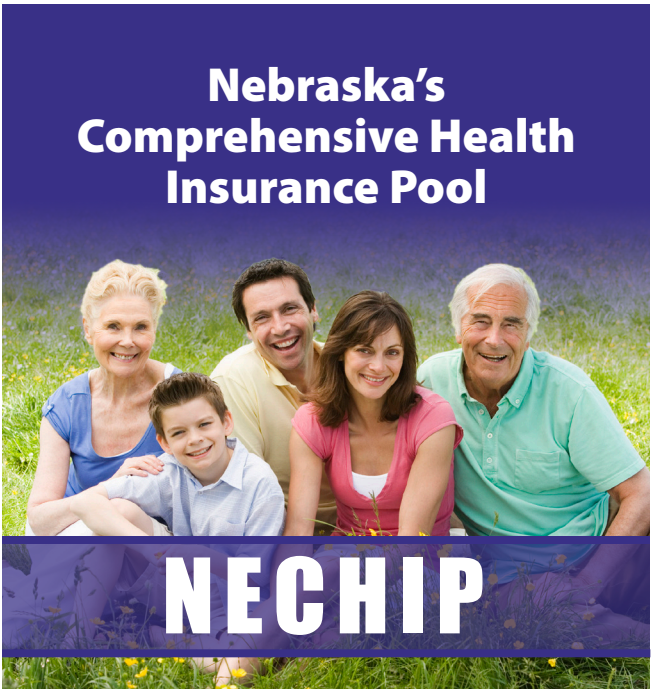

Health Care Coverage

Please note: Treatment of a pre-existing condition is a noncovered service until the policy has been in force for at least six months (unless a waiver is in effect). Please see the "Pre-existing Conditions" section of this brochure for further details.

Administered by
Coventry Health and Life
Insurance Company

What is NECHIP?

The Nebraska Comprehensive Health Insurance Pool (NECHIP) was created by the Nebraska legislature in 1985 to provide health care coverage to people who can't otherwise obtain it at an affordable price or without health restrictions. If you've had trouble getting health insurance for medical reasons, this state program may help you obtain the coverage you need.

All insurers authorized to issue or provide health care coverage in Nebraska are members of NECHIP. Coventry Health and Life Insurance Company is the administrator of the program, responsible for determining applicant eligibility, collecting premiums and paying claims.

Who is Eligible for NECHIP?

To be eligible to purchase NECHIP coverage, you must qualify under one of the following:

1. Be a legal Nebraska resident at least six months prior to application,* who is not eligible for coverage under a group health plan comparable to pool coverage, Medicare by reason of age, Medicaid or any successor program, and who does not have any other health insurance comparable to pool coverage; and

    a. Have both elected and exhausted COBRA or similar continuation coverage, if it was offered to you; and

    b. Have been rejected for health insurance coverage for medical reasons within the last six months from a Nebraska insurer; or

    c. Have, or have been offered, health insurance coverage within the last six months which includes a restrictive rider limiting coverage for a pre-existing medical condition; or

    d. Have been offered health insurance coverage comparable to that available through NECHIP, at a higher premium within the last six months.

2. Be a legal Nebraska resident,* and

   a. Have an aggregate of at least 18 months prior creditable coverage, most recently under a employer group health plan, governmental plan or church plan; and

   b. Not be eligible for group health plan, Medicare by reason of age or Medicaid, or have other health insurance coverage; and

   c. Continuation coverage under COBRA or a similar program, if offered, has been elected and exhausted

3. You have one of the specified conditions listed on pages 19 and 20 of this brochure. If so, you are automatically eligible for NECHIP enrollment, provided that you are a Nebraska resident.*

4. Be a legal Nebraska resident* and potentially eligible for the Health Coverage Tax Credit under the Trade Adjustment Assistance Reform Act of 2002.

If you're eligible for Medicare (by reason of age), Medicaid, or a group health plan comparable to NECHIP, you cannot purchase NECHIP coverage. If you have NECHIP coverage, it will terminate when you become eligible for Medicaid or Medicare by reason of age. A person who becomes eligible for Medicare for reasons other than age (e.g. disability, kidney transplant, dialysis) will continue to be eligible for NECHIP coverage.

Please note: An individual is not eligible for NECHIP coverage if his or her premium is paid by a person other than the individual or a member of his/her family, or an entity operating under the Ryan White HIV/AIDSTreatment Modernization Act.

Reduction in benefits
If you are covered by other insurance, a major medical plan, or a local, state or federal program, NECHIP benefits will be reduced by all amounts payable under your other plans.

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* *To be eligible for continued NECHIP coverage, you must maintain residency in the state of Nebraska.*

Non-Tobacco User Premium Discount

If you do not use tobacco products (e.g. cigarettes, cigars, pipes, chewing tobacco), you are eligible to receive a discount on your monthly NECHIP premium.

Pre-Existing Conditions

Treatment of a pre-existing condition is not covered until the NECHIP policy has been in effect for at least six months. However, this exclusion may be waived if one of the following applies at the time of application for coverage:

1. Health coverage was involuntarily terminated because:

   - the insurer withdrew from the state;
   - the employer or employer trust fund declared bankruptcy or insolvency;
   - the employer ceased to provide any group health plan for its employees.

   The person must be eligible for NECHIP coverage and must apply for the pre-existing condition waiver within 60 days after termination of prior coverage. The NECHIP board may assess additional premiums for this waiver. The person cannot be eligible for a conversion policy or a continuation of coverage policy under federal or state law.

2. The applicant received medical assistance through the Medically Handicapped Children's Program within six months of the effective date of NECHIP coverage.

3. The applicant was an organ transplant recipient terminated from Medicare within six months of the effective date of NECHIP coverage.

4. Medicaid coverage ended within six months of the effective date of NECHIP coverage.

5. Coverage under a continuation of coverage policy under federal or state law terminated for reasons other than non-payment. Application for NECHIP coverage must be made within 90 days of the end of prior coverage.

6. The applicant has an aggregate of at least 18 months of prior creditable coverage which has terminated less than 63 days prior to the application date.

In all cases, the applicant must provide documentation to verify eligibility for the waiver.

Preadmission Certification and Concurrent Review

The Preadmission Certification and Concurrent Review Programs work to ensure that needed medical care is received in the most appropriate and cost-effective setting. Many times care can be provided more conveniently and comfortably without having to be admitted into the hospital, such as in an outpatient facility, a doctor's office – or even in your own home.

HOW THE PROGRAM WORKS

When you are hospitalized in an in-network hospital, there is no need for NECHIP benefit precertification, except when the admission is for treatment of mental illness, drug abuse or alcoholism.

If you are hospitalized in an out-of-network hospital, you must certify benefits as described below. You must also certify benefits whenever the admission is for the treatment of mental illness, drug abuse or alcoholism, whether or not your hospital and doctor are in the PPO network.

- **Non-emergency hospitalization**
  All non-emergency hospital stays must be certified prior to admission. You or your physician must call NECHIP Admission Certification prior to any non-emergency hospital admission. You will receive written notification of whether or not benefits for the hospitalization are available. If the proposed inpatient care is determined to be the most medically appropriate setting for your health care according to established criteria, benefit payment will be authorized according to the terms of the CHIP policy.

- **Emergency admissions**
  If the hospitalization is the result of an accident or medical emergency, you or your physician must call NECHIP Admission Certification within 24 hours of your admission or during the next business day. Coventry Health and Life Insurance Company will contact you and your physician to confirm that benefits are available for the hospitalization, and the number of days that have been approved.

- **Extending a hospital stay**
  If you are hospitalized longer than was originally approved, those additional days must be certified for benefit payment. If additional days are determined to be medically necessary, benefits for covered services will be paid according to the terms of your NECHIP policy. If additional days are determined to be not medically necessary, all benefits for those days will be denied.

To certify NECHIP benefits for inpatient hospitalization, call 1-855-247-5201

If you do not follow these procedures, all benefits for covered medically necessary services will be reduced by 25%. Benefits for all charges NECHIP considers not medically necessary will be denied.

Please note: Certification is not a guarantee of benefit payment. If certified, available benefits for your hospital stay will be determined according to the terms of your policy. This means benefits will be subject to membership eligibility, waiting periods, any deductible and coinsurance requirements, limitations and exclusions.

NECHIP PPO Coverage

PPO stands for "preferred provider organization." PPOs are special arrangements between an insurer and a network of hospitals, doctors and other health care providers to pay for customers' medical care.

Coventry Health and Life Insurance Company has contracted with a network of hospitals and doctors to provide NECHIP customers with medical care. As a result, you pay less out of pocket when you use these in-network providers. If you use a doctor or hospital which is not in the PPO network, benefits for covered services are still available, but are subject to the out-of-network deductible and coinsurance.

Be sure to ask your doctor prior to receiving treatment if he or she is an in-network provider. If your in-network doctor refers you to a specialist, ask if that specialist is also in-network.

In-Network Benefits Away from Home

To obtain an updated listing of in-network hospitals and doctors, contact the NECHIP Customer Service Center (see numbers on the back of this brochure).

As the administrator of the NECHIP program, Coventry Health and Life Insurance Company offers you access to the Coventry National Network. Be sure to access care through a Coventry National Network provider while traveling outside Coventry Health and Life Insurance Company's service area.

When you do, you also enjoy the discount and claim filing agreements that Coventry Health and Life Insurance Company has negotiated.

Locate Coventry National Network providers:

855-247-5201
www.chcnebraska.com

ALLOWABLE CHARGE

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount. The allowable charge for services by noncontracting providers will generally be the lesser of the billed charge or the Reasonable Allowance for the service.

CHOICE OF TEN CALENDAR YEAR DEDUCTIBLES

	In-Network	Out-of-Network
Option 1	$500	$1,000
Option 2	$1,000	$2,000
Option 3	$1,500	$3,000
Option 4	$2,000	$4,000
Option 5	$3,000	$6,000
Option 6	$4,000	$8,000
Option 7	$5,000	$10,000
Option 8	$7,500	$15,000
Option 9	$10,000	$20,000
Option 10 HSA-Eligible Plan	$2,000	$4,000

YOUR COINSURANCE AND MAXIMUM COINSURANCE EXPENSE

After you have met your calendar year deductible, you pay a certain percentage of allowable charges (called "coinsurance") until you reach the maximum coinsurance expense. The maximum coinsurance expense is the most you pay out of your own pocket in coinsurance in a calendar year. Once you reach this maximum, you pay nothing for most covered services for the rest of the calendar year.

Please note: Under Options 1 through 9, the coinsurance you pay for mental illness, drug abuse and alcoholism treatment does not apply toward the maximum coinsurance expense. Coinsurance for mental illness, drug abuse and alcoholism treatment does apply toward the maximum coinsurance expense under Option 10.

A BRIEF SUMMARY OF OPTIONS 1 THROUGH 9

	In-Network	Out-of-Network
Calendar year deductible	See listing of deductible options on page 7	
Maximum coinsurance expense per calendar year*	$1,500	$3,000
Coinsurance you pay for most hospital/medical/surgical covered services	20% of allowable charges	30% of allowable charges
Mental Illness, drug abuse and alcoholism treatment	50% of allowable charges	60% of allowable charges
NECHIP policy maximum for mental illness, drug abuse and alcoholism benefits	$25,000	
Office visits	$30 copay	Benefits subject to deductible and coinsurance
Prescription drug copays, per 30-day supply Generic drugs Formulary brand-name drugs Nonformulary drugs	$10 20% coinsurance, $35 minimum, $50 max 50% coinsurance, $50 minimum, $75 max	
Overall NECHIP policy maximum	$1 million	
Emergency room visit	$50 copay (benefits subject to deductible and coinsurance)	

* *Copayments are not applicable to the maximum coinsurance limit.*

A BRIEF SUMMARY OF HSA-ELIGIBLE OPTION 10

	In-Network	Out-of-Network
Calendar year deductible	$2,000	$4,000
Maximum coinsurance expense per calendar year	$3,000	$6,000
Coinsurance you pay for most hospital/medical/surgical covered services	20% of allowable charges	40% of allowable charges
Mental Illness, drug abuse and alcoholism treatment	50% of allowable charges	60% of allowable charges
NECHIP policy maximum for mental illness, drug abuse and alcoholism benefits	$25,000	
Office visits	Benefits subject to deductible and coinsurance	Benefits subject to deductible and coinsurance
Prescription drug benefits	Benefits for covered prescription drugs are subject to the in-network deductible and coinsurance	
Overall NECHIP policy maximum	$1 million	

What is an HSA-Eligible Plan?

NECHIP Option 10 is an HSA-eligible health plan. HSA stands for "Health Savings Account." An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

In general, any individual who is covered under a "high deductible health plan" is eligible to establish an HSA. To qualify as a high deductible health plan, the plan must satisfy certain requirements with respect to deductibles and out-of-pocket expenses.

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, charges for noncovered services, and health and long term care insurance premiums. Withdrawals for other purposes are taxable (and before age 65, subject to a 10% penalty).

For 2012, the maximum annual HSA contribution for an eligible individual with self-only coverage is $3,100. The catch-up contribution for individuals who are 55 or older has been increased by statute to $1,000 for 2009 and all years going forward.

Covered Services

If you qualify to purchase NECHIP coverage, you are eligible to receive the benefits briefly described in this brochure. Please refer to the NECHIP PPO policy for a complete description of covered and noncovered services and supplies.

- **Hospital room and board**
  Pays for the cost of a semi-private room. If the hospital has all private (one-bed) rooms, the average cost of a semi-private room will be applied toward the charge for the private room. Benefits are also available for cardiac and intensive care units.

- **Physician charges**
  We pay NECHIP benefits for medically necessary covered services up to the allowable charge.

- **$30 office visit copay**
  Under Options 1 through 9, when an in-network physician is used, you pay only a $30 copay for a diagnostic office visit charge. Copay amounts do not apply toward the maximum out-of-pocket expense.

- **Physical therapy**
  Pays benefits for services of a licensed physical therapist or licensed physical therapist assistant supervised by the licensed physical therapist.

- **Speech therapy**
  Speech therapy is payable when covered services are received from a licensed speech-language pathologist, registered speech language pathology assistant or registered communications assistant practicing under the direct supervision of a licensed speech-language pathologist.

- **Occupational therapy**
  Services must be provided by a licensed occupational therapist or licensed occupational therapist assistant under the supervision of the licensed occupational therapist. Outpatient sessions are limited to no more than 60 four-hour sessions per calendar year.

- **Anesthetics and their administration**
  Services must be performed by a physician or a certified registered nurse anesthetist.

- **X-ray and lab**

- **Routine screening mammograms**

- **Ambulance service in an emergency**
  Benefits are available for ambulance service to the nearest facility for appropriate care in a medical emergency. Benefits are also available for transportation within the U.S. by a professional non-air ambulance or on a regularly scheduled flight on a commercial airline when: (1) special and unique covered hospital expenses are required which are not provided by a local hospital; (2) transportation is medically necessary; and (3) transportation is to the nearest hospital equipped to furnish the services.

- **Skilled nursing facility care**
  Benefits are available for a maximum of 30 days each calendar year, subject to the conditions stated in the NECHIP PPO policy. The skilled nursing facility stay must occur within 14 days of a hospitalization lasting a minimum of three consecutive days.

- **Cardiac and pulmonary rehabilitation**
  A maximum of six consecutive weeks of outpatient cardiac or pulmonary rehabilitation is available, subject to the conditions stated in the policy.

- **Medical supplies and equipment**
  Benefits are available for rental or initial purchase of certain items of medically necessary home medical equipment when prescribed by a physician. Please refer to the NECHIP PPO policy for further details.

- **Renal dialysis**

- **Home infusion therapy**

- **Oxygen and equipment for its administration**

- **Inhalation therapy**

- **Hospice care**
  Covered services include inpatient hospice care, physician's services and home health aide services. Counseling (other than bereavement counseling) for the covered person's immediate family (spouse, children, parents) is payable up to a total policy maximum benefit of $500. Bereavement counseling for the covered person's immediate family will be payable up to a total policy maximum benefit of $100.

  Please note: Limitations apply to these benefits. Please refer to the NECHIP PPO policy for further information.

- **Home health care**
  Benefits are available for 40 days of home health care each calendar year, subject to applicable deductible and 20% coinsurance.

- **Mental illness, drug abuse and alcoholism**
  NECHIP benefits are available for medically necessary covered inpatient and outpatient services, up to a total policy maximum of $25,000. When in-network providers are used, you pay 50% of allowable charges for covered inpatient and outpatient services. When out-of-network providers are used, you pay 60% of allowable charges for covered inpatient and outpatient services.

  Inpatient benefits are available for 30 days per calendar year. Benefits for outpatient services are available for up to 60 units per calendar year. One unit of outpatient treatment is defined as: (1) one individual or group therapy session; (2) one day in a licensed day or partial hospitalization program; (3) one day in a certified alcoholism and drug abuse partial care program; (4) one biofeedback procedure.

  Services may be received from a qualified physician, licensed psychologist, licensed special psychologist or licensed mental health practitioner.

The licensed mental health practitioner may also be a licensed professional counselor or a licensed clinical social worker. When under the supervision of and billed by one of the above types of professional, services may also be received from a psychiatric nurse, certified social worker, certified alcoholism and drug abuse counselor or other provider approved by state law.

Please note: Coinsurance for mental illness, drug abuse and alcoholism treatment is not applied toward the maximum out-of-pocket expense for the PPO policy. It is applied toward the out-of-pocket expense for the HSA-eligible option. Inpatient admissions must be precertified for benefit payment. Please see your NECHIP PPO policy or the "Preadmission Certification and Concurrent Review" section of this brochure.

- **Diabetes education**
  You are responsible for 10% of allowable charges for the cost of completing a diabetes education program. Under Options 1 through 9, the calendar year deductible does not apply.

  Educational benefits are available up to a maximum of $500 in a two-year period. Services must be prescribed by a physician and provided by an American Diabetes Association-recognized diabetes self-management education program or health care professional certified by the National Certification Board for Diabetes Educators.

- **Prescription drugs: Options 1 through 9**
  Your benefits are based on the Coventry Health Care Formulary, a listing of medications divided into three tiers.

  The copay you pay for each 30-day supply of your covered prescription drug depends on the tier in which your medication is listed. Please refer to the chart on page 8 for your prescription drug copay amounts.

  The drug formulary is revised on a regular basis. Visit the website for the most up-to-date version of the drug formulary:

  www.chcnebraska.com

To access your NECHIP prescription drug benefits, you must present your NECHIP I.D. card, along with your doctor's prescription, at a participating pharmacy. At the time of purchase, you will be required to pay your plan's applicable copay amount, as shown on the chart on page 8, for a 30-day supply of a covered medication.

Please note: Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand-name drug, you will be responsible for the difference in cost, plus the applicable copay amount.

- **Prescription drugs: Option 10**
  Your prescription drug benefits are subject to your plan's in-network deductible and coinsurance amounts. Once the deductible has been satisfied, we will reimburse you for the cost of the covered prescription drug, minus your coinsurance.

  When you use a participating Rx Nebraska pharmacy, you'll automatically receive a special pre-negotiated discount on most of your prescription drugs (the actual discount you receive depends on the pharmacy and the type of drug you purchase).

- **Women's Health and Cancer Rights Act**
  Services are covered in accordance with the Women's Health and Cancer Rights Act, which requires that a health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

- **Oral Surgery**
  NECHIP benefits are available for the following types of oral surgery and dentistry: removal of bony growths, tumors and cysts; cutting and draining of cellulitis; surgery involving the TMJ (temporomandibular jaw joint); the reduction of a complete dislocation or fracture of the TMJ required as a direct result of an accident or injury.

Services must be received within 12 months of the date of the injury. Benefits are not available when the TMJ dislocation or fracture occurs as a result of eating, biting or chewing.

Benefits are also available for the removal of impacted teeth on an outpatient basis and bone grafts to the jaw (except those done to prepare the mouth for dentures or for periodontal purposes).

Also covered are services, supplies and appliances for dental treatment of natural teeth required as the direct result of an accidental injury. Benefits are limited to treatment provided within 12 months of the date of injury. Injuries resulting from eating, chewing or biting are not covered.

Osteotomies performed for gross congenital abnormalities of the jaw are payable when orthodontic treatment or appliances cannot correct the condition.

Please note: NECHIP will cover inpatient hospital admissions related to oral surgery and dentistry, but only if you have a nondental physical condition which makes hospitalization essential to safeguard your life and health or if it is medically necessary as determined by NECHIP.

- **Organ and tissue transplants**
  The Comprehensive Health Insurance Pool, in conjunction with Coventry Health and Life Insurance Company, has developed a listing of Preferred Transplant Centers in cities across the country. When you use one of these facilities for a covered organ and/or tissue transplant, benefits are not subject to the $100,000 transplant maximum.

  Instead, benefits for covered services are only subject to the policy's overall $1 million maximum. If, however, you choose not to use a Preferred Transplant Center, benefits for covered services will be subject to a $100,000 transplant maximum.

- **Hospital preadmission testing**
  When you receive covered services for hospital preadmission testing, you pay no coinsurance for covered services, subject to the limitations in the NECHIP policy. Under Options 1 through 9, the calendar year deductible is not applied.

- **Routine care benefits**
  Under all plans, up to $150 in benefits is available each calendar year for routine care. Covered services include office visits, cardiac stress tests, lab and radiology, Pap smears and non-pediatric immunizations. If an in-network provider is used, no deductible or coinsurance is applied. If an out-of-network provider is used, benefits are subject to the out-of-network deductible and coinsurance.

- **Pediatric immunizations**
  Pediatric immunizations are payable without application of the deductible, subject to applicable coinsurance. Pediatric immunizations include a complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, chicken pox and haemophilus influenza type B. These immunizations do not count toward the $150 routine care benefit.

- **Maternity care (Optional)**
  If you have been covered by the optional Maternity Benefit Rider for at least nine months prior to the birth of your child and have been continuously covered throughout the pregnancy, benefits are available for covered services for normal pregnancy and childbirth. Benefits are subject to a $3,000 policy maximum.

  Please note: If you are eligible for a waiver of the pre-existing condition exclusion and purchase the maternity rider at initial application, this nine-month coverage requirement may be waived or reduced.

- **Newborn coverage**
  Benefits for covered services are available for your newborn for 31 days from the date of birth. NECHIP coverage for the newborn shall terminate at the end of this 31 day period.

Noncovered Services

The following is a partial listing of the exclusions and limitations that apply to NECHIP PPO coverage. For a complete list, please refer to the policy.

No benefits are available for the following:

- Services not specifically covered by this policy, or amounts in excess of charges for covered services
- Charges in excess of the Reimbursement Schedule Amount
- Services or supplies which are not actually provided while the policy is in force
- Any service or supply which would be provided without cost to you in the absence of insurance
- Services performed by a member of your family
- Orthodontics, dental splints or appliances; treatment, filling, removal, repositioning, replacement or movement of teeth or tissues next to the teeth (except due to injury)
- Injuries or sickness covered by Workers' Compensation or employers' liability laws
- Care or treatment in a hospital owned or operated by the government or any of its agencies
- Routine eye exams, eye exercises, or visual training (orthoptics)
- Routine audiological exams, audiant bone conductors or hearing aids and their fitting
- Refractive corneal surgery (except grafts)
- Private duty nursing
- Loss resulting from duty in the armed services
- Loss resulting from an act of declared or undeclared war
- Normal pregnancy/childbirth without optional Maternity Benefit Rider coverage
- Voluntary abortion
- Care of a newborn, except as specifically stated
- Complications of pregnancy when the pregnancy had its inception before the effective date of coverage; for a person eligible for a waiver of the pre-existing condition exclusion, the policy will pay for complications of pregnancy regardless of whether the pregnancy began prior to the inception of eligibility for benefits under the NECHIP policy

- Gender transformations/changes
- Fertility tests and related services
- Reversal of surgical sterilization
- Direct attempts to cause pregnancy by hormone therapy, artificial insemination, invitro fertilization or embryo transfer
- Routine physical exams or tests in excess of the benefits allowed under this policy
- Self-inflicted injuries
- Transplant expenses when you are the donor
- Treatment of a pre-existing condition or any complications of or resulting from such pre-existing condition, with the exception of prescription medication until the policy has been in force at least six months (unless pre-existing condition waiver is in force)
- Investigative/experimental treatment
- Expenses covered by local, state or federal programs
- Services covered by another insurance plan
- Custodial care
- Therapy which is primarily recreational or educational; music therapy, work-hardening therapy, pre-vocational therapy, or any forms of nonmedical self-care
- Genetic treatment or engineering
- Weight modification or treatment of obesity, including surgery
- Transplant surgery which has not been preauthorized
- Services by or for blood donors
- Breast reduction/augmentation
- Charges made separately for services, supplies or other materials considered by the NECHIP administrator to be included within the total charge payable
- Services not determined payable after consideration by the Utilization Review program

- This program evaluates use of a medical/surgical procedure or service or the utilization of medical supplies, drugs or durable medical equipment compared to established criteria, to determine whether benefits are payable; benefits for services, procedures, drugs, supplies or durable medical equipment determined not medically necessary are not payable
- Services for treatment of sexual disorders or dysfunction
- Orthopedic shoes or foot supports except as prescribed for complications of diabetes

NECHIP Specified Conditions

If you have one of the following conditions, and are a legal Nebraska resident, you are automatically eligible for NECHIP coverage:

- AIDS / HIV
- Addison's Disease
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Aneurysm
- Angina Pectoris
- Aplastic Anemia
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Attempted Suicide
- Autism
- Bipolar Disorder
- Brain Tumors
- Cariomyopathy
- Cerebral Palsy
- Chemical Dependency (alcohol/drug abuse)
- Cirrhosis of the Liver
- Congestive Heart Failure
- Coronary Artery Disease
- Crohn's Disease
- Cystic Fibrosis
- Dementia
- Diabetes (Type I or II)
- Down's Syndrome
- Emphysema / COPD
- Epilepsy
- Gastric Bypass Surgery

- Hemophilia
- Hepatitis, Chronic Active
- Hodgkin's Disease
- Hydrocephalus
- Kidney Failure requiring Dialysis
- Leukemia
- Lupus
- Major Depressive Disorder
- Malignant Tumor (last 8 years)
- Melanoma
- Metastatic Cancer (last 8 years)
- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myocardial Infarction
- Open Heart Surgery
- Pacemaker
- Pancreatitis
- Paraplegia or Quadriplegia
- Parkinson's Disease
- Peripheral Vascular Disease
- Progressive Systemic Sclerosis (Scleroderma)
- Pulmonary Embolism
- Rheumatoid Arthritis
- Schizophrenia
- Sickle Cell Anemia
- Sleep Apnea
- Tetralogy of Fallot
- Transcient Ischemic Attack (TIA)/Stroke
- Transplant Recipient

Please note: This list is subject to change. Contact the NECHIP Customer Service Center (see phone numbers on back of this brochure) or visit **www.nechip.com** for a current list.

NECHIP Customer Service Center

855-247-5201

Mailing Address

Nebraska Comprehensive Health Insurance Pool
c/o Coventry Health and Life Insurance Company
P.O. Box 541210
Omaha, NE 68154

www.nechip.com

This brochure contains only a partial description of the benefits, limitations, exclusions and other provisions of NECHIP coverage. It describes the more important parts of the contract in a general way, and should not be considered to be all or part of the contract. If you have questions regarding costs or further details of the coverage (including exclusions, reductions, limitations and terms under which the policy may be continued in force), or you need assistance, contact the NECHIP Customer Service Center.

Notice Required By Federal Law

- Not a deposit
- Not FDIC insured
- Not insured by any federal government agency
- Not guaranteed by any bank