JMH Health Plan

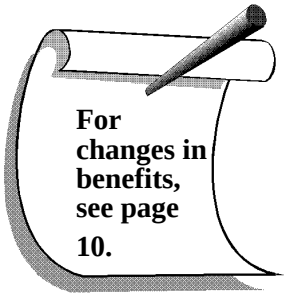
http://www.jmhhp.com

2007

A Health Maintenance Organization

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 7 for requirements.



Enrollment code for this Plan:

J81 Self Only
J82 Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

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 terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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.

Table of Contents

Introduction

This brochure describes the benefits of 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
1801 NW 9th Avenue, Suite 700, Miami, FL. 33137

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007 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 800/721-2993 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); o

  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.

Want more information on patient safety?

Ø 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.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø 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.

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.

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

Each family member that is covered by the JMH Health Plan must choose a Primary Care Physician from the Provider Directory. This list includes more thatn 1500 doctors who specialize in Family Practice, Internal Medicane, or Pediatrics. The Primary Care Physician you choose will coordinate your overall medical care, including arranging for hospital admissions or care by a specialist when medically necessary. 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 no longer accepting 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 with you r selection.

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.

If you want more information about us, call 800/721-2993, or write to JMH Health Plan, 1801 NW 9th Avenue, Suite 700; Miami, FL 33136. You may also contact us by fax at 305/545-5212 or access our website at http://www.jmhhp.com.

- JMH Health Plan service area
- JMH Health Plan Federal brochure
- Member rights and responsibilities
- Continuity of treatment
    - Arrange for the continuation of treatment by a provider
    - Assist the member in selecting a new provider
- Additional Information
    - Provider information
    - Physician credentials
    - Physician status/ discipline
    - Who to contact

- Information Disclosure

  - A detailed description of the authorization and referral process for health care services
  - A detailed description of the process used to determine whether health care services are "medically necessary"
  - A description of the organization's quality assurance program
  - Policies and procedures relating to the organization's prescription drug benefits
  - Policies and procedures relating to the confidentiality and disclosure of the subscriber's medical records
  - Decision making process used for approving or denying experimental or investigational medical treatments
  - Information regarding the absence fo malpractice insurance coverage
- Years in existence
- Profit status

If you want more information about us, call 800/721-2993, or write to JMH Health Plan. You may also contact us by fax at 305/545-5212 or visit our Web site at http://www.jmhhp.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Miami Dade and Broward Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2: How we change for 2007

Do not rely on these change descriptions; this section is not an official statement of benefits. For that, go to Section 5 Benfits. 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 this Plan

Your share of non-Postal premium will increase by 6.9% for Self Only or 10.3% for Self and Family.

We have added a new retail prescription drug benefit called Mail at Retail.

Mail at Retail allows members to choose to get from a participating retail pharmacy up to a 90 day supply of covered prescriptions for two times the applicable generic or brand name copayment. Mail at Retail has the following features. (See Prescription drugs benefits section in this brochure for more details).

(a) Prescriptions are subject to prior authorization and all the other limitations and exclusions discussed in your brochure.

(b) Quantity-limited drugs, such as erectile dysfunction medications are covered limited to the number of days in the refill.

(c) Injectibles are not covered.

- The primary care doctor office visit copayment is now $15 instead of $10.
- The specialists' office visit copayment is now $25 instead of $10.
- The emergency room visit copayment is now $75 instead of $50.
- The inpatient hspital admission copayment is $100 per day up to $500 maximum per admission. Previously, the member paid nothing.
- The outpatient hospital copayment is now $100 per facility use instead of no member copayment.

We have added a Health and Wellness Program under Non-FEHB benefits.

Section 3. How you get care

Identification cards

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.

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 (305) 575-3700 or write to us at JMH Health Plan, 1801 NW 9th Avenue, Suite 700, Miami, FL. 33136 .

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

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.

Health care services must be obtained through, or under the direction of your Primary Care Physician . He or she will coordinate your health care, and when medically necessary, refer you to a specialist from our network of health care providers. Your role is to always work with your Primary Care Physician for your health care needs.

We list Plan providers in the provider directory, which we update periodically.

- **Plan facilities**

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.

What you must do to get covered care

First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. As a member, you must choose a Primary Care Physician (PCP) for yourself and your dependents, if any, on the date of enrollement. If ou do not choose a Primary Care Physician, we will assign one to you and notify you of the assignment.

- **Primary care**

Your primary care physician can be a family practitioner, internist, general practitioner or pediatrician . Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If for any reason you become dissatisfied with your assigned primary care physician and/ or sevice location, you may select a new physician and/or service location, at anytme by notifying our Member Services Department at (800) 721-2993 or (305) 575-3700. The effective date of the change will be the first day of the following month. You must notify us before receiving covered services from a new Primary Care Physician.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician or the specialist may request authorization for any follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see *a chiropractor, podiatrist, dermatologist and a gynecologist (one annual visit) without a referal.*

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- 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 he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- 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, 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

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) 575-3700. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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: follow-up consultations by specialists, 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, to whom you have been appropriately referred, is responsible for coordinating any necessary hospitalizations. Scheduled admissions require advance authorization form the JMH health Plan. Emergency admissions require notification of the JMH Health Plan within 48 hours, 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.

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. Example: When you see your primary care physician you pay a copayment of $15 per office visit, a specialitst 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.
Deductible	We have no deductible.
Coinsurance	Coinsurance is thepercentage of our negotiated fee that you must pay for your care.
Your catastrophic protection out-of-pocket maximum	After your copayments total $ 1,500 per person or $3,000 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.

Section 5. Benefits

(See page 8 for how our benefits changed this year and page 60 for a benefits summary)

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 facililty 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	
Professional services of physicians • In physician's office	$15 per visit to a primary care physician $25 per visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion	 • Nothing • Nothing • Nothing • $15 per visit to a primary care physician • $25 per visit to a specialist
At home	$15.00
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - 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 *Diagnosis and Treatment*, above. - Routine Pap test	$15 per visit to a primary care physician $25 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: • 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
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per visit to a primary care physician $25 per visit to a specialist
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - 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

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
- Examinations done on the day of immunizations (up to age 22)	$15 per visit to a primary care physician $25 per visit to a specialist
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page xx 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *Reversal of voluntary surgical sterilization* • Genetic counseling	*All charges.*

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility such as: • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI)	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • *in vitro fertilization* • *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Zygote transfer* • *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.*
Allergy care	
• Testing and treatment • Allergy injections	$15 per visit to a primary care physician $25 per visit to a specialist
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges.*
Treatment therapies	
• 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. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$15 per visit to a primary care physician $25 per visit to a specialist

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	
Note: Growth hormone is covered under the prescription drug benefit. Note: – We only cover GHT when we preauthorize the treatment. Call (800) 721-2993 or (305) 575-3700 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 *Services requiring our prior approval* in Section 3.	$15 per visit to a primary care physician $25 per visit to a specialist
Physical and occupational therapies	
Two consecutive months per condition per year are covered if significant improvement can be expected within the two months. Services are covered for each of the following: • qualified physical therapists and • occupational therapists 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. Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided with same limitations listed above.	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Massage therapy*	*All charges.*
Speech therapy	
Up to two consecutive months per calendar year, for the services of qualified speech therapists.	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered:	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17, which include; (see *Preventive care, children)*	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions • Eye exam to determine the need for vision correction for children through age 17(See Preventive care, children) Annual eye refractions.	Nothing $15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *Eyeglassesor contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eyeglasses for ocular surgery*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per visit to a primary care physician $25 per visit to a specialist
Not covered: • *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)*	*All charges.*

Benefit Description	You pay
Orthopedic and prosthetic devices	
• 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.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacement unless the Plan or your Plan physician determines it is necessary because of growth or change.*	*All charges*
Durable medical equipment (DME)	
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: · **Standard wheelchairs;** · **Crutches;** · **Walkers;** · **Nebulizers;** · **Breast pumps;**	$25 per episode of illness up to our maximum Plan benefit for durable medical equipmnet not listed.

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	
· **Insulin pumps.** Note: Blood glucose monitoring machines are covered under our prescription drug benefit. Coverage for durable medical equipment not listed above is limited to $500 per member per calendar year.	$25 per episode of illness up to our maximum Plan benefit for durable medical equipmnet not listed.
Not covered:	*All charges.*
Home health services	
• 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	Nothing
Not covered: • 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; • *Personal comfort or convenience items such as television and telephone services;* - *Private duty nursing.*	*All charges.*
Chiropractic	
• 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
Alternative treatments	
No benefits	All charges
Educational classes and programs	
Coverage is limited to: • 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; $25 per visit to a specialist up to our benefit maximum $15 per visit to a primary care physician; $25 per visit to a specialist

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 OF 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
Surgical procedures	
A comprehensive range of services, such as: • 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; • 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;	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• 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 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. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 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.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
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.	Nothing
All stages of breast reconstruction surgery following a mastectomy, such as: 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) 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.	Nothing
Not covered: 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 Surgeries related to sex transformation	All charges
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • 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
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Benefit Description	You pay
Organ/tissue transplants	
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas Blood or marrow stem cell transplants limited to the stages of the following diagnoses (The medical necessity limitation is considered satisfied if the patient meets the staging description): • Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic myelogenous leukemia • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants limited to the stages of the following diagnosis: (The medical necessity limitiation is considered satisfed if the patients meets the staging description). • Allogeneic transplants for • Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for • Multiple myeloma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
• Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer • Epithelial ovarian cancer Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May be Limited to Clinical Trials. 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. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. *Not covered:* • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *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 servicesImplants of artificial organs* • *Implants of artificial organs* • *Transplants not listed as covered* • •	Nothing
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	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 OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per day upto a $500 maximum per admission
Other hospital services and supplies, such as: • 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 Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial or domiciliary care, basic care or housekeeping*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care except when medically necessary* • *Services or products provided by Convalescent Homes, Homes for the Aged, or Adult Foster Care Facilities* *Blood and blood derivatives not replaced by member*	*All Charges*
Outpatient hospital or ambulatory surgical center	
• 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 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.	$100 per procedure
Not covered: • *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*	*All charges.*

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
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: • Bed, board, and general nursing care; Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: • *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*	*All charges*
Hospice care	
We provide supportive and palliative care for a terminally ill member in the home or hospice facility. Services included: • Inpatient and outpatient care; • Family counseling 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.	Nothing
Not covered: • *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*	*All Charges*

Benefit Description	You pay
Ambulance	
Local professional ambulance service when medically appropriate	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 tretment is rendered inside or outside the service area.

Emergencies within our service area:

You are covered for treatment when a ture 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 sevices rendered by a non-participating provider within our sevice area are covered. Also service 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 sevice area, you may go to the closest urgent or emergency cazare facility. Emergency admissions require notification of the JMH Health Plan within 24 hours, or as soon therafter as ossible. You may call the JMH Health Plan 24 hours a day at the n;umber onthe back of your JMH Health plan identification care. 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 sevices.

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 consitute 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.

Benefit Description	You pay
Emergency within our service area	
• 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 Note: We waive the ER copay if you are admitted to the hospital.	$15 per visit to a primary care physician, $25 per visit to a specialist $25 per visit $75 per visit (waived if admitted)
Not covered: Elective care or non-emergency care	*All Charges.*
Emergency outside our service area	
• 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 Note: We waive the ER copay if you are admitted to the hospital.	$15 per visit to a primary care physician, $25 per visit to a specialist $25 per visit $75 per visit (waived if admitted)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges.*
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing
Not covered: Air ambulance	*All Charges.*

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 OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit to a primary care physician $25 per visit to a specialist
Diagnostic tests	Nothing
• 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	Nothing
Not covered: Services we have not approved. *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.*	*All Charges.*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:

	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.
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 drugs and 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 calenendar year deductible.
- YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR SOME PRESCRIPTION DRUGS. Please refer to the precertification information shown in Section 3 to be sure which prescription drugs 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 durgs within the scope of his or her license must write the prescription.
- **Where you can obtain them.**You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We have an open formulary.** The prescription drug co-payments for generic and brand name are shown below. To order a prescription drug brochure, call 1-888-243-6250..
- "Mail at Retail" is a voluntary program developed by JMH Health Plan where you choose to get a 90 day supply of covered prescriptions for two times the applicable generic or brand name copayment. A few items to note:

  Some pharmacies may not participate with the "Mail at Retail" program.

  Prescriptions are subject to prior authorization and all other limitations and exclusions in this brochure.

  Quantity-limited drugs, such as erectile dysfunction medications are covered limited to the number of days in the refill.

  Injectables are not covered under this benefit.

  It is not medically appropriate to fill all drugs in a 90-day quantity. Your doctor is the health care professional who will determine what is best.

- **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 t;he cost difference between the generic and brand name product in addition to the applicable brand co-payment. Retail pharmacy prescriptons are limited to 30 days per prescription. Our new 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. You pay two times the co-payment for generic drugs or 50% of the cost per brand name up to a maximum of $200 plus the cost difference if you or your doctor requests a brand name when a generic equivalent is available. You still have the mail order option available to yo with the same copayment structure.
- Members called to active military duty in a time of national or other emergency who need to obtain a greater then normal supply of prescribed medicaitons 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 oriiginal 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 do have to file a claim. Our members may occasionally receive bills for health care services. This may occur for a number of reaqsons. such as computer errors or out of area emerency treatment. If you receive a bill or statement , or are requesting reimbursement, mail the bills to us within 90 days of the date of service. Please be sure that the bill contains the following information.

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

Adderess the enveloe as follows.

JMH Health Plan

Attention Claims Department

1801 NW 9th Avenue, Suite 700

Miami, FL. 33136

Attention: Claims

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

Benefit Description	You pay
Covered medications and supplies	
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: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • 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 • Drugs for sexual dysfunction • Oral contraceptive drugs and devices [contrceptive devices and diaphragms are covered under medical services, see section 5(a)]	Retail Pharmacy $5 per generic 50% of the cost per brand name up to a maximum of $100 **Mail at Retail Pharmacy** **"Mail at Retail"** is a voluntary program developed by JMH Health Plan where you choose to get a 90 day supply of covered prescriptions for two times the applicable generic or brand name copayment. Refer to page 37 for more information on this program. **Mail order to cover maintenance drugs (up to 90 day supply)** $10 per generic 50% of the cost per brand name up to a maximum of $200.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
	Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except forout-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Prescription refills in excess of the number specified by the physician or dispensed more than on e year form 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* • *Any portion of a prescripiton or refill that exceeds 30 days unless specified above* • *Nonprescription medicines*	*All Charges.*

Section 5(g) Special features

Flexible benefit option	

Section 5(h) 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
- 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. We do not cover the dental procedure unless it is described below.
- 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 Desription	You Pay
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

Dental Benefits	You Pay
Service	

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.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible…
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion • kiajdad	
Not covered:	*All Charges.*
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	

Benefit Description	You pay After the calendar year deductible…
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page xx 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5c) and *Surgerybenefits* (Section 5b).	
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptive s • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - **intravaginal insemination (IVI)** - **intracervical insemination (ICI)** - **intrauterine insemination (IUI)** • Fertility drugs Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • Cost of donor egg.	*All Charges.*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	
Allergy serum	
Not covered:	*All Charges.*
Treatment therapies	**High Option**
• 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 xx. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**High Option**
Note: – We only cover GHT when we preauthorize the treatment. 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 *Services requiring our prior approval* in Section 3.	
Not covered:	*All Charges.*
Physical and occupational therapies	**High Option**
xx visits for the services of each of the following: • qualified physical therapists and • occupational therapists 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. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to xx sessions.	
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges.*
Speech therapy	**High Option**
xx visits	
Not covered:	*All Charges.*
Hearing services (testing, treatment, and supplies)	**High Option**
• First hearing aid and testing only when necessitated by accidental injury • Hearing exams for children through age 17, which include: (see *Preventive care, children)*	
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Annual eye refractions	
Not covered: • *Eyeglassesor contact lenses, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges.*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. *Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.*	
Not covered: • *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)*	*All Charges.*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose • 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: See 5(b) for coverage of the surgery to insert the device.	
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All Charges.*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than {X} years after the last one we covered*	*All Charges.*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Note: Call us at xxx-xxx-xxxx as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	
Not covered:	*All Charges.*
Home health services	**High Option**
• 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.	
Not covered: • *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.*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	
Not covered:	*All Charges.*
Alternative treatments	**High Option**
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief	
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All Charges.*
Educational classes and programs	**High Option**
Coverage is limited to: • Diabetes self management • Smoking cessation	

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.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to almost all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 OF 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 After the calendar year deductible…
Surgical procedures	**High Option**
A comprehensive range of services, such as: • 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) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 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.	

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All Charges.*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • 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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - 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) 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.	
Not covered: • *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* • *Surgeries related to sex transformation*	*All Charges.*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • 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.	
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges.*
Organ/tissue transplants	**High Option**
Solid organ transplants imited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - **Small intestine** - **Small intestine with the liver** - **Small intestine with multiple organs, such as the liver, stomach, and pancreas** Blood or marrow stem cell transplants limited to the stages of the following diagnoses and are not subject to medical necessity or experimental/investigational review: • Allogeneic transplants for - **Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia** Advanced Hodgkin's lymphoma	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses and are not subject to medical necessity or experimental/investigational review: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myleogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Allogeneic transplant for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteoporosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - Thalassemia majo	*All Charges*
Autologous transplants for - Multiple myeloma	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma	
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: • Allogeneic transplants for - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Coloncancer Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Renal cell carcinoma - Sarcomas	
Not covered:	*All Charges.*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
• *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges.*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient)	
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	

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.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • 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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	**High Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges.*
Outpatient hospital or ambulatory surgical center	**High Option**
• 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 • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	
Not covered: Blood and blood derivatives not replaced by the member	*All Charges.*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit:	
Skilled nursing facility (SNF):	
Not covered: Custodial care	
Hospice care	**High Option**
Not covered: Independent nursing, homemaker services	*All charges.*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate	

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.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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:

Emergencies within our service area

Emergencies outside our service area

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	
Not covered: Elective care or non-emergency care	*All Charges.*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	
Not covered:	*All Charges.*

Emergency outside our service area - continued on next page

Benefit Description	You pay After the calendar year deductible…
Emergency outside our service area (cont.)	**High Option**
• *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All Charges.*
Accidental injury	**High Option**
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	
Not covered: Air ambulance	*All Charges.*

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.

Here are some important things to 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.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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 OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits	**High Option**
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. 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.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologist s, or clinical social workers • Medication management	
• Diagnostic tests	
• 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	
Not covered: Services we have not approved.	*All Charges.*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	**High Option**
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.	*All Charges.*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:
Limitation	We may limit your benefits if you do not obtain a treatment plan

Section 5(f) Prescription drug benefits

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- 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 licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a xxx pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication
- **We use a formulary.** We cover non-formulary drugs prescribed by a Plan doctor.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call xxx.

- **These are the dispensing limitations.**

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs?**
- **When you do have to file a claim.**

Benefit Description	You pay After the calendar year deductible…
Prescription Drugs	**High Option**
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices	Note: If there is no generic equivalent available, you will still have to pay the name brand copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Smoking cessation drugs*	*All charges.*

Section 5(g) Special features

Feature	Description
Feature	
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
High risk pregnancies	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.
Centers of excellence for Trauma Facilities, Burn Center, and Transplant Services	The following is a Center of excellence available when appropriately referred: University of Miami/Jackson Memorial Medical Center, Miami, FL

Section 5(h) 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.
- Plan dentists must provide or arrange your care.
- The deductible is $xxxx for Self Only enrollment and $xxxx for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- 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. We do not cover the dental procedure unless it is described below.
- 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.

Accidental injury benefit	You Pay
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.	

Dental benefits	You Pay
We have no other dental benefits	

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) wants to make your efforts to get and stay healthy easier and more affordable. In addtion to providing great medical care through top physicians, the JMH Health Plan has a new program designed to promote preventive and personal health management through fitness activities and wellness resources. This benefit intorduces memberes to discounts on Jenny Craig, Alternative /Holistic Health, Fitness Center Membership and Cosmetic Surgery, etc. Best of all , after you enroll, there are no forms or referrals to go through. For more information regarding the program, please call the ADI Customer care department toll free number 1-877-479-1580.

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.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **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 HCFA-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) 575-3700.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the HCFA-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, 1801 NW 9th Avenue, Suite 700, Miami, FL 33136

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, 1801 NW 9th Avenue, Suite 700, Miami, FL 33136; 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 x, 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.

5 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) 575-3700 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 x 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 have coverage under any other health plan or have 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. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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.Your care must continue to be authorized by your Plan PCP, or precertified as required.

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. You will not need to do anything. To find out if you need to do something to file your claim, call us at (800) 721-2993 or (305) 575-3700 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 our Medicare Advantage plan: We do not have a Medicare Advantage Plan.

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.

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 or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓ *	
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	✓	
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.

Primary Payer Chart

Primary Payer Chart		

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. See page xx.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page xx.
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.
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 Employees Health Benefits Plans,* 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;
- 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 ar 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 2007 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 2006 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 Employees Health Benefits Plans 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 Employees Health Benefits Plans 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 Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** 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. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

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)** –Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or 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 other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time. .

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over the counter medicines ans products related to dental and vision care (but not insurance premiums)

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, 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.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

The Federal Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a brand new program, separate from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including 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 a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

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

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

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

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2007. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 - December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollements will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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 will reduce your out-of- pocket cost.

Index

- **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.

Below, an asterisk (*) means the item is subject to the $xx calendar year deductible.

Summary of benefits for the JMH Health Plan- 2007

- 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	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $25 specialist	15
Services provided by a hospital:		
• Inpatient	$100 per day upto a $500 maximum per admission	29
• Outpatient	$100 per procedure	30
Emergency benefits:		32
• In-area	$15 per office visit; $25 specialist; $25 per urgent care center visit; $75 per hospital emergency care visit	33
• Out-of-area	$15 per office visit; $25 specialist; $25 pr urgent care center visit; $75 per hospital emergency care visit	33
Mental health and substance abuse treatment:	Regular cost sharing	34
Prescription drugs:		36
• Retail pharmacy	$5 per generic; 50% of the cost per brand name up to a maximum of $100	38
• Mail at Retail	"Mail at Retail" is a voluntary program developed by JMH Health Plan where you choose to get a 90 day supply of covered prescriptions for two times the applicable generic or brand name copayment. Refer to page 36 for more informationon on this program.	38
• Mail order	$10 per generic; 50% of the cost per brand name up to a maximum of $200.	38
Dental care (Accidental Injury Only)	Nothing	40
Vision care (Annual Refraction)	$15 per office visit.	20

Special features: • Flexible Benefit Options • High Risk Pregnancies • Centers for Excellence for Trauma/Burns/Transplants		37
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $1500/Self Only or $3000/ Family enrollment per year	13

2007 Rate Information for -

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide 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 FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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 FEHB Guide.

Type of Enrollment	Enrollment Code	Non-Postal Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share

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