

Coventry Health Care of Nebraska, Inc.

<http://www.chenebraska.com>

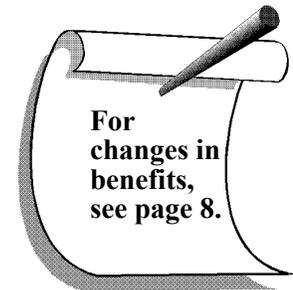


2008

A Health Maintenance Organization

Serving: Central and Eastern Nebraska counties

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



**ACCREDITED
HEALTH UTILIZATION
MANAGEMENT**

Enrollment codes for this Plan:

IE1 - Self Only

IE2 - Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-838

**Important Notice from Coventry Health Care of Nebraska, Inc. About
Our Prescription Drug Coverage and Medicare**

OPM has determined that Coventry Health Care of Nebraska prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable 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 Coventry Health Care of Nebraska will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, 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.

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Introduction

This brochure describes the benefits of Coventry Health Care of Nebraska, Inc. under our contract (CS 2891) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Coventry Health Care of Nebraska administrative offices is:

Coventry Health Care of Nebraska, Inc.

13305 Birch Drive, Suite 100

Omaha, Nebraska 68164

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, 2008, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2008, and changes are summarized on page 9. 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 Coventry Health Care of Nebraska, Inc.
- 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 fehwebcomments@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:

- Be wary of giving 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 800/288-3343 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, DC20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

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

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

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

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

www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

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

HMO's 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 and/or coinsurance 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 and/or coinsurance.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$2,000 for Self Only enrollment, or \$4,000 family coverage.

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.

Coventry Health Care of Nebraska, Inc. is an Omaha based health maintenance organization (HMO) that is a wholly owned subsidiary of Coventry Health Care, Inc. of Bethesda, MD. The Coventry approach to delivering health care is to focus on strong regional plans, rather than one national plan to best meet the specific customer needs in each area. Formed as Principal Health Care Inc., of Nebraska in 1987, Coventry Health Care of Nebraska, Inc. is a for profit health maintenance organization (HMO) which offers a full range of managed care benefit packages. The company maintains certificates of authority to operate in Nebraska and Iowa. Coventry Health Care of Nebraska, Inc.'s corporate offices are located in Omaha, Nebraska and its Customer Service Center is located in Bismark, North Dakota.

If you want more information about us, call 800-471-0240, or write to Coventry Health Care of Nebraska, Inc., 13305 Birch Drive, Suite 100, Omaha, Nebraska 68164. You may also contact us by fax at 302-498-9706 or visit our Web site at www.chcnebraska.com.

Your medical and claims records are confidential

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

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our network providers practice. Our Service Area is:

Adams, Antelope, Arthur, Blaine, Boone, Buffalo, Burt, Butler, Cass, Cedar, Chase, Cherry, Clay, Colfax, Cuming, Custer, Dakota, Dawson, Dixon, Dodge, Douglas, Dundy, Fillmore, Franklin, Frontier, Furnas, Gage, Garden, Garfield, Gosper, Grant, Greely, Hall, Hamilton, Harlan, Hayes, Hitchcock, Holt, Hooker, Jefferson, Johnson, Kearney, Keith, Knox, Lancaster, Lincoln, Logan, Loup, Madison, McPherson, Merrick, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Perkins, Phelps, Pierce, Platte, Polk, Red Willow, Richardson, Rock, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thomas, Thurston, Valley, Washington, Wayne, Webster, Wheeler, and York

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 a dependent lives 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 another plan 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 2008

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

Changes to this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 59.
- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. See page 59.
- Your share of the non-Postal premium will decrease for Self Only or decrease for Self and Family. See page xx.
- The out-of-pocket maximum is now \$2,000 Self Only and \$4,000 Self and Family enrollment. Previously, the respective amounts were \$1,000 Self Only and \$3,000 Self and Family.
- The primary doctor's office visit copayment has been decreased to \$15 per visit from \$20 per visit.
- The specialist office visit copayment has been increased to \$25 per visit from \$20 per visit.
- The maternity initial office visit copayment is now \$15 per primary care doctor or \$25 per specialist visit. Member pays no copayments for all additional office visits. Previously, member paid \$20 per visit for initial and each subsequent office visit.
- The home health visit copayment is now \$50 per visit instead of no member copayment.
- Chiropractic care is now covered for 25 visits subject to a member copayment of \$25 per visit. Previously, chiropractic care was covered as part of the Physical and Occupational therapy benefit.
- The inpatient hospital admission copayment is now \$600 per day up to \$3,000 maximum per admission. Previously, the member paid nothing.
- The outpatient hospital admission copayment is now \$600 per facility use. Previously, the member paid nothing.
- The outpatient laboratory test/radiology copayment is now \$50 per facility use instead of no member copayment.
- The skilled nursing care facility benefit copayment is now \$150 per day up to a maximum member copayment of \$750 per admission. Previously, the member paid nothing.
- The ambulance per trip copayment has been increased to \$125 from \$25.
- Emergency care visit copayments are now \$15 per doctor's office visit, \$50 per urgent care center visit and \$250 per outpatient hospital visit. Previously, the copayments were \$20 per doctor's office visit, \$25 per urgent care center visit and \$50 per outpatient hospital visit.

Section 3. How you get care

<p>Identification cards</p>	<p>We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.</p> <p>If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-288-3343 or write to us at 13305 Birch Drive, Suite 100, Omaha, Nebraska 68164. You may also request replacement cards through our Web site: www.chcnebraska.com through <i>MyOnlineServices</i>.</p>
<p>Where you get covered care</p>	<p>You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance.</p>
<p>• Plan providers</p>	<p>Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.</p> <p>We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.</p>
<p>• Plan facilities</p>	<p>Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.</p>
<p>What you must do to get covered care</p>	<p>It depends on the type of care you need. 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. Health Plan members choose their PCP from the Directory of Health Care Providers. In the event you require a Specialist’s services or hospitalization, your PCP will coordinate your care. All care must be obtained from a Participating Provider unless specifically authorized by us</p>
<p>• Primary care</p>	<p>Health Plan members choose their PCP from the Directory of Health Care Providers, a list of Participating Family and General Practitioners, Internists, and Pediatricians. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.</p> <p>Should you wish to change your PCP, you must first contact the Health Plan Customer Service Department at 800-288-3343. Your change must be submitted by the 20th of the month for the change to be effective by the first day of the following month.</p>
<p>• Specialty care</p>	<p>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 must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.</p> <p>Here are some other things you should know about specialty care:</p> <ul style="list-style-type: none"> • 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).

	<ul style="list-style-type: none"> • 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, 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: <ul style="list-style-type: none"> - 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, <p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> • Hospital care 	<p>Your Plan physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility. Your PCP or the Participating Physician who admits you to an inpatient or outpatient facility is responsible for obtaining authorization from us.</p>
<p>If you are hospitalized when your coverage begins</p>	<p>We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-288-3343. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.</p> <p>If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:</p> <ul style="list-style-type: none"> • You are discharged, not merely moved to an alternative care center; or • The day your benefits from your former plan runs out; or • The 92nd day after you become a member of this Plan, whichever happens first. <p>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.</p>
<p>Circumstances beyond our control</p>	<p>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.</p>
<p>Services requiring our prior approval</p>	<p>Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. 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 prior authorization.</p>

	<p>The Health Plan has given approval for payment for certain services to be performed. Upon Authorization, all inpatient Hospital stays are then subject to concurrent review criteria established by the Health Plan. If you need specialty services from a Non-Participating Provider, an Authorization means the member's PCP has recommended a Non-Participating Provider for treatment of a specific condition, and the Health Plan has assigned an Authorization for a certain number of visits or days. Authorization does not guarantee payment if you are not eligible for Covered Services at the time the service is provided.</p> <p>All Inpatient Admissions, as well as certain Outpatient services require prior authorization. Outpatient services requiring prior authorization include, home health care, durable medical equipment, prosthetics, non-participating providers, outpatient surgical procedures, outpatient testing and short rehabilitative therapy.</p>
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Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care

Copayments	<p>A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.</p> <p>Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go to the Emergency Room, you pay \$250 per visit.</p>
Cost-sharing	<p>Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.</p>
Deductible	<p>We have no calendar year deductible.</p>
Coinsurance	<p>Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.</p> <p>Example: In our Plan, you pay 50% of our allowance for infertility services and 20% for durable medical equipment.</p>
Your catastrophic protection out-of-pocket maximum	<p>After your (copayments and coinsurance) total \$2,000 per person or \$4,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments even after the out-of-pocket maximum is met for the following services:</p> <ul style="list-style-type: none"> • Physician Services • Short-Term Therapies • Elective Sterilization • Urgent Care Service • Emergency Care Services <p>Be sure to keep accurate records of your copayments and coinsurance amounts as you are responsible for informing us when you reach the maximum.</p>
When Government facilities bill us	<p>Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.</p>

Section 5. Benefits-OVERVIEW

See page 8 for how our benefits changed this year.

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-471-0240 or at our Web site at www.chcnebraska.com.

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.

We have no calendar year deductible.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultation • Second surgical opinion 	\$50 per visit to an urgent care center \$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission \$150 copayment per day up to a maximum of \$750 per admission \$15 per visit to your primary care physician \$25 per visit to a specialist
<ul style="list-style-type: none"> • At home 	\$50 per visit
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$15 per office visit with your primary care physician or \$25 per office visit with a specialist

Benefit Description	You pay
Preventive care, adult	High Option
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
Routine pap test Note: You do not pay a separate copayment for a Pap test performed during your routine annual physical; see <i>Diagnosis and treatment services</i> , above.	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>
Preventive care, children	High Option
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist

Benefit Description	You pay
Maternity care	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 for first office visit to your primary care physician. After first visit, no office visit copayments will be required until delivery.</p> <p>\$25 for first office visit to a specialist. After first visit, no office visit copayments will be required until delivery.</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges</i>
Family planning	High Option
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: Depo Provera, diaphragms, and oral contraceptives are covered under the prescription drug benefit.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
Voluntary sterilization (see Surgical procedures Section 5b)	\$100 per procedure
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges</i>

Benefit Description	You pay
Infertility services	High Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	50% of allowable charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> • <i>in vitro fertilization</i> • <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<i>All charges</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
Allergy serum	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges</i>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	High Option
<p>Note: Growth hormone therapy medications which are listed on the Self-Administered Injectable (SAI) formulary are covered under the prescription drug benefit; all others will be covered under the medical benefit as deemed medically necessary.</p> <p>Note: – GHT requires prior authorization. Call (800) 471-0240, ext. 6352 for prior authorization. Prior authorization is required prior to receiving treatment. Coverage will be limited to those services received after appropriate prior authorization is received.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
Physical and occupational therapies	High Option
<p>60 days per condition for the services of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>Nothing per visit if during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges</i></p>
Speech therapy	High Option
<p>60 days per condition per calendar year.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>Nothing per visit during covered inpatient admission</p>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges</i></p>

Benefit Description	You pay
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17>Note: See Preventive care, children for eye exams for children 	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Eye refractions</i> 	<i>All charges</i>
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$15 per office visit to your primary care physician \$25 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	High Option
<p>Initial prosthetic device is a covered service when determined to be Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part.</p> <ul style="list-style-type: none"> • 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. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	20% of allowable charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	High Option
<p>Not covered:</p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Penile prostheses</i> 	<i>All charges</i>
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at (402) 498-9030 ext. 6352 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.</p>	20% of allowable expenses
<p><i>Not covered:</i></p> <p><i>Motorized wheelchairs</i></p>	<i>All charges</i>
Home health services	High Option
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	\$50 per visit

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>
Chiropractic	High Option
<p>25 visits per condition per year</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrashound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$25 per office visit
Alternative treatments	High Option
<i>No benefit</i>	<i>All charges</i>
Educational classes and programs	High Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>

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 PRIOR AUTHORIZATION FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require prior authorization.

Benefit Description	You pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over <ul style="list-style-type: none"> - Surgical treatment, vertical-banded gastroplasty (gastric stapling) and roux-en-y gastric bypass (Roux-en-Y), of morbid obesity will be covered by the health plans of Coventry Health Care, Inc. (Coventry) when <u>all</u> of the following criteria are met: - The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; 	<p>\$600 per outpatient procedure</p> <p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> - There is presence of morbid obesity, defined as a body mass index conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); - The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; - The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, - The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient's medical record) and the patient's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions. <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See – Orthopedic and prosthetic devices for device coverage information • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$600 per outpatient procedure</p> <p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>
<p>Voluntary sterilization (e.g., Tubal ligation, Vasectomy)</p>	<p>\$100 per procedure</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges</i>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • 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. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$600 per outpatient procedure</p> <p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>
<p><i>Not covered:</i></p> <p><i>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</i></p> <p><i>Surgeries related to sex transformation</i></p>	<i>All Charges</i>

Benefit Description	You pay
Oral and maxillofacial surgery	High Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and <p>TMJ related services (non-dental)</p>	<p>\$600 per outpatient procedure</p> <p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	High Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single or double lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - 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 <ul style="list-style-type: none"> - 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) 	<p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g. Wiskott-Aldrich Syndrome) • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p>
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Breast cancer - Epithelial ovarian cancer 	<p>Nothing</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	High Option
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All Charges</i>
Anesthesia	High Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	\$600 per day for inpatient care, up to a maximum of \$3,000 per admission
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$25 per office visit to a specialist \$150 copayment per day up to a maximum of \$750 per skilled nursing facility admission \$600 per outpatient procedure

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 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 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 PRIOR AUTHORIZATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior authorization.

Benefit Description	You pay
Inpatient hospital	High Option
Room and board, such as <ul style="list-style-type: none"> • 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.	\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • 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 	\$600 per day for inpatient care, up to a maximum of \$3,000 per admission

Benefit Description	You pay
Inpatient hospital (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 	<p><i>All Charges</i></p>
Outpatient hospital or ambulatory surgical center	High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$600 copayment per outpatient surgical procedure</p> <p>\$50 copayment for outpatient laboratory tests, x-rays, and pathology</p>
<p><i>Not covered: Blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Extended care benefit/Skilled Nursing Facility: Coverage of up to 30 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary.</p>	<p>\$150 copayment per day, up to a maximum of \$750 per admission</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All Charges</i></p>
Hospice care	High Option
<p>Covered Service when all the following requirements are met:</p> <ul style="list-style-type: none"> • When in the judgment of a Participating Provider, the Member’s life expectancy is six (6) months or less; • Services are Authorized for Coverage by us; and • Provided by a state licensed hospice 	<p>Nothing</p>

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	High Option
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>
Ambulance	High Option
Local professional ambulance service when medically appropriate	\$125 per trip

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:

In a life-threatening emergency, call the local emergency system (e.g. the local 911-telephone system) or go to the nearest emergency facility.

You should contact us at our Customer Service department as soon, as is reasonably possible under the circumstances. The number is 800-288-3343. The determination of covered Services for services rendered in an emergency facility is based on our review of your emergency room medical records, along with those relevant symptoms and circumstances that preceded the provision of care. Services rendered by non-Participating Providers or in non-Participating facilities are not a Covered Service if you remain in a non-Participating facility after we have made the appropriate arrangements for transfer to a Participating facility.

Emergencies within our service area: In the event you experience an Emergency Medical Condition, contact your PCP before receiving services if time permits. If you are unable to contact your PCP, seek help immediately at the nearest Participating Hospital, Participating Physician's office or other Participating emergency facility.

Emergencies outside our service area: If you are unable to indicate a choice of Hospital, or if travel to the nearest Participating Hospital would create a danger to your health, you should obtain medical attention from the nearest Hospital or through 911 emergency services (where available). Screening and stabilization services provided in a Hospital emergency room for an Emergency Medical Condition may be received from either Participating or Non-Participating Providers and do not require Prior Authorization.

Benefit Description	You pay
Emergency within our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor's services 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>\$50 per visit to an urgent care center</p> <p>\$250 per visit to an outpatient hospital emergency room (waived if admitted)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> 	<i>All Charges</i>

Benefit Description	You pay
Emergency outside our service area	High Option
<ul style="list-style-type: none"> • Emergency care at a doctors' office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctor's services. 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>\$50 per visit to an urgent care center</p> <p>\$250 per visit to an outpatient hospital emergency room (waived if admitted)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<p><i>All Charges</i></p>
Ambulance	High Option
<p>Professional ambulance service when medically appropriate.</p>	<p>\$125 per trip</p>
<p><i>Not covered: Air ambulance</i></p>	<p><i>All Charges</i></p>

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 PRIOR AUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	High Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$25 per office visit</p>
<p>Diagnostic tests</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>\$50 copayment for outpatient laboratory tests, x-rays, and pathology</p>
<p>Services provided by a hospital or other facility</p> <p>Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</p>	<p>\$600 copayment per day for inpatient care, up to a maximum of \$3,000 per admission</p> <p>\$150 copayment per day up to a maximum of \$750 per admission in an extended care facility</p>
<p><i>Not covered: Services we have not approved.</i></p>	<p><i>All Charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay
Mental health and substance abuse benefits (cont.)	High Option
<p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>

Prior Authorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>United Behavioral Health is contracted by Coventry Health Care of Nebraska, Inc. to provide a network of providers who offer a variety of therapeutic services on an inpatient and outpatient basis. All inpatient and outpatient treatment must be authorized through United Behavioral Health, at (866) 860-7476.</p>
Limitation	<p>We may limit your benefits if you do not obtain a treatment plan.</p>

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 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.

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

- **Who can write your prescription.** A licensed doctor of medicine or other health care professional who may, in the usual course of business, legally write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy (except for Emergency services or Urgent Care Services, out of the Service Area). You may obtain maintenance medication through Caremark, our mail order prescription program. Caremark's Customer Service number is 800-378-7040.
- **We use a formulary.** A formulary is a list of specific generic and brand name prescription drugs authorized by the Health Plan, and subject to periodic review and modification. Since there may be more than one brand name of the prescription drug not all brands of the same prescription drug (e.g. different manufactures) may be included in the formulary. If you would like information on whether a specific drug is included in our drug formulary, please call our Customer Service Department at 800-288-3343.
- **These are the dispensing limitations.**

Prescription drugs will be dispensed in the quantity determined by the Prescribing Physician. The following shall also apply:

- One (1) Copayment is due each time a prescription is filled or refilled up to thirty-one (31) days supply.
- Insulin & diabetic supplies (insulin syringes, with or without needles, blood & urine glucose test strips, lancets and devices, keytone test strips and tabs), up to a ninety-three (93) days supply, may be dispensed with one (1) appropriate level of Copayment(s) for each prescription up to a thirty-one (31) days supply
- Maintenance drugs obtained through a mail order pharmacy, designated by the Health Plan, May be dispensed with two (2) Copayments for a ninety-three (93) days supply. To order prescription drugs or refills please contact Caremark's Customer Service at 800-378-7040 or visit the website www.rxrequest.com. This service is available 24 hours a day – 7 days a week.
- Generic oral contraceptives, up to a maximum of three cycles may be dispensed with one (1) generic level Copayment for each cycle.
- Brand name oral contraceptives will be dispensed at the brand name Copayment for each cycle. The Ancillary Charge does not apply to brand name oral contraceptives.
- Members called to active duty in a time of a national or other emergency who need to obtain a greater-than-normal supply of prescribed medication should call us at (877) 215-4098.
- **If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge in addition to the Formulary brand name Copayment. The Ancillary charge will be due regardless of whether or not the Prescribing Provider indicates that the pharmacy is to "Dispense as Written". The Ancillary Charge is the difference between the average wholesale price (AWP) of the brand name prescription and the MAC price of the generic prescription.**
- **Coventry Health Care of Nebraska utilizes Prescription Drug rebates as a mechanism to reduce Prescription Drug costs.**

Total Member payments shall not exceed the usual and customary charge of the Prescription Drug.

Why use generic drugs? Generic drugs are lower-priced drugs that are therapeutically equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand name product. 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 the brand-name drug. Generic drugs are listed on the formulary listing of prescription drugs.

When you do have to file a claim. When you receive drugs from Plan Pharmacy, you do not have to file a claim. For a covered out-of-area emergency, you will need to file a claim when you receive drugs from a non-Plan pharmacy. To file a pharmacy claim, call Caremark at 800-378-7040.

Benefit Description	You pay
Covered medications and supplies	High Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior authorization below) • Contraceptive drugs and devices 	<p>Retail Pharmacy (31-day supply)</p> <p>\$10 per generic formulary</p> <p>\$30 per formulary brand name drug</p> <p>\$55 per non-formulary drug</p> <p>Mail Order (93-day supply)</p> <p>\$20 per generic formulary</p> <p>\$60 per formulary brand name drug</p> <p>\$110 per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Self-Administered injectable drugs are only available through a Specialty Pharmacy.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All Charges</i></p>

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.

Plan dentists must provide or arrange your care.

We have no calendar year deductible.

We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See section 5(c) for inpatient hospital benefits. 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 Description	You Pay
Accidental injury benefit	High Option
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.	\$15 per office visit to your primary care physician \$25 per office visit to a specialist \$50 per visit to an urgent care center \$250 per visit to an outpatient hospital emergency room (waived if admitted)
Dental Benefits	High Option
<i>We have no other dental benefits.</i>	<i>All Charges</i>

Section 5(h). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none">• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.• Alternative benefits are subject to our ongoing review.• By approving an alternative benefit, we cannot guarantee you will get it in the future.• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
Travel benefit/services overseas	<p>Coverage for Out of Service area travel is limited to Emergency Medical Conditions only. All other covered medically necessary care must be received within the Health Plan Service Area.</p>

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless we determine 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 or coinsurance.

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

<p>Medical and hospital benefits</p>	<p>In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility must file on the UB-92 form. For claims questions and assistance, call us at 800-288-3343</p> <p>When you must file a claim – such as for services you receive outside of 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:</p> <ul style="list-style-type: none"> • 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. <p>Submit your claims to:</p> <p style="text-align: center;"><i>Coventry Health Care of Nebraska, Inc.</i></p> <p style="text-align: center;"><i>P.O. Box 7705</i></p> <p style="text-align: center;"><i>London, KY 40742</i></p>
<p>Prescription drugs</p>	<p>Please follow rules outlined above.</p> <p>Submit your claims to:</p> <p style="text-align: center;"><i>Caremark, Inc.</i></p> <p style="text-align: center;"><i>P.O. Box 659574</i></p> <p style="text-align: center;"><i>San Antonio, TX 78265</i></p> <p style="text-align: center;"><i>800-378-7040</i></p>
<p>Mental Health</p>	<p>Submit your claims to:</p> <p style="text-align: center;"><i>United Behavioral Health</i></p> <p style="text-align: center;"><i>P.O. Box 60757</i></p> <p style="text-align: center;"><i>Salt Lake City, Utah 84130</i></p>
<p>Deadline for filing your claim</p>	<p>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.</p>
<p>When we need more information</p>	<p>Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.</p>

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.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <p>a) Write to us within 6 months from the date of our decision; and</p> <p>b) Send your request to us at: Coventry Health Care of Nebraska, Inc., 13305 Birch Drive, Suite 100, Omaha, NE 68164; and</p> <p>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</p> <p>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</p>
2	<p>We have 30 days from the date we receive your request to:</p> <p>a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</p> <p>b) Write to you and maintain our denial - go to step 4; or</p> <p>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.</p>
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

	<p>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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 (800)288-3343 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM’s Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

<p>When you have other health coverage</p>	<p>You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”</p> <p>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.</p> <p>When we are the primary payer, we will pay the benefits described in this brochure.</p> <p>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.</p>
<p>What is Medicare?</p>	<p>Medicare is a Health Insurance Program for:</p> <ul style="list-style-type: none"> • 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). <p>Medicare has four parts:</p> <ul style="list-style-type: none"> • 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.

<ul style="list-style-type: none"> • Should I enroll in Medicare? 	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> • The Original Medicare Plan (Part A or Part B) 	<p>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.</p> <p>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.</p> <p>If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.</p> <p>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.</p> <ul style="list-style-type: none"> • When we are the primary payer, we process the claim first. • When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at <i>800-288-3343</i> or see our Web site at www.chcnebraska.com. <p>We do not waive any costs if the Original Medicare Plan is your primary payer.</p>
<ul style="list-style-type: none"> • Medicare Advantage (Part C) 	<p>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.</p>

	<p>If you enroll in a Medicare Advantage plan, the following options are available to you:</p> <p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> • Medicare prescription drug coverage (Part D) 	<p>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.</p>

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.

<p>TRICARE and CHAMPVA</p>	<p>TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.</p> <p>Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.</p>
<p>Workers' Compensation</p>	<p>We do not cover services that:</p> <ul style="list-style-type: none"> • You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or • OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws. <p>Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.</p>
<p>Medicaid</p>	<p>When you have this Plan and Medicaid, we pay first.</p> <p>Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.</p>
<p>When other Government agencies are responsible for your care</p>	<p>We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.</p>
<p>When others are responsible for injuries</p>	<p>When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.</p> <p>If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.</p>
<p>When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage</p>	<p>Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.</p>

Section 10. Definitions of terms we use in this brochure

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 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14
Experimental or investigational services	<p>A service, supply, equipment, drug or procedure is deemed experimental or investigational if one or more of the following conditions are met:</p> <ul style="list-style-type: none"> • Any drug not approved for use by the FDA; and drug that is classified as IND (investigational new drug) by the FDA; any drug for which Prior Authorization is requested that is proposed for off-label use; • Any service, supply, equipment, drug or procedure that is subject to the Medical Review Department review and/or approval; • Any service, supply, equipment, drug or procedure that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; • Any service, supply, equipment, drug or procedure that is considered not to have demonstrated value based on clinical evidence reported by Peer-Review Medical.
Medical necessity	<p>Medical Necessity means those service, supplies, equipment and facilities charges that: are not expressly excluded under the Agreement and determined by us to be:</p> <ul style="list-style-type: none"> • Medically appropriate, so that expected health benefits (increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks; • Necessary to meet your health improve physiological function and required for a reason other than improving appearance; • Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service; • Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested; • Consistent with the diagnosis of the condition at issue; • Required for reasons other than your comfort or the comfort and convenience of your physician; and • Not Experimental or Investigational as determined by us under our Experimental Procedures Determination Policy.

Plan allowance	The Out-of-Network Rate is equivalent to the current Medicare fee schedule or diagnosis group rate, as applicable, for the services and supplies rendered, taking into account the appropriate Medicare geographic adjustments. If there is no corresponding Medicare rate for the particular service, the Plan shall pay the amount that the Plan would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with us.
Us/We	Us and We refer to Coventry Health Care of Nebraska, Inc.
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.
<ul style="list-style-type: none"> • Where you can get information about enrolling in the FEHB Program 	<p>See www.opm.gov/insure/health for enrollment information as well as:</p> <ul style="list-style-type: none"> • 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 <p>Also, your employing or retirement office can answer your questions, and give you a <i>Guide to Federal Benefits</i>, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
<ul style="list-style-type: none"> • Types of coverage available for you and your family 	<p>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.</p> <p>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.</p> <p>Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.</p> <p>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.</p>
<ul style="list-style-type: none"> • 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).

	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
<ul style="list-style-type: none"> • When benefits and premiums start 	<p>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 2008 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 2007 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.</p>
<ul style="list-style-type: none"> • When you retire 	<p>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).</p>

When you lose benefits

<ul style="list-style-type: none"> • When FEHB coverage ends 	<p>You will receive an additional 31 days of coverage, for no additional premium, when:</p> <ul style="list-style-type: none"> • Your enrollment ends, unless you cancel your enrollment, or • You are a family member no longer eligible for coverage. <p>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.</p> <p>You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)</p>
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<ul style="list-style-type: none"> • Upon divorce 	<p>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 <i>Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees</i>, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.</p>
<ul style="list-style-type: none"> • Temporary Continuation of Coverage (TCC) 	<p>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.</p> <p>You may not elect TCC if you are fired from your Federal job due to gross misconduct.</p> <p>Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the <i>Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees</i>, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.</p>
<ul style="list-style-type: none"> • Converting to individual coverage 	<p>You may convert to a non-FEHB individual policy if:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>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.</p>
<ul style="list-style-type: none"> • Getting a Certificate of Group Health Plan Coverage 	<p>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.</p> <p>For more information, get OPM pamphlet RI 79-27, <i>Temporary Continuation of Coverage (TCC) under the FEHB Program</i>. 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.</p>

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependants unable to care for themselves 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.

Where can I get more information about FSAFEDS?

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

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

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

Additional Information

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

How do I enroll?

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

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

Summary of benefits for Coventry Health Care of Nebraska- 2008

Do not rely on this chart alone. All benefits 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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: \$15 primary care; \$25 specialist	17
Services provided by a hospital:		
• Inpatient	\$600 copayment per day of inpatient care, up to \$3,000 maximum	
• Outpatient	\$600 copayment per outpatient procedure \$50 copayment for outpatient laboratory tests, x-rays, and pathology	
Emergency benefits:		
• In-area	\$15 per primary care office visit; \$25 per specialist; \$50 per urgent care center visit; \$250 per emergency room visit	29
• Out-of-area	Same as in-area	29
Mental health and substance abuse treatment:		
	Regular cost sharing	30
Prescription drugs:		
	Retail Pharmacy (31-day supply) \$10 per formulary generic drug ; \$30 per formulary brand name drug; \$55 per non-formulary drug Mail Order (93-day supply) \$20 per formulary generic drug; \$60 per formulary brand name drug; \$110 per non-formulary drug	33
Dental care (Accidental injury only)		
	\$15 per primary care office visit; \$25 per specialist; \$50 per urgent care center visit; \$250 per emergency room visit.	
Special features:		
	Flexible benefits option; Travel benefit/ services overseas	
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum):		
	Nothing after \$2,000/Self Only or \$4,000/Family Enrollment per year Some costs do not count toward this protection	

2008 Rate Information for Coventry Health Care of Nebraska

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

Postal Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees*, RI 70-2, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call.

Human Resources Shared Service Center

1-877-3273, Option 5

TTY: 1-866-260-7507

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	IE1	\$125.93	\$41.98	\$272.86	\$90.95	\$20.99	\$18.89
High Option Self and Family	IE2	\$316.91	\$105.64	\$686.65	\$228.88	\$52.82	\$47.54