-800-750-0750). Nurses are available around the clock to help you decide what kind of care is best for you. You'll need your ID number, so have your ID card with you when you call.

© 2014 CareSource

CareSource™
Just4Me™

Claim Information

11

If you have questions about your claims, we want to help you find answers. Follow these steps when you need information: Contact us at 800-479-9502 or visit us at CareSource.com/Just4Me.

If your claim was denied due to missing information or requests for additional information, you or your provider may resubmit the claim with the complete information.

If you are covered by more than one benefit plan, file all claims with each plan. **Tell us about your other health insurance coverage.** Having other health insurance coverage does not change your coverage with us.

You may request more explanation when your claim is denied or the cost of the service you received was not fully covered: Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the cost was not fully covered;
- Cannot find the applicable provision in your Evidence of Coverage Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- You can also request diagnosis and treatment codes and descriptions.

Adverse Benefit Determination Information

An Adverse Benefit Determination is a decision we make not to provide benefits because we believe they are not medically necessary, you are not eligible for this benefit or the benefit is not covered under your plan. It can also be a decision to deny health benefit plan coverage or to rescind coverage. You may ask to have a copy of the medical reasons and/or benefit rules used to make our decision at no cost to you. To do this, please call Member Services at 1-800-479-9502 (TTY 1-800-750-0750 or 711). If we decline to provide benefits, in whole or in part, for the requested treatment or service, then the reasons for the denial will be indicated in the claims section of this document. If you think this determination was made in error, you have the right to appeal (see the Important Information About Your Appeal Rights section of this notice).

Important Information about Your Appeal Rights

What if I need help understanding this denial? If you need assistance understanding this notice or our decision to deny you a service or coverage please contact us at:

Phone - 1-800-479-9502
Website - www.caresource.com/Just4Me
Mailing Address - P.O. Box 8738, Dayton, Ohio 45401-8738

What if I don't agree with this decision? You have a right to appeal any decision to decline to provide or pay for any item or service (in whole or in part), not to issue health benefit plan coverage to you, or to rescind your coverage.

© 2014 CareSource

How do I file an appeal? Call Member Services at 1-800-479-9502 to request a copy of the Appeal Request Form. Complete the Appeal Request Form, keep a copy for yourself and send the Appeal Request Form to us at the following address or fax to:

Mailing Address: CareSource Just4Me, Attn: Member Appeals,
P.O. Box 1947, Dayton, Ohio 45401-1947
Fax: 937-487-0629 (Attn: Member Appeals)

Please see the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent as shown below, your review will generally be conducted within 72 hours after we receive the request. An urgent situation is one in which your health or life may be in serious jeopardy, you may not be able to regain maximum function if treatment is delayed, or you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by checking the appropriate box on the Appeal Request Form. If your treating physician believes you will require a Concurrent Expedited Internal Appeal and Expedited External Review due to your urgent medical condition or a proposed experimental or investigational treatment that must begin promptly, please check the appropriate box on the Appeal Request Form. Your doctor must complete the Treating Physician Certification Form for Internal Appeal and/or External Review to verify your situation.

Who may file an appeal? You, someone you name or someone who is authorized by law to act for you (your authorized representative) may file an appeal. Please complete the Appointment of Authorized Representative section of the Appeal Request Form.

Can I provide additional information about my claim? Yes, you may supply additional information. Please forward your information along with a copy of this Explanation of Benefits Statement to the following address or fax to:

Mailing Address: CareSource Just4Me, Attn: Member Appeals,
P.O. Box 1947, Dayton, Ohio 45401-1947
Fax: 855-795-0088

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, then you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at:
Phone: 1-800-479-9502
Fax: 937-487-0629
Website: www.caresource.com/Just4Me
Mailing Address: CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, Ohio 45401-1947

What happens next? If you request an appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a decision within 30 days, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

© 2014 CareSource

Other resources to help you:

For questions about your rights, this notice, or for further assistance you may contact:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint: http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

If you have any problems in reading or understanding this information, please contact CareSource Just4Me Member Services at 1-800-479-9502 (TTY 1- 800-750-0750 or 711). We can help to explain the information or provide the information orally, in English or in your primary language at no cost to you. We may have this information printed in certain other languages or in other ways. If you are visually or hearing-impaired, then special help can be provided to you at no cost.

Help us Prevent Fraud

Please review this Explanation of Benefits Statement carefully. Notify us immediately if you suspect fraud. Please contact us using any of the following options:

- Call: 1-800-479-9502
- Mail: CareSource Special Investigations Unit, P.O. Box 1940, Dayton, OH 45401-1940
- Email: fraud@caresource.com
- Fax: 1-800-418-0248

At CareSource, your personal, health and financial information is confidential. CareSource protects your information and only uses or discloses your information in accordance with federal and state privacy laws and CareSource's privacy policy. For additional information on CareSource's privacy policy, please access CareSource's Notice of Privacy Practices on the Web at CareSource.com/Just4Me/privacy-policy.

© 2014 CareSource

This page is Intentionally left blank.

© 2014 CareSource

Legend for EOB

1. The Statement Period is the time in which the claims were processed.

2. This section is a summary of the weekly claims activity for the entire family. If more than one member has a claim, this section is the combined activity for the week.

3. This section is showing your family's cost for deductibles, co-insurance and copays by member for this statement period.

4. The Plan Year-to-Date indicates the year for your family's deductibles and Out-of-pockets.

5. This summarizes the overall expenses that have been paid for your family for the plan year.

6. This is a summary of your family's deductible and out-of-pocket for the plan year. The chart is showing you a scale of where you are for your deductibles and out-of-pocket.

7. This section represents each individual medical claim that has been processed for you or your family member for this statement period.

8. This section represents each individual prescription claim that has been processed for you or your family member for this statement period.

9. This represents all medical claims processed for your family during this statement period.

10. This represents all prescriptions claims processed for your family during this statement period.

11. This section is for information regarding any questions or appeals rights if you do not agree with the Explanation of Benefits for this Statement Period.