

JMH Health Plan

<http://www.jmhhp.com>

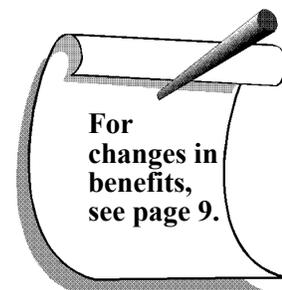


2009

A Health Maintenance Organization (High Option with Point of Service and Standard Option)

Serving: Miami-Dade and Broward Counties

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

- J81 Self Only
 - J82 Self and Family
 - J84 Self Only
 - J85 Self and Family
-



Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-818

**Important Notice from JMH Health Plan About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the JMH Health Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and the JMH Health Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of the JMH Health Plan under our contract (CS 2870) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the JMH Health Plan administrative offices is:

JMH Health Plan
155 S. Miami Avenue, Suite 110, Miami, FL. 33130

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009 and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means JMH Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800-721-2993 or 305-575-3640 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise);
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option, or a Standard Option Plan.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General Features of our High Option (with Point of Service) and Standard Options

High Option (with Point of Service)

JMH Health Plan will be offering Point of Service benefits to its FEHB members as of January 2009. Although the Health Plan offers a large provider network, by choosing the Point of Service (POS) plan with your High Option HMO plan, you will have the ability to receive services from out of network providers. The out of network option will enable you to receive medical services from providers who do not participate in the JMH Health Plan provider network. However, your out of pocket expenses will be higher when receiving services from out of network providers.

Standard Option

In order to offer health insurance to you at a lower premium rate, JMH Health Plan also offers a Standard option benefit package. This option will help you to carry health coverage for you and your families with a higher out of pocket, however, at a lower premium rate.

We have Open Access Benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician, or by another participating physician in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who Provides my health care

You can choose any physician, primary care or specialist, from the Premier Access Plus Network. Members are encouraged, but not required, to select a primary care physician. The same applies to the Covered family members. With our Open Access program, any participating specialists you need to see for covered services can be seen without a referral from your Primary Care Physician. The JMH Health Plan strives to keep the Provider Directory as up to date as possible. However, information may change after the Directory is printed. If the physician you wish to select is not accepting JMH Health Plan patients, please select another. You may want to call the physician you have chosen prior to calling the JMH Health Plan Member Service Department at 1(800) 721- 2993 or 305-575-3640 with your selection.

JMH Health Plan has arranged for benefit coverage for dependents that reside in out of service areas, and for members while they are traveling. This arrangement has been made for routine care through Beech Street Provider Network, which we call Premier Access Network. In most cases this will allow your dependents who are students attending school out of area to receive in-network benefits, in either of the HMO Plans, High Option with POS, or Standard Option. It will also permit members to access in-network benefits while traveling. The JMH Health Plan identification card issued to you and your dependents will include the Beech Street logo which will allow you access to the Beech Street national network. Keep in mind that Emergency services are always covered for you and your dependents.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

The JMH Health Plan is a fully licensed Health Maintenance Organization (HMO) in the State of Florida and is accredited by the Accreditation Association for Ambulatory Health Care.

The JMH Health Plan has long been committed to serving the managed care health care needs of the community. Founded as a pilot project, the JMH Health Plan was created to determine if managed care was a viable health care alternative for the medically needy. With grant monies and commitments from the Robert Wood Johnson Foundation, the State of Florida Department of H.R.S., and the Public Health Trust, the JMH Health Plan began providing managed health care services to members in 1985.

Our commitment to service has resulted in the JMH Health Plan's consistent ranking as one of the top health plans for customer satisfaction in Miami-Dade and Broward Counties in the Agency for Health Care Administration's Consumer Survey.

In addition to Jackson Health System's network of healthcare services, the JMH Health Plan backs up its commitment to service with South Florida's most comprehensive network of quality health care providers in the community. Anchored by one of America's finest medical facilities, Jackson Memorial Hospital, the JMH Health Plan offers the full range of services available at the University of Miami/Jackson Memorial Medical Center. To augment these specialized health care services, the JMH Health Plan boasts a broad network of over 6800 physicians and 46 hospitals in Miami-Dade and Broward Counties alone. All our providers are duly credentialed in accordance with Federal, State of Florida, and industry requirements.

If you want more information about us, call 800/721-2993 or 305-575-3640, or write to JMH Health Plan, 155 S. Miami Avenue, Suite 110, Miami, FL 33130. You may also contact us by fax at 305/545-5212 or access our website at <http://www.jmhhp.com>.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

Although our service areas are Miami Dade County and Broward County, JMH Health Plan has arranged for routine care benefit coverage for dependents that reside in out of service areas, and for members while they are traveling. This arrangement has been made through Beech Street Provider Network, which we call Premier Access Plus Network. In most cases this will allow your dependents who are students attending school out of area, to receive in-network benefits, in either of the HMO Plans, High Option, or Standard Option. For example, if your dependent goes to school in Georgia, you will complete a form included in your enrollment packet and fax or mail to the JMH Health Plan. When your dependent requires medical services, you may call the number on the member ID card or go online to Beech Street's website to select a provider or to determine if the provider you wish to use participates in the Beech Street network.

This new arrangement will, with a non-emergency condition, permit members to access in-network benefits while traveling. For example, when you are traveling, and become ill, and need medical attention, you may call the number on your ID card or go to the Beech Street's website to locate a provider. As always, emergency care remains covered.

The JMH Health Plan identification card issued to you and your dependents will include the Beech Street logo which will allow you access to the Beech Street national network.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

CHANGES TO THE PLAN

- **Hearing Benefits for Adults:** We have enhanced our hearing benefits for adults to include hearing aids for adults; including screening and testing services, based on medical necessity.
- **Point of Service:** JM Health Plan will be offering Point of Service benefits to its FEHB members as of January 2009. Although the Health Plan offers a large provider network, by choosing the Point of Service (POS) plan with your High Option HMO plan, you will have the ability to receive services from out of network providers. The out of network option will enable you to receive medical services from providers who do not participate in the JM Health Plan provider network. However, your out of pocket expenses will be higher when receiving services from out of network providers.

Following is important information to keep in mind when choosing the High Option **Point of Service** plan.

Annual Deductible - \$250 Self and \$750 Family

Annual coinsurance out of pocket maximum - \$3,000 Self and \$6,000 Family

Lifetime Maximum - \$2,000,000 per member

Precertification - Approval must be obtained for out of network inpatient admissions. There is a penalty for not obtaining prior authorization.

Emergency Care and Services: Hospital Emergency Room - \$75

Ambulance - No payment

Emergency Care in Provider's Office - \$15

Urgent Care Centers - \$25

Prescription Drugs - Generic \$10, Preferred Brand \$20, and Non-Preferred Brand \$30

For using out of network providers such as any Physician, Specialist, Hospital, and Outpatient services (including diagnostic tests), Allergy treatments, Physical, Speech, and Occupational Therapies, Cardiac Rehabilitation, Skilled Nursing facilities and Rehabilitation Centers, Home Health Care, Durable Medical Equipment, Prosthetic devices and Orthotic appliances, Infertility Services, Prescription Drug benefits, and Vision Care, you pay 30% of the Usual and Customary charge, subject to the deductible

Out of Area Services for dependents and members while traveling

Although our service areas are Miami Dade County and Broward County, JM Health Plan has arranged for routine benefit coverage for dependents that reside in out-of-service areas, and for members while they are traveling. This arrangement has been made through Beech Street Provider Network, which we call Premier Access Plus Network. In most cases this will allow your dependents who are students attending school out of area, to receive in-network benefits, in either of the HMO Plans -High Option, with POS, or Standard Option. For example, if your dependent goes to school in another state, you will complete the " Away from Home Network Access Information Form" included in your enrollment packet and fax or mail to the JM Health Plan. When your dependent requires medical services, you may call the number on the member ID card or go online to Beech Street's website www.Beechstreet.com to select a provider or to determine if the provider you wish to use participates in the Beech Street network. There is 30% of Usual and Customary charge, subject to the deductible if you have chosen the POS plan and choose to go out of network.

This new arrangement will, with a non-emergency condition, permit members to access in- network benefits while traveling. For example, when you are traveling, and need medical attention, you may call the number on your ID card or go to the Beech Street's website to locate a provider. Once you locate the Beechstreet provider, you may see this doctor and receive in network benefits. You can also access emergent and urgent care services from any emergency room or urgent care center in the country.

The JMH Health Plan identification card issued to you and your dependents will include the Beech Street logo which will allow you access to the Beech Street national network.

Section 3. How you get care

Identification cards	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-721-2993 or (305) 575-3640 or write to us at JMH Health Plan, 155 S. Miami Avenue, Suite 110, Miami, FL. 33130 . You may also request replacement cards through our website.</p>
Where you get covered care	<p>You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and coinsurance. If you use our Open Access program you can receive covered services from participating providers without a required referral from your primary care physician or by another participating provider in the network.</p>
<ul style="list-style-type: none">• Plan providers	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our website at http://www.jmhhp.com.</p>
<ul style="list-style-type: none">• Plan facilities	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically.</p>
What you must do to get covered care	<p>You can choose any physician, primary care or specialist, from the Premier Access Plus Network. Members are encouraged, but not required, to select a primary care physician. The same applies to your Covered family members.</p>
<ul style="list-style-type: none">• Primary care	<p>If you select a primary care physician, who can be a family practitioner, internist, general practitioner or pediatrician, he or she will provide most of your health care.</p> <p>If for any reason you become dissatisfied with your primary care physician and/ or service location, you may select a new physician and/ or service location, at anytime from our Premier Access Plus Network.</p>
<ul style="list-style-type: none">• Specialty care	<p>You will have direct access to specialty care physicians without a referral from the primary care physician if you are signed up with our High Option with POS Plan. You have the right to select a specialist, as long as the specialist is a participating provider and qualified to provide the necessary treatment. Elective admissions; outpatient procedures; Durable Medical Equipment; physical, occupational, and speech therapy; Home Health services and plastic surgery, and certain diagnostic procedures require a referral from the primary or specialty care physician and authorization from the Health Plan. Under the Standard Option Plan, you are required to choose a Primary Care Physician, and require referrals for specialty care services, except to gynecologists, dermatologists, chiropractors, podiatrists and other practitioners as specified by law.</p>

If you choose a specialist beyond those participating with the Health Plan, and have chosen the High Option with POS, you can pick a specialist from our extensive network, or decide to go out of network. Going out of network is subject to applicable deductibles, coinsurances and lifetime maximums (See Section 5i for POS benefits). As the procedures for specialty care vary for health maintenance organizations, the covered person is responsible for following the procedures established by the Health Plan.

Here are some other things you should know about specialty care:

- If you have signed up for High Option with POS, and need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician or specialist will develop a treatment plan that allows you to see your specialist for a certain number of visits without requiring referrals. Your primary care physician will use our criteria when creating your treatment plan. If you have chosen the Standard Option Plan, any specialty care will require referrals.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If your current specialist participates with us, you can visit the specialist without a referral, or go to an out-of-network specialist, if you have chosen High Option with POS, which will be subject to applicable deductibles, coinsurances and lifetime maximums (See Section 5i for POS benefits). If you have ongoing care needs with non-participating providers, we encourage you to submit a Transition of Care form to request coverage for these services.
- If you are seeing a specialist and your specialist leaves the Plan, or you are not satisfied with the services you are receiving from this specialist, you can choose another specialist from our extensive list of providers, or go to an out-of-network specialist, if you have chosen High Option with POS. If you have chosen the Standard Option, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan,

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care** Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.
- **If you are hospitalized when your enrollment begins** We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 721-2993 or (305) 575-3640. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

You have direct access to in network specialty care physician without a referral from your primary care physician. Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Your physician must obtain authorization for services such as, but not limited to: hospitalization, Growth Hormone Therapy (GHT), Home Health Service, Durable Medical Equipment, biological, injectable or intravenous drugs provided on an outpatient basis, and other comprehensive diagnostic and treatment services. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval process precertification.

Your Primary Care Physician or Specialist, is responsible for coordinating any necessary hospitalizations. Scheduled admissions require advance authorization from the JMH health Plan. Emergency admissions require notification of the JMH Health Plan within 48 hours by the member, if the emergency services are rendered in an out of network hospital, or as soon thereafter as possible. Authorization occurs when we approve the admission and issue a complete authorization number to the hospital. The telephone number to call is on the back of your identification card. If the emergency services are rendered at an in network hospital, then the hospital will notify JMH Health Plan. .

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. To provide better access to healthcare, JM Health Plan is now offering two options. A High Option with POS, and a Standard Option. Each option comes with its own copayments.

Example: If you have chosen the High Option with POS, and you visit your primary care physician you pay a copayment of \$15 per office visit, a specialist copayment of \$25 per office visit; and when you go to the hospital you pay \$100 per day up to a \$500 maximum per admission.

If you have chosen the Standard Option, and you visit your primary care physician you pay a copayment of \$30 per office visit, a specialist copayment of \$40 per office visit; and when you go to the hospital you pay \$150 per day up to a \$750 maximum per admission.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Deductible Our annual deductible for High Option with POS, going to out of network providers is \$250 for individual, and \$750 for the family. If you choose the Standard Option, there is no deductible to meet.

Coinsurance Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Your catastrophic protection out-of-pocket maximum After your (copayments and coinsurance) total \$3,000 per person or \$6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. When the covered person has paid copayments that total the annual maximum, no further copayments shall be required by that covered person for the remainder of the calendar year. The covered person is responsible for providing documentation of the amount of copayments paid.

Carryover If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us, for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 62 and 64 are a benefit summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefit Overview

This Plan offers both a High Option with Point of Service and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled. These options are divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain more information about High Option with Point of Service, and Standard Option benefits, contact us at 1-800-721-2993 or at our Web site at www.jmhhp.com. Each option offers unique features.

**Section 5(a) Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion • At home 	Nothing Nothing Nothing \$15 \$25 Nothing	Nothing Nothing Nothing \$30 \$40 Nothing
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing	Nothing

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol - once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above. <ul style="list-style-type: none"> - Routine Pap test 	\$15 per visit to a primary care physician \$25 per visit to a specialist \$100 in outpatient department of a hospital or ambulatory surgical facility	\$30 per visit to a primary care physician \$40 per visit to a specialist \$200 in outpatient department of a hospital or ambulatory surgical facility
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing	Nothing
Adult Routine immunizations endorsed by the Center for Disease Control and Prevention (CDC):	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist
<i>Not covered: Examinations, reports, or any other service related to requirements or documentation of health status for employment, licenses, insurance, travel, or for educational or sports/recreational purposes.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per visit to a primary care physician	\$30 per visit to a primary care physician
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction 	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Hearing Aids for children till the age of 17 based on medical necessity every three years - Examinations done on the day of immunizations (up to age 22) 	<p>\$15 per visit to a primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$30 per visit to a primary care physician</p> <p>\$40 per visit to a specialist</p>
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 per visit to a primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$30 per visit to a primary care physician</p> <p>\$40 per visit to a specialist</p>
Family planning	High Option	Standard Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per visit to a primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$30 per visit to a primary care physician</p> <p>\$40 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Family planning - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Family planning (cont.)		
<ul style="list-style-type: none"> Genetic counseling 	All charges	All charges
Infertility services		
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> Artificial insemination: <ul style="list-style-type: none"> intravaginal insemination (IVI) intracervical insemination (ICI) intrauterine insemination (IUI) 	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> in vitro fertilization embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) Services and supplies related to ART procedures Infertility services if one of the partners has previously undergone surgical sterilization or if one of the partners is menopausal or post menopausal Cost of donor sperm Cost of donor egg Fertility Drugs 	All charges	All charges
Allergy care		
<ul style="list-style-type: none"> Testing and treatment Allergy injections 	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist
Allergy serum	Nothing	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> Provocative food testing Sublingual allergy desensitization 	All charges	All charges
Treatment therapies		
<ul style="list-style-type: none"> Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 25. <ul style="list-style-type: none"> Respiratory and inhalation therapy Dialysis – hemodialysis and peritoneal dialysis 	Nothing	Nothing

Treatment therapies - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Treatment therapies (cont.)</p> <ul style="list-style-type: none"> Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call (800) 721-2993 or (305) 575-3640 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	Nothing	Nothing
<p>Physical and occupational therapies</p> <p>Short term physical, and occupational therapy for acute conditions is covered. Services are limited to 60 visits per calendar year for all services combined. Services are covered for each of the following:</p> <ul style="list-style-type: none"> qualified physical therapists and occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided with same limitations listed above.</p>	\$15 per visit	\$30 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Long-term rehabilitative therapy</i> <i>Exercise programs</i> <i>Massage therapy</i> 	<i>All charges</i>	<i>All charges</i>
<p>Speech therapy</p> <p>Speech therapy will be covered at 60 visits per calendar year.</p>	\$15 per visit	\$30 per visit

Benefit Description	You pay	
	High Option	Standard Option
Hearing services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> Hearing aids for adults, including screening, and testing services based on medical necessity Hearing testing for children through age 17, include; (see <i>Preventive care, children</i>) Also hearing aids for children till the age of 17 based on medical necessity, every three years 	<p>\$15 per visit to a primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$30 per visit to a primary care physician</p> <p>\$40 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> All other hearing testing 	<i>All charges</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> Annual eye refractions Eye exam to determine the need for vision correction for children through age 17(See Preventive care, children) Annual eye refractions. One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>\$15 per visit for primary care</p> <p>\$25 per visit for specialist</p>	<p>\$30 per visit for primary care</p> <p>\$40 per visit for specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses, except as shown above Eye exercises and orthoptics Radial keratotomy and other refractive surgery Eyeglasses for ocular surgery 	<i>All charges</i>	<i>All charges</i>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>An initial pair of shoe orthotics when ordered from a participating provider is covered and no copay applies. Benefits for hand or wrist splints are also covered with no copay</p>	<p>\$15 per visit to a primary care physician</p> <p>\$25 per visit to a specialist</p>	<p>\$30 per visit to a primary care physician</p> <p>\$40 per visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Coverage for orthotic appliances is limited to leg, arm, back, and neck custom-made braces when related to a surgical procedure or when used in an attempt to avoid surgery and are necessary to carry out normal activities of daily living, excluding sports activities. • One initial pair of shoe orthotics • hand and wrist splints 	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacement unless the Plan or your Plan physician determines it is necessary because of growth or change.</i> 	<i>All charges</i>	<i>All charges</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>Rental or purchase, at our option, including repair and adjustment, of medically necessary durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Standard wheelchairs; • Crutches; • Walkers; • Nebulizers; 	\$25 per durable medical equipment item over \$100 to our maximum Plan benefit of \$500	\$50 per durable medical equipment item over \$100 to our maximum Plan benefit of \$500

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> · Breast pumps; · Insulin pumps. <p>Note: Blood glucose monitoring machines are covered under our prescription drug benefit.</p> <p>Coverage for durable medical equipment not listed above is limited to \$500 per member per calendar year.</p>	<p>\$25 per durable medical equipment item over \$100 to our maximum Plan benefit of \$500</p>	<p>\$50 per durable medical equipment item over \$100 to our maximum Plan benefit of \$500</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Motorized wheel chair; • Custom wheel chairs; • Modifications to motor vehicles or homes such as wheelchair lifts or ramps; • Water therapy devices such as jacuzzis, hot tubs or whirlpools and exercise equipment; • <i>Any equipment that is not deemed medically necessary or is an upgrade to accepted standard;</i> • <i>Any repairs or adjustments on equipment that is purchased for you</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Home health services	High Option	Standard Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>	<p>Nothing</p>
<p>Not covered:</p> <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative; • <i>Personal comfort or convenience items such as television and telephone services;</i> • <i>Private duty nursing.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
Chiropractic	High Option	Standard Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$15 per visit to a primary care physician \$25 per visit to a specialist	\$30 per visit to a primary care physician \$40 per visit to a specialist
Alternative treatments	High Option	Standard Option
No benefits	<i>All charges</i>	<i>All charges</i>
Educational classes and programs	High Option	Standard Option
Coverage is limited to: <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management 	\$15 per visit to a primary care physician up to our benefit maximum; \$15 per visit to a primary care physician	\$30 per visit to a primary care physician up to our benefit maximum; \$30 per visit to a primary care physician

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) will be covered when the following conditions are met: • Eligible members are age 18 or over; • Surgery for morbid obesity is performed only as a last resort, when the member's health is endangered and failures in established weight control programs including use of prescription drugs such as appetite suppressants are documented; 	Nothing	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Patients whose BMI exceeds 40 or less severely obese patients (with BMI's between 35 and 40) with high-risk co-morbid conditions such as life-threatening cardiopulmonary problems, severe diabetes mellitus or with joint disease, or body size problems precluding or severely interfering with employment, family function, and mobility; • Patients must be evaluated by a multidisciplinary team with medical, surgical, psychiatric and nutritional expertise; and • The operation is performed at a Bariatric Center of Excellence according to the guidelines defined by American Society of Bariatric Surgery and the surgery is performed by a surgeon with the necessary expertise • Insertion of internal prosthetic devices . See 5(a) – Orthopedic and prosthetic devices for device coverage information. <p>Note: The internal prosthetic device must be medically necessary to restore bodily function and require a surgical incision (as opposed to an external prosthetic device). Examples: artificial knuckles and joints, pacemakers, defibrillator, penile implants, breast implants and artificial eyes. Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p> <ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges</i></p>	<p><i>All Charges</i></p>

Benefit Description	You pay	
	High Option	Standard Option
<p>Reconstructive surgery</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery <p>Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</p>	Nothing	Nothing
<p>All stages of breast reconstruction surgery following a mastectomy, such as:</p> <ul style="list-style-type: none"> • surgery to produce a symmetrical appearance of breasts; • treatment of any physical complications, such as lymphedemas; • breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> <hr/> <p>Not covered:</p> <p>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</p> <p>Surgeries related to sex transformation</p>	Nothing	Nothing
	<i>All charges</i>	<i>All charges</i>
<p>Oral and maxillofacial surgery</p> <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	Nothing	Nothing
	<i>All charges</i>	<i>All charges</i>

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Kidney/Pancreas • Liver • Lung: Single-Double • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <p>1) Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Hemoglobinopathy (i.e.Fanconi;s, Thalessemia major) • Myelodysplasia/Myelodysplastic syndromes • Severe combined immunodeficiency • Severe or very severe aplastic anemia 	<p>Nothing</p>	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Amyloidosis <p>2) Autologous transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Neuroblastoma • Amyloidosis <p>3) Autologous tandem transplants for</p> <ul style="list-style-type: none"> • Recurrent germ cell tumors (including testicular cancer) • Multiple myeloma • De-novo myeloma <p>Blood or marrow stem cell transplants for</p> <p>4) Allogeneic transplants for</p> <ul style="list-style-type: none"> • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) <p>5) Autologous transplants for</p> <ul style="list-style-type: none"> • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer <p>Mini-transplants (non-myeloblastic, reduced intensity conditioning): for covered transplants: Subject to medical necessity</p> <p>Tandem transplants for covered transplants: Subject to medical necessity</p> <p>Blood or marrow stem cell Transplants: Not Subject to Medical Necessity, may be Limited to Clinical Trials.</p> <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute - or National Institutes of Health approved clinical trial at a Plan designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p>	<p>Nothing</p>	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Medical expenses incurred by a non-member who donates an organ or tissue to a Member will only be covered if the non-member does not have coverage for these services</i> • <i>Implants of artificial organs</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	Nothing	Nothing
Anesthesia	High Option	Standard Option
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing	Nothing
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	Nothing

Section 5(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductibles.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$100 per day up to a \$500 maximum per admission	\$150 per day up to a \$750 maximum per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items <p>Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)</p>	Nothing	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial or domiciliary care, basic care or housekeeping</i> 	<i>All charges</i>	<i>All charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Inpatient hospital (cont.)</p> <ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care except when medically necessary</i> • <i>Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care Facilities</i> <p><i>Blood and blood derivatives not replaced by member</i></p>	<i>All charges</i>	<i>All charges</i>
<p>Outpatient hospital or ambulatory surgical center</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 per procedure	\$200 per procedure
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial or domiciliary care, basic care or housekeeping</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Blood and blood derivatives not replaced by member</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Extended care benefits/Skilled nursing care facility benefits		
<p>Skilled nursing facility (SNF): We provide a comprehensive range of benefits for up to 60 post-hospital days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor, and approved by the Plan. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care; <p>Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.</p> <hr/> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial or domiciliary care, basic care or housekeeping • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Blood and blood derivatives not replaced by member 	<p>Nothing</p> <hr/> <p><i>All charges</i></p>	<p>Nothing</p> <hr/> <p><i>All charges</i></p>
Hospice care	High Option	Standard Option
<p>We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services included:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care; • Family counseling <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial or domiciliary care, basic care or housekeeping • Independent nursing, homemaker services • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Skilled nursing services provided on a twenty-four (24) hour basis in the home 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

High and Standard Option

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	Nothing	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

The procedure the covered person should follow for emergency care, as defined in this section, depends on whether the treatment is rendered inside or outside the service area.

Emergencies within our service area:

You are covered for treatment when a true emergency exists. If you are in doubt of the seriousness of the medical condition and have time to call your Primary Care Physician, you should do so. If your physician feels that the problem requires immediate attention, he or she will direct your treatment. Please note: Emergency health services rendered by a non-participating provider within our service area are covered. Also services will be covered if they are rendered by a non-participating provider because an emergency prevents you from receiving services from a participating provider.

Emergencies outside our service area:

In case of an emergency when you are out of the Plan's service area, we provide coverage for necessary emergency care. If your problem is too serious, and prevents you from returning to the service area, you may go to the closest urgent or emergency care facility. Emergency admissions require notification of the JMH Health Plan within 24 hours, or as soon thereafter as possible. You may call the JMH Health Plan 24 hours a day at the number on the back of your JMH Health plan identification card. Please call the Plan within 24 hours if it is reasonable to do so after an emergency in order to confirm coverage, ensure proper follow-up care and assure payment for covered services.

Note: We reserve the right not to pay for non emergency treatment received at emergency facilities. If you are hospitalized at an out of network hospital, you may be transferred to an in network hospital as soon as it is medically appropriate in the opinion of the attending physician. Should you, or your designee, refuse a transfer to an in network hospital, continued care provided to you at an out of network shall not constitute covered services and shall no longer be the financial responsibility of us. Follow-up visits shall be provided by participating providers. Your Primary Care Physician will coordinate your follow-up care.

High and Standard Option

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital , including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per visit to a primary care physician, \$25 per visit to a specialist</p> <p>\$25 per visit</p> <p>\$75 per visit (waived if admitted)</p>	<p>\$30 per visit to a primary care physician, \$40 per visit to a specialist</p> <p>\$50 per visit</p> <p>\$100 per visit (waived if admitted)</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>	<i>All charges</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$15 per visit to a primary care physician, \$25 per visit to a specialist</p> <p>\$25 per visit</p> <p>\$75 per visit (waived if admitted)</p>	<p>\$30 per visit to a primary care physician, \$40 per visit to a specialist</p> <p>\$50 per visit</p> <p>\$100 per visit (waived if admitted)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
<p>Professional ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing	Nothing
<i>Not covered: Air ambulance</i>	<i>All charges</i>	<i>All charges</i>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per visit</p>	<p>\$30 per visit</p>
<p>Diagnostic tests</p> <hr/> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p> <hr/> <p>\$100 per day - \$500 maximum per admission</p>	<p>Nothing</p> <hr/> <p>\$150 per day - \$750 maximum per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>You must call University of Miami Behavioral Health (UMBH) at (800) 294-8642. You do not need a referral from your primary care physician or approval from us. UMBH is a managed behavioral health care firm with over 500 providers in our service area. A UMBH provider will evaluate you and develop a treatment plan. Once the treatment plan has been approved, you must follow it. If you need inpatient care, your UMBH provider will arrange it for you. Call UMBH for the participating providers in your area.</p>
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible or annual maximums.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME PRESCRIPTION DRUGS.** Please refer to your Drug Formulary on JM Health Plan website at www.jmhhp.com to see the list of drugs that require prior authorization.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A Plan physician or licensed dentist authorized to prescribe drugs within the scope of his or her license must write the prescription.
- **Where you can obtain them.** You must fill the prescription at any participating pharmacy.
- **We have an open formulary.** The prescription drug co-payments for Generic drugs, Preferred Brand names and Non-Preferred brands are shown in the table below. Please visit our website at www.jmhhp.com for more pharmacy information or call Member Services at 305-575-3640.
- **“Mail at Retail”** is a maintenance drug program developed by JM Health Plan where you may obtain up to a 90 day supply of covered prescriptions for two times the copayment. Some pharmacies may not participate with the “Mail at Retail” program.

Some prescription medications are subject to drug restrictions such as step therapy, age, gender, quantity limits or prior authorization required.

This program is based on an approved list of maintenance drugs that are used on a long term basis. The JM Maintenance Drug List (MDL) comprises over 4,500 medications of different strengths and formulations and is updated periodically.

These are the dispensing limitations. A generic equivalent will be dispensed when available. If you, or your physician request a brand name product when a generic is available, you will pay the cost difference between the generic and brand name product in addition to the applicable brand co-payment. Retail pharmacy prescriptions are limited to 30 days per prescription. Our program of Mail at Retail is an option for defined maintenance medications as needed for chronic or long term health conditions. This option allows you the benefit of picking up your medication at any of the Plan pharmacies participating in this program, for a 90 day supply, with 2 times the copayment. You still have the mail order option available to you with the same copayment structure.

There are two conditions that need to be met prior to obtaining a 90 day supply for 2 copayments:

The medication must be listed on the JM Health Plan **Maintenance Drug List (MDL)** located on the Plan's website at www.jmhhp.com.

You must be on the same medication and the same dose for a minimum of 3 months.

Members called to active military duty in a time of national or other emergency who need to obtain a greater than normal supply of prescribed medications should call our Member Services Department at (305) 575-3640.

Why use generic drugs? Generic drugs are lower priced drugs that are the therapeutic equivalent to more expensive brand name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand name products. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs.

You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost effective medication saves money.

When you are seeking reimbursement for out of pocket costs. If you are seeking reimbursement for out of pocket costs, please call our Member Services Department @ 1-800-721-2993 or 305-575-3640 and a Member Services Agent will assist you. You can also obtain a Member Reimbursement Form from our website at www.jmhhp.com. Please review the form and follow the instructions. You must mail proof of payment along with the signed Reimbursement Form within 90 days of the date of service.

- Patient name
- Subscriber number and the patients two digit relationship code as shown on your identification card
- Amount billed
- Amount paid
- Description of service and procedure codes
- Diagnosis and diagnosis codes
- Location of service
- Date of Service

Address the envelope as follows.

JMH Health Plan

Attention Member Services Department

155 S. Miami Avenue, Suite 110

Miami, FL. 33130

Attention: Member Services

If you need further assistance, or have questions, please call our Member Services Department at (800) 721-2993 or 305-575-3640

Benefit Description	You pay	
	High Option	Standard Option
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our Mail at Retail program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin and FDA approved glucose strips and tablets, and chemstrip test tapes • Disposable needles and syringes for the administration of covered medications • Blood glucose monitoring machines 	<p><u>Retail Pharmacy</u> - 30 days supply</p> <p>\$10 Generic Drugs</p> <p>\$20 Preferred Brand Drugs</p> <p>\$30 Non-Preferred Brand Drugs</p> <p>50% for injectibles up to maximum of \$100</p>	<p><u>Retail Pharmacy</u> - 30 days supply</p> <p>\$10 per generic</p> <p>50% of the cost for Preferred and Non Preferred Brand up to a maximum of \$100</p> <p>50% for injectibles up to a maximum of \$100</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Drugs for sexual dysfunction • Oral contraceptive drugs and devices [contraceptive devices and diaphragms are covered under medical services, see section 5(a)] 	<p>Mail at Retail Pharmacy or Mail order</p> <p><u>(for maintenance drugs up to a 90 day supply for 2 copays)</u></p> <p>\$20 Generic medications</p> <p>\$40 Preferred Brand names</p> <p>\$60 Non Preferred Brand names</p> <p>See page 41 for more information on Mail at Retail.</p>	<p>Mail at Retail Pharmacy or Mail order</p> <p><u>(for maintenance drugs up to a 90 day supply for 2 copays)</u></p> <p>\$20 per generic</p> <p>50% of the cost for Preferred and Non Preferred Brand up to a maximum of \$200</p> <p>See page 41 for more information on Mail at Retail.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Prescription refills in excess of the number specified by the physician or dispensed more than one year from the date of the original order of the physician or other participating provider authorized to prescribe drugs within the scope of his or her license</i> • <i>Any portion of a prescription or refill that exceeds 30 days unless specified above</i> • <i>Nonprescription medicines except for select OTC medications</i> 	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Section 5(g) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary .
- If you are enrolled in a Federal Employees Dental/Vision Insurance program (FEDVIP) Dental Plan, your FEHB Plan will be First/ Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits.
- Make sure to read information regarding our **discount dental program** that we are offering through Atlantic Dental Incorporated (ADI), under "Non- FEHB Benefits" to promote health and wellness within our membership.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing	Nothing
Dental benefits		
Please see Non FEHB benefits Section for Dental Benefits Coverage schedule.	<i>Pay according to Dental Benefit schedule</i>	<i>Pay according to Dental Benefit schedule</i>

Section 5(h) Special Features

<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
<p>High risk pregnancies</p>	<p>A case manager is assigned upon notification of a high risk pregnancy. The physician, member, and case manger develop a treatment plan specific to the member's medical needs</p>
<p>Centers of excellence for Trauma Facilities, Burn Center, and Transplant Services</p>	<p>The following is a Center of excellence available when appropriately referred: University of Miami/Jackson Memorial Medical Center, Miami, FL.</p>

Section 5(i). Point of Service benefits

Point of Service (POS)

Although the JMH Health Plan offers a large provider network, by choosing the Point of Service (POS) plan with your High Option HMO plan, you will have the ability to receive services from out of network providers, however, your out of pocket expenses will be higher when receiving services from out of network providers. If you have questions, please call our Member Services Department at 1-800-721-2993 or 305-575-3640.

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- All out of network services are subject to applicable deductibles, coinsurances and lifetime maximums as listed in this section.
- All non-emergency out of network inpatient admissions and designated out patient procedures require precertification (prior authorization).
- You will be subject to a penalty of \$500 for all non emergency out of network services received without precertification (prior authorization) from us.
- Non-participating out-of-network providers have not agreed to accept JMH Health Plan's usual and customary standard (U & C) as payment in full for covered services. Therefore, if a non-participating provider is used the member is also responsible for the difference between U & C and the non-participating provider's actual charges.

Point of Service (POS) Benefits

Coverage

This Plan will cover you for services through in network (providers that participate in the JMHP network) and out of network providers that do not participate in JMHP Health Plan provider network. All services through out of network providers will be subject to a deductible, coinsurance and a maximum lifetime benefit as stated below.

Deductible

A specified dollar amount for out of network services that must be incurred and paid by you before the Plan will assume any liability for all or part of the remaining covered services. The deductible must be met every calendar year. For a Self Only enrollment the calendar year deductible is \$250; for a Self and Family enrollment the calendar year deductible is \$750.

Precertification (prior authorization)

Precertification is the process whereby all non emergency out of network inpatient admissions and designated out patient procedures are reviewed and approved by the Plan, prior to the provision of services in order to determine medical necessity and appropriate length of stay.

Coinsurance

A specified portion of the Plan's usual, customary, and reasonable (UCR) allowance you are required to pay. After your deductible is met we pay 70% of the UCR allowance, and you pay 30% of the UCR allowance until you reach the annual out-of-pocket amount.

Maximum Benefit

There is an out of pocket coinsurance maximum of \$3,000 for a Self Only enrollment; for a Self and Family enrollment the out of pocket maximum coinsurance is \$3,000 per person up to a maximum of \$6,000. This will be the maximum dollar amount, excluding deductibles and amounts in excess of the Plan's UCR allowance, which you are required to pay toward out of network services each calendar year.

The lifetime maximum benefit for out of network services is \$2,000,000 per member. This is the maximum amount of benefits we will cover under this point of service provision for out of network services. Once you reach the maximum out-of-pocket amount, we will pay 100% of the Plan's UCR allowance until the lifetime maximum of \$2,000,000 is reached. There is no in-network lifetime maximum.

Hospital and Extended care benefits

Non-emergency out of network inpatient hospital admissions require precertification as described above. They will be covered subject to deductible, coinsurance and maximum benefit limits, also listed above. The hospital charge, sometimes called a facility charge, does not cover any charges for doctor's services.

Emergency care and Services

Your Emergency care visit to a hospital will be subject to a copay of \$75, and emergency services rendered in a provider's office and Urgent care centers will be subject to a copayment of \$15 and \$25 respectively.

How do you obtain benefits

To receive coverage for out of network services, you will be required to file a claim form, CMS1500 after services were provided for all out of network services. The claim form can be obtained by calling our member services department at 1-800-721-2993 or 305-575-3640, or you can visit our website at www.jmhhp.com. You should keep a record of out of network services incurred by yourself and each family dependent. The claim form can be filled out and sent to the following address:

JMH Health Plan

Attention: Claims Department

155 South Miami Avenue

Suite 110

Miami, Florida 33130

You must sign the claim form before we will issue payment to a provider or reimburse you for out-of-network services under this provision. If the claim qualifies as a covered expense, you or the provider will receive reimbursement from us. Claims for services must be submitted to us no later than twelve months after the end of the calendar year in which covered services are provided. If you are not satisfied with our adjudication of a claim, you may utilize our established Grievance procedure.

Non-FEHB benefits available to Plan members

Health and Wellness Discount Program

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out of pocket maximums.

JMH Health Plan in partnership with Atlantic Dental Incorporated, (ADI) is currently offering a Health and Wellness Discount program to promote good health by offering discounts on weight reduction programs, fitness center memberships, and cosmetic surgery. **For the year 2009, JMH Health Plan is pleased to add a discount dental Plan to its Health and Wellness program.** This will help you in your efforts to stay healthy and make the services more affordable. Best of all, after you enroll, there are no forms or referrals to complete. For more information regarding the dental benefits, please call our Member Services Department, at 1-800- 721-2003 or 305-575-3640, or the ADI Customer care department toll free number at 1-877-479-1580.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at (800) 731-2993 or (305) 575-3640.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: JMH Health Plan, Attention Claims, 155 South Miami Avenue, Suite 110, Miami, FL 33130

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: JMH Health Plan, Attention: Grievance and Appeals Coordinator, 155 South Miami Avenue, Suite 110, Miami, Florida 33130, and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

 - 90 days after the date of our letter upholding our initial decision; or
 - 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
 - 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630

Send OPM the following information:

 - A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
 - Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
 - Copies of all letters you sent to us about the claim;
 - Copies of all letters we sent to you about the claim; and
 - Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (305) 575-3640 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The same limitations in regards to the number of visits allowed apply when we are secondary.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (800) 721-2993 or (305) 575-3640 see our Web site at www.jmhhp.com.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Accident	Accidental bodily injury sustained by you and resulting in medical expenses
Accidental Dental Injury	An injury to your mouth or parts within the mouth including teeth caused by a sudden unintentional or unexpected event.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Cost-sharing	Cost sharing is the general term used to refer to your out of pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	Custodial Care is care which shall not require skilled nursing care or rehabilitation services and is designed solely to assist you with the activities of daily living, such as: help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Custodial care that lasts 90 days or more is sometimes known as Long term care.
Deductible	A specified dollar amount for out of network services that must be incurred and paid by you before the Plan will assume any liability for all or part of the remaining covered services. The deductible must be met every calendar year.
Dental Care	Services or procedures which concern maintenance or repair of the teeth an/or gums or are performed to prepare the mouth for dentures.
Durable Medical Equipment	Equipment of the type approved by the Plan which is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury.
Experimental or investigational service	A service that is of doubtful medical usefulness or effectiveness to the Member, as assessed by local medical community standards.
Home Health Agency	An institution or agency licensed pursuant to Section 408, Florida Statute which provides home health services.
Hospice	A provider which is licensed, certified, or otherwise authorized pursuant to Florida Statute to supply pain relief, symptom management, and supportive services to individuals suffering from a disease or condition with a terminal prognosis.
Members	The subscriber and his or her Dependents covered under this contract.
Skilled Nursing Facility	A facility licensed to provide Skilled Nursing Care in accordance with Section 400, part I, Florida Statutes.
Us/We	Us and We refer to JMH Health Plan.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension, is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program - *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay -all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of High Option benefits for the JMH Health Plan- 2009

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$25 specialist	18
Services provided by a hospital:		
• Inpatient	\$100 per day up to a \$500 maximum per admission	33
• Outpatient	\$100 per procedure	34
Emergency benefits:		
• In-area	\$15 per office visit; \$25 specialist; \$25 per urgent care center visit; \$75 per hospital emergency care visit	38
• Out-of-area	\$15 per office visit; \$25 specialist; \$25 per urgent care center visit; \$75 per hospital emergency care visit	38
Mental health and substance abuse treatment:	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy	\$10 Generic, \$20 Preferred Brand, and \$30 Non Preferred Brands- 50% Copay for injectible drugs for maximum of \$100.	42
• Mail at Retail and Mail Order	These programs are maintenance drug programs developed by JMH Health Plan where you may obtain up to a 90 day supply of covered prescriptions for two times the copayment. The Copayments for these programs are \$20 for Generic, \$40 for Preferred and \$60 for Non-Preferred. Some pharmacies may not participate with the "Mail at Retail" program. Please refer to page 41- 43 for more information.	41-43
Dental care (Accidental Injury Only)	Nothing	44
Vision care (Annual Refraction)	\$15 per office visit.	23
Special features:		
<ul style="list-style-type: none"> • Flexible Benefit Options • High Risk Pregnancies • Centers for Excellence for Trauma/Burns/Transplants 		45

Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3000 Self Only or \$6000/Family enrollment per year	14

Summary of Standard Option Benefits for JMH Health Plan-2009

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical Services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$30 primary care; \$40 specialist	18
Services provided by a hospital:		
• Inpatient	\$150 per day up to \$750 maximum per admission	33
• Outpatient	\$200 per procedure	34
Emergency benefits:		
• In-area	\$30 per office visit; \$40 specialist; \$50 per urgent care center visit; \$100 per hospital emergency care visit	38
• Out-of- area	\$30 per office visit; \$40 specialist; \$50 urgent care center visit; \$100 per hospital emergency care visit	38
Mental health and substance abuse treatment:		
	Regular cost sharing	39
Prescription drugs:		
• Retail pharmacy	\$10 per Generic; 50% of the cost per Preferred and Non Preferred Brand name up to a maximum of \$100	42
• Mail at Retail and Mail Order	These programs are maintenance drug programs developed by JMH Health Plan where you may obtain up to a 90 day supply of covered prescriptions for two times the copayment. The Copayments for these programs are \$20 for Generic, 50% for Preferred and Non Preferred brands up to a maximum of \$200. Some pharmacies may not participate with the "Mail at Retail" program. Please refer to page 41- 43 for more information.	41-43
Dental care (Accidental Injury only)	Nothing	44
Vision care (Annual Refraction)	\$30	23
Special features:		
	<ul style="list-style-type: none"> • Flexible Benefit Options • High Risk Pregnancies 	45

	<ul style="list-style-type: none"> Centers for Excellence for Trauma/ Burns/ Transplants 	
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3000/Self Only or \$6000/ Family enrollment per year	14

2009 Rate Information for JMH Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits for Career United States postal Service Employees, R170-2 and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees (RI 70-21N). Postal Service Nurses should refer to the Guide to Benefits for United States Postal Nurses (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	J81	\$155.66	\$52.17	\$337.26	\$113.04	\$179.45	\$28.38
High Option Self and Family	J82	\$352.56	\$161.86	\$763.88	\$350.70	\$406.42	\$108.00
Standard Option Self Only	J84	\$136.05	\$45.35	\$294.77	\$98.26	\$156.91	\$24.49
Standard Option Self and Family	J85	\$348.11	\$116.04	\$754.25	\$251.41	\$401.49	\$62.66