2009 • 2010

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN

NEVADA STATE COLLEGE

at HENDERSON

Policy Number: CUH201754

THE COMPANY

The plan is insured by Combined Insurance Company of America, Chicago, Illinois

Direct all inquiries regarding enrollment to The Plan Administrator:

ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC.
Post Office Box 189
Libertyville, Illinois 60048

Pre-Certification is not required
Policy benefits are not guaranteed

Student Insurance Information Internet Site:
www.NVStateInsurance.com
(800) 452-5772 • Fax (847) 281-8813
email: office@AIPInternational.com
Please contact between the hours of 5:00 a.m. to 5:00 p.m. Pacific Time.

Detach and retain.

Student Insurance Identification Card
Nevada State College at Henderson
2009-2010

_____
Print name and school ID number

is entitled to the benefits provided under the policy issued by Combined Insurance Company of America, for the entire period for which premium has been paid, 24 hours per day, anywhere in the world. Coverage expires at 12:01 a.m. on the last date for which premium has been paid. Possession of this card does not guarantee benefits. Contact the Plan Administrator to verify coverage at (800) 452-5772.

Policy Number: Nevada State College at Henderson CUH201754

Direct all claim inquiries and correspondence to: Administrative Concepts, Inc. **Payor #: 22384**
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
(800) 452-5772 • www.visit-aci.com
5:00 a.m. to 5:00 p.m. Pacific Time
www.NVStateInsurance.com

Beech Street
A VIANT NETWORK

Please keep card in your possession at all times. Pre-Certification is not required.
NOTE: In a life threatening emergency, go to the nearest emergency room for treatment

NEVADA STATE COLLEGE

PLAN HIGHLIGHTS

- Coverage anywhere in the world
- National Preferred Provider Network
- Benefits for Accidental Death, Repatriation, Medical Evacuation and Travel Assistance

HOW DO I RECEIVE ASSISTANCE WITH A QUESTION OR PROBLEM?

Please call the Administrator, at (800) 452-5772, Monday through Friday, between the hours of 5:00 a.m. to 5:00 p.m. Pacific Time, or email us through the Student Insurance Information Internet site:

www.NVStateInsurance.com

We appreciate hearing from you with your comments, questions, and concerns.

POLICY TERM

The insurance under the Student Health Insurance Plan for the Annual Policy is effective 12:01 a.m., Pacific Standard Time on August 24, 2009. An eligible student's coverage becomes effective on that date or the date the application and full payment are postmarked and received by the Company or the Plan Administrator, whichever is later. The Annual Policy terminates at 12:01 a.m. Pacific Standard Time on August 24, 2010 or at the end of the period through which the payments are paid. Coverage is effective 24 hours a day on a worldwide basis.

PERIODS OF COVERAGE

If paying other than Annual, coverage will be in effect as shown below. Please see Cost of Insurance in this brochure.

Full Policy Year	August 24, 2009 through August 23, 2010
Enrollment Ends	September 30, 2009
Fall Semester	August 24, 2009 through January 18, 2010
Enrollment Ends	September 30, 2009
Spring Semester	January 19, 2010 through May 16, 2010
Enrollment Ends	February 28, 2010
Spring & Summer Semesters	January 19, 2010 through August 23, 2010
Enrollment Ends	February 28, 2010
Summer Semester	May 17, 2010 through August 23, 2010
Enrollment Ends	February 28, 2010
Quarterly enrollment	**Initial payment due August 24, 2009, subsequent payments due November 24, 2009, February 24, 2010 and May 24, 2010.**
Enrollment Ends	September 30, 2009

You must meet the eligibility requirements listed in the eligibility section to continue insurance coverage. (To avoid a lapse in coverage, your payment must be received within 14 days after the date your coverage terminates, based on the payment method you selected.) It is the student's responsibility to make timely renewal payments to avoid a lapse in coverage. The Company will send renewal notices to the address on file, prior to the Insured's termination date.

ELIGIBILITY

Undergraduate students formally admitted to a Nevada State College program (includes J-1 Visas), and currently enrolled for 6 or more credit hours and Graduate students formally admitted and currently enrolled for 3 or more credit hours are eligible for coverage under this Plan. **Students must maintain the minimum credit hours in order to be eligible.**

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased (annual, fall, spring, or summer), shall not be covered under the Policy and a full refund of the payment will be made. Unless otherwise noted, there is no provision for cancellation. **Students withdrawing after such 31 days will remain covered under the Policy for the full period for which payment has been paid and no refund will be available, except for active participation in the armed forces.**

The Company maintains its right to investigate student status to verify that the Policy eligibility requirements have been met. If and when the Company determines that eligibility requirements have not been met, coverage will be terminated.

ENROLLMENT PROCESS FOR DOMESTIC STUDENTS ONLY

Enrollment applications may be obtained from the Student Health Insurance Information Internet Site:
www.NVStateInsurance.com

1. You may enroll on-line at: **www.NVStateInsurance.com** with an e-check or major credit card.

2. Application and payment may be mailed directly to:
STUDENT INSURANCE PLAN
Post Office Box 189
Libertyville, IL 60048
www.NVStateInsurance.com
(800) 452-5772

3. You may call and enroll over the telephone using a Major Credit Card (800) 452-5772.

4. You can email questions to us at: office@AIPInternational.com.

You must meet the Eligibility Requirements listed in the Eligibility Section to continue insurance coverage. **To avoid a lapse in coverage, your payment must be received within 14 days after the date your coverage terminates,** based upon the payment method selected.

NOTE: Renewal notices will be mailed to the address provided however, it is your responsibility to submit payment prior to expiration date in order to avoid a lapse in coverage. You must re-enroll in the insurance plan. We do not automatically debit your card.

It is important to update all address changes with the Plan Administrator, (800) 452-5772, or by sending an email through the Internet Site: **www.NVStateInsurance.com**.

HOW DO I OBTAIN MY IDENTIFICATION CARD

1. You may detach and retain the Identification Card provided on the brochure.
2. You may obtain your Identification Card on the Internet at: **www.NVStateInsurance.com**. "Click" on Print ID Card. You will need to provide your name, Student Identification Number, and your birth date. If you experience any difficulty, please call us at (800) 452-5772.
3. You may call (800) 452-5772 and request that an Identification Card is mailed to you.

DEPENDENT ELIGIBILITY

Eligible students who enroll in the plan may also enroll their eligible dependents. Eligible dependents are the spouse (residing with the Insured Student) and unmarried dependent children under 19 years of age, who are not self-supporting. Dependent children will continue to be eligible for coverage if at the age of 19 the child is 1) incapable of self-sustaining employment by reason of mental retardation or physical handicap and 2) chiefly dependent upon the student insured for support and maintenance. Proof of the incapacity and dependency shall be furnished to the insurer by the Insured within 31 days of the child's reaching age 19. Continued proof shall be furnished to the insurer on an annual basis thereafter. Dependent coverage expires concurrently with that of the covered students. Stepchildren, foster children, children placed for adoption, and legally adopted children may be included the same as your natural children provided they depend upon you for support and maintenance. **You must enroll your dependents and make the required payment at the time of your initial enrollment in the Plan.**

If you acquire a new dependent or after a dependent becomes ineligible for coverage under another health insurance Policy, you must enroll and pay any additional cost for the newly acquired dependent within thirty-one (31) calendar days.

After the time periods described above, you must wait until the next enrollment period, except in the case of a newborn child, as described below.

If a dependent, except a child covered at birth, is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement.

No one will be eligible as a dependent while in active military service.

NEWBORN CHILDREN

In the event of the birth of a child to a covered student while the student's insurance is in force, the child will automatically become a covered person from the moment of birth. Coverage will continue for 31 days. If the student has no other covered children, payment to continue the child's coverage must be remitted within 31 days, or the coverage will terminate for that child at the end of the 31 day period.

PAYMENT REFUND POLICY

There is no provision for cancellation other than upon entry into the Armed Forces or for medical withdrawal due to a covered Injury or Sickness. Any student withdrawing from school during the first 31 days of the period for which coverage is purchased (annual, fall, spring, or summer) shall not be covered under the Policy and a full refund of the payment will be made. Such a student will not be entitled to any benefits during the days preceding withdrawal, and no claims received will be honored. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which the payment has been paid and no refund will be available. Pro-rata refunds will be made upon the entry of any insured person into the Armed Forces of any country. **NO OTHER REFUNDS WILL BE PERMITTED.**

CONTINUATION OF COVERAGE

Continuation of coverage is offered to students and their dependents should they become ineligible to continue the Student Health Insurance Program for up to 9 months. The benefits and Provisions will be similar to the Student Health Insurance Program, but the cost will be higher. Application must be made within 31 days of termination of the Student Health Insurance. Please contact (800) 452-5772 for information.

CERTIFICATION OF HEALTH PLAN COVERAGE

If your coverage terminates, the Insured should request a Certification of Health Plan Coverage from Associated Insurance Plans International, Inc. This request can be made by phone or in writing through the Student Health Insurance Information Internet site: **www.NVStateInsurance.com**. This request must include the name of the school and the name of each person who is no longer eligible under the Plan. If mailed, direct your request to Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL (800) 452-5772.

DEFINITIONS

Claim Form is a form that must be completed and sent to the claim office when any medical/dental expenses are incurred. This claim form is available at: **www.NVStateInsurance.com**.

Coinsurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Plan is in force as to the Insured Person.

Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

DEFINITIONS (CONTINUED)

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state or residence of such practitioner; (c) a certified nurse midwife while acting within the scope of that certification.

Injury means bodily injury caused by an accident, which is the sole cause of the Loss. All injuries due to the same or related cause are considered one Injury.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Plan.

Lifetime Per Condition Aggregate Maximum means for each Insured Person, the maximum amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy or Policies issued to the Policyholder prior to this Policy.

Loss means medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a Loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

Medically Necessary means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a licensed Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, drug or supply shall not be considered as Medically Necessary if it is investigational, experimental, or educational.

Policy Year: August 24, 2009 through August 24, 2010.

Reasonable and Customary Expense means fees and prices generally charged within the locality where performed for medically necessary services and supplies required for treatment of cases of comparable severity and nature. For information on payment of a specific procedure, please contact the Claim Office, (800) 452-5772 between the hours of 5:00 a.m. to 5:00 p.m. PST.

Sickness means sickness or disease, which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us or Our means Combined Insurance Company of America.

You, Your or Yours means the Insured Student.

PREFERRED PROVIDER NETWORK

Persons insured under this Plan may choose to be treated within, or out of, the Preferred Provider Network. The Preferred Provider Network consists of hospitals, Doctors, and other health care providers, which are organized into a network for the purpose of delivering quality health care at a preferred fee. Reimbursement rates will vary according to the source of care, as described under the Description of Benefits herein.

When an Insured Person uses the services of a Beech Street Preferred Provider Network provider, the covered expenses incurred will be payable at 80% of PPO Allowance. However, when treatment is rendered by providers outside the Beech Street Preferred Provider Network, expenses will be payable at 50% of Reasonable and Customary Covered Charges.

Assignment of a network Doctor does not guarantee eligibility or the right to Student Health Benefits.

In order to use the services of a participating provider, you must present your Combined Insurance Company of America Medical Identification Card that is provided to all students insured under the Insurance Plan.

You should always confirm that a Preferred Provider is participating at the time services are required (by asking the provider when you make an appointment for service).

A complete listing of participating providers under both Networks is available on the web at:

www.NVStateInsurance.com

When IN OR OUT OF NEVADA, you should utilize Beech Street Preferred Provider Network (800) 432-1776.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT EXPENSE BENEFIT

When, because of an Injury, the Insured Person suffers any of the following losses within 180 days from the date of the accident, We will pay as follows:

For Loss Of:	Amount
Life	$3,000
Two Hands, Two Feet, or Sight of Two Eyes	$3,000
One Hand and One Foot	$3,000
One Hand and the Sight of One Eye	$3,000
One Foot and the Sight of One Eye	$3,000
One Hand or One Foot or Sight of One Eye	$1,250
Thumb or Index Finger	$ 625

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of sight in that eye means total irrecoverable loss of the entire sight. Only one of the amounts named above will be paid for Injuries resulting from any one accident. The amount so paid shall be the largest amount that applies. Loss of thumb and index finger means actual severance through or above the metacarpophalangeal joints.

ACCIDENTAL DEATH AND DISMEMBERMENT EXPENSE BENEFIT (CONTINUED)

This provision does not cover the Loss if it in any way results from or is caused by or contributed to:

(1) By physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;

(2) By an infection, unless it is caused solely and independently by a covered Accident;

(3) Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or

(4) By the Insured Person being legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.

DEDUCTIBLE

The deductible per Insured Person is $300 per Policy Year. If you have dependent coverage, the deductible maximum will be $600 per family per Policy Year. If two or more covered members of a family are injured in the same Accident, only one deductible will be charged each Policy Year against their combined eligible expenses due to the Accident.

Although a new deductible will apply each Policy Year, eligible expenses incurred from June 1st through August 15th which are applied against the Policy Year's deductible will also be applied toward the deductible for the next Policy Year and thus reduce or eliminate that Policy Year's deductible.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

If as a result of an Injury or Sickness, an Insured Person incurs covered Medical Expenses, We will pay 80% of the PPO Allowance In Network and 50% of Reasonable and Customary Out-of-Network. Benefits are subject to a $300 per Insured Person per policy year deductible, $600 per Family per Policy Year.

Once the Out-of-Pocket eligible expenses exceed $5,000 per condition, additional benefits are payable at 100%, up to the Per Condition Aggregate Maximum of $100,000 per Injury or Sickness. The following Expenses will be paid: (a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) inpatient and outpatient consultant; (g) accidental dental injury; (h) licensed nurse; (i) hospital outpatient expenses; (j) emergency room treatment; (k) diagnostic x-ray and laboratory tests; (l) outpatient prescription drugs; (m) ambulance; (n) other expenses incurred for the treatment of an Injury or Sickness. The first eligible expense must be incurred within 90 days from the date of accident.

STOP LOSS

When Insured's "out of pocket" expenses exceed $5,000 per condition, additional covered medical expenses are paid at 100%.

SCHEDULE OF BENEFITS

$100,000 AGGREGATE LIFETIME MAXIMUM BENEFIT PER INJURY OR SICKNESS

DEDUCTIBLE: $300 Per Insured, per **POLICY YEAR**.
MAXIMUM DEDUCTIBLE: $600 per Family, Per **POLICY YEAR**.

COVERED MEDICAL EXPENSES

IN-PATIENT HOSPITAL SERVICES	PPO Allowance	Any Provider / R&C
Inpatient Hospital Services: Daily charge for semi-private room, general nursing services and ancillary services. Not to exceed 30 days (maximum) per Policy Year.	80%	50%
Surgical/Medical Services: Pre-admission Testing, Surgery and Medical Services, Physician's Visits (limited to one visit per day), Surgical Assistant Consultation, Obstetrical, Anesthesia	80%	50%
OUT-PATIENT HOSPITAL SERVICES		
Day Surgery and Medical Services: Surgery and medical services, Physician's Visits (limited to one visit per day) subject to a $15 co-pay, Surgical Assistant Consultation, Obstetrical, Anesthesia	80%	50%
Out-Patient Hospital Services and Emergency Room Care	80%	50%
Out-patient Diagnostic Services: Radiology, Ultrasound, Nuclear Medicine, Laboratory, Pathology, ECG, EEF and other Electronic Diagnostic Medical Procedures.	80%	50%
Out-patient Therapy Services: Radiation Therapy, Chemotherapy, Dialysis Treatment, Manipulation, Physical Therapy, Respiration Therapy, Occupational Therapy, Speech Therapy, IV Therapy, all visits limited to one visit per day.	80%	50%
Home Health Care:	80%	50%
Out-patient Prescription Medication (including birth control): 50% of charges to subject to pre-existing condition limitation, and/or the deductible		50%
Maternity Care Services: Same as In-patient and Out-patient Hospital Services, and Surgical Medical Services. NOTE: Abortion is not covered, except in circumstances that are life-threatening to a mother.	80%	50%
Mental Health Services/Alcohol and Chemical Dependency		
In-patient: Same as In-patient Hospital Services. Not to exceed 40 days per policy year. Co-pay applies.	80%	50%
Out-patient: $75 per visit, not to exceed a maximum of 40 visits per policy year. All visits limited to one per day. $15 co-pay.	80%	50%

OTHER SERVICES

Ambulance Service: Limited to $1,000 for air ambulance and $500 for ground ambulance	80%	50%
Skilled Nursing Facility Services: Same as Inpatient Hospital Services	80%	50%
Dental Services: Relating to injury to sound, natural teeth only	80%	50%
Durable Medical Equipment, Prosthetic Appliances and Medical Supplies: Only when determined to be medically necessary	80%	50%
Hospice Care: Payable to a lifetime maximum benefit of $4,000	80%	50%
Well Child Care, including immunizations and age appropriate screening tests:	80%	50%
Preventative Mammography: One Baseline Mammogram for women ages 35-39. Annual exams for women 40 and over	80%	50%
Cytologic Screening	80%	50%

SPECIFIC CO-PAYS

$100 co-pay for Emergency Room Treatment **$15 co-pay for Physician's Visits**
$20 co-pay for Prescription Drugs

Multiple Surgical Procedures Expense Benefit

When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.

PREGNANCY

Benefits for expenses resulting from pregnancy including childbirth or miscarriage, will be determined in the same manner as for Sickness. Elective abortion is not covered, except in circumstances which are life-threatening to the mother.

Coverage for newborn includes care and treatment of medically diagnosed congenital defects and birth abnormalities. Routine nursery care for the well newborn is covered as a part of the mother's bill, if the mother is a covered person. Inpatient medical service visits to examine the well newborn are covered according to the ***Schedule of Benefits***.

REPATRIATION OF BODY REMAINS EXPENSE BENEFIT

This benefit applies only to Domestic Students while Studying Abroad, International Students, and their Dependents. In the event of the death of an Insured Person, We will pay the actual charges for the Covered Expenses for the preparation and transportation of the Insured Person's remains to his or her Home Country. This will be done in accordance with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit. The benefit will be paid up to a maximum of $25,000. You must first seek approval from the Company Claim Office, (800) 452-5772.

EMERGENCY MEDICAL EVACUATION EXPENSE BENEFIT

This benefit applies only to Domestic Students while studying abroad, International Students and their Dependents. This benefit will pay benefits for the Covered Percentage of the Covered Charges incurred, if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. The benefit will be paid up to a maximum of $25,000. You must first seek approval from the Company Claim Office, (800) 452-5772.

INTERNATIONAL ASSISTANCE PROGRAM

The International Assistance Program (IAP) is included in the Student Insurance Plan that provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, schools and Insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.

INTERNATIONAL ASSISTANCE PROGRAM (CONTINUED)

5. Arranging and coordinating emergency medical evacuation and repatriation of remains.
6. Emergency travel arrangement for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:
Toll Free from United States and Canada: (800) 850-4556
Dial Direct or Call Collect Worldwide: (603) 898-9159
Contact our website: www.oncallinternational.com

STATE MANDATED BENEFITS

This Plan also covers all mandated benefits as required by the state in which this Policy is issued.

Maternity Expense Benefit: We will pay benefits for an Insured Person's Covered Charges for maternity care, including Hospital, surgical and medical care.

We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Doctor in consultation with the mother, makes a decision for an earlier discharge from the Hospital.

For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, we will pay for one home health care visit if prescribed by the attending Doctor.

For a mother and newborn child which have a shorter Hospital stay, we will pay for one home visit scheduled within 24 hours after Hospital discharge; and an additional home visit if prescribed by an attending provider.

Newborn infant care is covered when the infant is confined in the Hospital and has received continuous Hospital care from the moment of birth. This includes: (a) nursery charges; (b) charges for routine Doctor's examinations and tests; and (c) charges for routine procedures. This benefit does not include circumcision. This benefit also includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of newborn children covered from birth.

Covered services may be provided by a certified nurse midwife under qualified medical direction if he or she is affiliated with or practicing in conjunction with a licensed facility.

We cover such charges the same way we treat Covered Charges for any other Sickness.

Home Health Care Expense Benefit: We will cover charges for Home Health Care services furnished to an Insured Person. Such benefits must be provided by a licensed Home Health Agency.

We will pay for Covered Charges up to a maximum of 100 visits in any calendar year or in any continuous period of 12 months. Covered Charges are subject to 80% of the Reasonable and Customary Expense. Except for a home health aide, each visit by a representative of a Home Health Agency shall be considered as one home health visit. A visit of four (4) hours or less by a home health aide, shall be considered as one home health visit.

Charges for such services are not subject to the Deductible.

What we pay is shown in the Plan of Insurance.

Definitions:

"Home Health Care" This term means the continued care and treatment of an Insured Person who is under the direct care and supervision of a Doctor but only if: (a) continued hospitalization would have been required if Home Health Care were not provided; (b) the home health treatment plan is established and approved by a Doctor within 14 days after the inpatient Hospital Confinement has ended and such treatment plan is for the same related condition for which the Insured Person was hospitalized; and (c) Home Health Care commences within 14 days after the Hospital Confinement has ended.

"Home Health Services" consist of, but shall not be limited to, the following: (a) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (b) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (c) physical, occupational or speech therapy; and (d) medical supplies, drug and medicines prescribed by a Doctor and related pharmaceutical services, and laboratory services to the extent such charges or cost would have been covered under the Policy if the Insured Person had remained in the Hospital.

"Home Health Agency" means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of the Home and Safety Code.

Cytologic Screening (PAP Smear) Expense Benefit: We cover charges for Expenses incurred for an annual Cytologic Screening (Pap Smear) or more frequently when recommended by a Doctor, nurse practitioner, or a certified nurse midwife. Such benefits will include the examination, laboratory fee, and the Doctor's interpretation of the laboratory results.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Definition

"Cytologic Screening" This term means a pap test to detect cervical cancer through the simple microscope examination of cells scraped from the surface of the cervix.

EXCLUSIONS

The Plan does not cover nor provide benefits for unless otherwise provided within the Schedule of Benefits:

1. Preventative medicines, serums, immunizations or vaccines, except as specifically provided;
2. Routine periodic physical examinations, except as specifically provided.
3. Private duty nursing or skilled nursing services, except as specifically provided;
4. Home health care services, except as specifically provided;
5. Care and/or treatment in a skilled nursing facility, except as specifically provided;
6. Organ transplants, except as specifically provided;
7. Hospice services, except as specifically provided;
8. Pre-existing Conditions as defined in this Policy;
9. Non-prescription drugs or medicines;
10. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata cost of insurance to such Insured Person;
11. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports and professional sports;
12. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery, which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child, which has resulted in a functional defect;
13. Correction of congenital defects except as specifically provided;
14. Services incurred prior to the Insured Person's Effective Date or during Hospital Confinement in one or more facilities, which began prior to the Insured Person's Effective Date;
15. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to sound, natural teeth;
16. Expense incurred for non-surgical treatment of temporo-mandibular joint dysfunction and associated myofacial pain, except as specifically provided;
17. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
18. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
19. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
20. Injury or Sickness for which benefits are paid under Workers' Compensation or Occupational Disease Law;

EXCLUSIONS (CONTINUED)

21. For services or supplies rendered by a close relative of the Insured Person or by a home health aide who is a member of your household. By "close relative", We mean an Insured Person's spouse, children, parents, brothers and sisters;
22. Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;
23. For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
24. Expenses incurred in connection with foot care only to improve comfort or appearance such as care for weak, strained or flat feet; subluxation; corns; calluses; bunions, except open cutting operations; routine care of toenails, except for the removal of the nail root and necessary services in treatment of metabolic or peripheral-vascular disease; treatment of the instability and imbalance of the feet; and any tarsalgia, metatarsalgia. Expenses incurred for the care and treatment of Injury, infection, or disease are not excluded;
25. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
26. Expenses incurred for transsexual surgery or any treatment leading to or in connection with transsexual surgery;
29. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or Lasic or other vision procedures except as required for repair caused by a covered Injury;
30. Well baby care, including routine exams and immunizations, except as specifically provided;
31. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
32. Expenses for any service or supply not specified in this Policy as a covered service;
33. An amount of a charge in excess of the Reasonable and Customary Expense;
34. Elective Treatment or elective surgery, except as specifically provided;
35. Services not Medically Necessary;
36. Treatment of mental or nervous disorders, except as specifically provided;
37. Treatment of alcohol and substance abuse except as specifically provided
38. Tubal ligation; vasectomy; breast implants; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-cystic acne; non-prescription birth control; submucus resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism; and learning disabilities or disorders or Attention Deficit Disorder;
39. Voluntary or elective abortion;

EXCLUSIONS (CONTINUED)

40. Expense incurred for any service, treatment or supply for the diagnosis or treatment of sexual dysfunction (including erectile dysfunction). This includes, but is not limited to, drugs, laboratory and x-ray tests, counseling, transsexual procedures or penile prostheses necessary due to any medical condition or organic disease. A penile prosthesis will be eligible for payment only after prostate surgery;
41. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;
42. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
43. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;
44. Services, supplies and facility that are provided mainly for rest care, maintenance or custodial care;
45. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
46. Care, treatment or supplies furnished by a program or agency funded by any government;
47. Professional services billed by a Doctor or nurse who is an employee of a Hospital or skilled nursing facility, and who is paid by that facility for the service;
48. Alternative health care, including but not limited to acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;
49. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
50. Illness, accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, bungee jumping, racing or speed contests, skin diving, parachuting, bungi-cord jumping.
51. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
52. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;
53. Services, supplies and facility that are provided mainly for rest care, maintenance or custodial care;
54. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
55. Care, treatment or supplies furnished by a program or agency funded by any government;
56. Professional services billed by a Doctor or nurse who is an employee of a Hospital or skilled nursing facility, and who is paid by that facility for the service.

PRE-EXISTING CONDITIONS LIMITATION

A "Pre-existing Condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the Effective Date of the Insured Person's coverage under this Policy. The term does not include genetic information in the absence of a diagnosis of the condition related to such information.

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-Existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student's effective date, and (b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

The Pre-existing Condition Waiting Period will be reduced by the aggregate period of Creditable Coverage of the Insured Person, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the coverage.

Payment will be in accordance with the provisions of this Policy. If the Insured Person has a lapse in coverage of more than 63 days, the Pre-existing Condition Waiting Period will have to be satisfied again.

The Pre-existing Condition Waiting Period will not apply:

(a) To pregnancy;
(b) In the case of an Insured Person who, as of the last day of the 30 day period beginning on the date of his birth, is covered under Creditable Coverage;
(c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30 day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under Creditable Coverage. The provision of this paragraph do not apply to coverage before the date of adoption or placement for adoption;
(d) In case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the diagnosis, care or treatment was a benefit under the plan, if the Creditable Coverage was continuous to a date not more than 63 days before the Effective Date of the new coverage.

PRE-EXISTING CONDITIONS LIMITATIONS (CONTINUED)

The provisions of paragraphs (b) and (c) do not apply to an Insured Person after the end of the first 63 day period during all of which the Insured Person was not covered under any Creditable Coverage.

Definition:
"Creditable Coverage" means health benefits or coverage provided to a person pursuant to:

(a) A group health plan;
(b) A health benefit plan;
(c) Part A or Part B of the Title XVIII of the Social Security Act, 42 U.S.C. Sec, 1395c et seq., also known as Medicare;
(d) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et esq., also known as Medicaid, other than coverage consisting solely of benefits under Sec. 1928 of that Title, 42 U.S.C. Sec.1392s;
(e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. Sec. 1071 et seq.;
(f) A medical care program of the Indian Health Service or of a tribal organization;
(g) A state health risk pool;
(h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. Sec. 8901 et seg.;
(i) A public health plan. A public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in this plan, as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Services Act, 42 U.S.C. Sec. 300 gg(c)(1)(I);
(j) A health benefit plan under insurance program established pursuant to 42 U.S.C. Sec. 2504(e);
(k) The children's health insurance program established pursuant to 42 U.S.C. Sec 1397aa 1397jj, inclusive;
(l) A short-term health insurance policy; or
(m) A blanket accident and health insurance policy.

CONTINUOUSLY INSURED

This Plan may be replacing a Prior Plan with another insurer. Prior Plan means (a) the Student Health Insurance policy or policies issued to Nevada State College immediately before the current Plan; and (b) other policies providing Creditable Coverage as defined in this Plan. Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Plan without a break in coverage. But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses.

The total amount of benefits payable for Injury or Sickness under this Plan and the Prior Plan cannot exceed the Per Condition Aggregate Maximum.

EXTENSION OF BENEFITS

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 31 day period following such termination of insurance.

EXCESS PROVISION

No benefits under this Policy is payable for any expense incurred for Injury or Sickness which is paid or payable by: (1) other valid and collectible insurance; or (2) under an automobile insurance policy.

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.

REIMBURSEMENT AND SUBROGATION

If we pay covered expenses for an accident or injury you incur as a result of any act or omission of a third party, and you later obtain recovery from the third party, you are obligated to reimburse us for the expenses paid. We may also take subrogation action against the third party. Our Reimbursement rights are limited by the amount you recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of your cost, disbursement and reasonable attorney fees. You must cooperate with and assist us in exercising our rights under this provision and do nothing to prejudice our rights.

COMPLAINT RESOLUTION

Insured persons or their representatives may call the Customer Service Department with questions or complaints at (800) 452-5772. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the claims review committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

CONFORMITY WITH STATE STATUTES

Any provisions of this Plan which, on its effective date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

APPEALS PROCEDURE

If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan description and the description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal.

CLAIM PROCEDURES

Should an Injury or Sickness occur, the following steps should be taken:

1. You must complete a claim form. Claim forms may be obtained at the Student Health Center or on the Student Health Insurance Information Internet Site: **www.NVStateInsurance.com.**

2. Please make certain all additional medical bills submitted show your name, School ID Number, school name, and description of medical condition. **Only one claim form, per condition, needs to be mailed.**

3. Mail the completed claim form and medical bills within 90 days from the date of accident or sickness to:

Administrative Concepts, Inc.
994 Old Eagle School Road, Suite 1005
Wayne, PA 19087-1802
(800) 452-5772

Please contact between 5:00 a.m. and 5:00 p.m. Pacific Time.

The Plan is Underwritten by:
Combined Insurance Company of America
Policy Number: CUH201754

Plan Administrator:

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

Post Office Box 189
Libertyville, IL 60048
(800) 452-5772
Fax (847) 281-8813
Please contact between the hours of 5:00 a.m. and 5:00 p.m. PST
Email us at: office@AIPInternational.com
Visit us on the web at:
www.NVStateInsurance.com

To obtain a list of Beech Street Preferred Providers call (800) 432-1776
Or, use the website: **www.NVStateInsurance.com**

HIPAA PRIVACY NOTICE

Under HIPAA's Privacy Rule, we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment material and it is available online at: **www.NVStateInsurance.com.** If, at anytime, you wish to request a copy of Combined Insurance Company of America's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640, Attn: HIPAA Privacy Office, call (800) 225-4500 select HIPAA, or also on-line at: http:www.combinedinsurance.com/customer-center/hipaa-insurance.html.

This brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Master Policy issued to Nevada State College.

OPTIONAL - ADDITIONAL PREMIUM REQUIRED
DENTAL/VISION/PHARMACY DISCOUNT PLAN

Additional premium required (see rates listed below).

No Claim forms
No Waiting Periods
No Pre-existing Conditions
No Deductibles or Maximums
No Age Restriction
Discount is immediate at time of service
Over 100,000 participating providers nationwide

The Co-Health Group Collegiate plan has been specifically designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students attending Nevada State College.

The Co-Health Benefit Plan provides discounts in certain health care areas not normally reimbursed by insurance. In the "Collegiate Plan" we are offering the Vision, Dental and Pharmacy Discount Program as a single package of Benefits, or you may purchase discounts for pharmacy or vision separately. Here's how the plan works.

This is not an Insurance Plan. The Co-Health Group Collegiate Plan is a Discount Care Plan offering discounts and savings for Vision, Dental and Prescription Pharmacy expenses.

Each of the benefit programs (Vision, Dental, and Prescription Pharmacy) has a network of Providers (for example, the participating dentists in the Dental Plan.) As a member of the Plan you can go to any of the providers listed and purchase their products or services on a negotiated discount basis. You receive your discount/savings on the spot. There are no exclusions for "pre-existing" conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership card at the time of your scheduled appointment or at a participating pharmacy.

The discounts you will receive are substantial and these savings can be very important to you. The services that make up the Collegiate Plan (Vision, Dental and Pharmacy) are also the three most common areas where you will have unexpected expenses. With our Benefits, you can substantially reduce your out of pocket expenses, and as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington.

You simply show your Co-Health ID Card and get your discount on the spot.

Annual Coverage Premiums - enroll anytime throughout the year at www.dentalvisionrxdiscount.com.

ANNUAL PREMIUMS	**Credit Card or Internet Payment**	**Check by mail**
Dental/Vision/Pharmacy		
Student Only	$72.00	$62.00
Family	$98.00	$88.00
Vision & Pharmacy		
Student Only	$50.00	$40.00
Family	$71.00	$61.00
Vision		
Student Only	$25.00	$15.00
Family	$30.00	$20.00
Pharmacy		
Student Only	$25.00	$15.00
Family	$30.00	$20.00

OPTIONAL DENTAL AND VISION INSURANCE FOR YOU AND YOUR FAMILY

(Additional premium required)

Underwritten by Security Life Insurance Company of America

- ***Freedom to Use Dentist of Your Choice***
- **Up to $2,000 Annual Maximum**
- **Coverage for Adult Sealants**
- **Three Plan Design Options**
- **No Waiting Periods for Most Services**
- **Optional Vision Coverage for Additional Premium**

PERSONAL DENTAL PLANS

Dental Benefits	Elite Plan	Premier Plan	Select Plan
Class A - Preventive Services			
Initial & Periodic Exams (2 per year), Cleanings (2 per year), Fluoride Treatments (to age 16), Sealants (no age limitation)			
Benefit Year One	100%	100%	75%
Benefit Year Two	100%	100%	85%
Benefit Year Three and Each Benefit Year Thereafter	100%	100%	100%
Deductible - Lifetime per Insured	$50	$50	$50
Waiting Period	None	None	None
Class B - Basic Services			
X-rays, Fillings, Simple Extractions			
Benefit Year One	35%	35%	25%
Benefit Year Two	65%	50%	35%
Benefit Year Three and Each Benefit Year Thereafter	80%	65%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class C - Major Services			
Oral Surgery, Endodontics, Periodontics, Crowns, Bridges, Dentures			
Benefit Year One	15%	10%	10%
Benefit Year Two	50%	25%	25%
Benefit Year Three and Each Benefit Year Thereafter	50%	50%	50%
Deductible - Lifetime per Insured	$50/year	$50/year	$50/year
Waiting Period	None	None	None
Class D - Orthodontic Services			
Straightening of Teeth (for children under age 19)			
Benefit Year One	N/A	0%	N/A
Benefit Year Two	N/A	0%	N/A
Benefit Year Three and Each Benefit Year Thereafter	N/A	50%	N/A
Deductible - Lifetime per Insured	—	None	—
Waiting Period	—	24 months	—

PERSONAL DENTAL PLANS (CONTINUED)

Dental Benefits	Elite Plan	**Premier Plan	Select Plan
Calendar Year Maximum for Classes A, B and C Combined	**$1,000**	**$1,000**	**$1,000**
Calendar Year Max. for Class C-Major Services	**$500**	**$500**	**$500**
Calendar Year Max. for Class D	**—**	**$500**	**—**
Lifetime Max. Per Child for Class D	**—**	**$1,000**	**—**
*** Class B & C Deductible is combined for each calendar year. A maximum of three (3) individual deductibles per family shall apply.**			
☆CALENDAR YEAR MAXIMUM INCREASE OPTIONS			
Option One (1) $1,500/Class C - Major Services limited to $750	**☆$1,500**	**☆$1,500**	**☆$1,500**
Option Two (2) $2,000/Class C - Major Service limited to $1,000	**☆$2,000**	**☆$2,000**	**☆$2,000**
****Optional Vision Benefits Rider (Not a Stand-Alone Benefit)**			
Class A - Vision Exams - 1/year Benefit Year One and Each Benefit Year Thereafter **No Waiting Period**	**100%**	**85%**	**85%**
Class B - Lenses and Frames - 1 pair every 2 years Benefit Year One and Each Benefit Year Thereafter **15 Month Waiting Period**	**50%**	**50%**	**50%**
Class C - Contact Lenses - 1 pair every 2 years (in lieu of frames and lenses) Benefit Year One and Each Benefit Year Thereafter **15 Month Waiting Period**	**50%**	**50%**	**50%**
Calendar Year Deductible	**$50/year**	**$50/year**	**$50/year**
Calendar Year Maximum for Classes A, B and C	**$200**	**$150**	**$150**

☆Optional Feature
You may increase your Calendar Year Maximum Benefit, per individual, for an additional monthly fee. If you elect this feature, your Calendar Year Maximum for Major Services (Class C) will also increase. You must indicate your election of this feature on the enrollment form.

The above plans provide for an increase in coinsurance levels based upon each Benefit Year of coverage. Benefit Year begins with each insured's effective date and continues for 12 months. Each primary insured and dependent will have their own Benefit Year beginning with their specific effective date of coverage. This plan reimburses at the above percentages for covered dental expenses based upon the Reasonable and Customary (R&C) fees for those covered expenses.

QUESTIONS? PLEASE CALL 800-452-5772.
You do not need to purchase health insurance to enroll in the optional dental and vision insurance plan. Enroll online at www.NVStateInsurance.com.

PRIMESTAR PERSONAL DENTAL
PREMIUM RATE TABLE
FOR EFFECTIVE DATES AUGUST 1, 2009
THROUGH MARCH 1, 2010

Monthly premiums illustrated are guaranteed for the initial twelve (12) months of coverage. Thereafter, premiums are likely to increase on a semi-annual basis.

RATE CHART			Nevada Zip Code: 890-891 Area 1	Nevada Zip Code: 894-895 & 898 Area 2	Any Other Nevada Zip Code Area 3
UNDER AGE 65	ELITE	Applicant Only	$ 30.00	$ 44.00	$ 36.00
		Applicant + Spouse	$ 61.00	$ 90.00	$ 75.00
		Applicant + Child(ren)	$ 66.00	$ 96.00	$ 79.00
		Applicant + Family	$ 103.00	$ 150.00	$ 124.00
	PREMIER	Applicant Only	$ 25.00	$ 37.00	$ 30.00
		Applicant + Spouse	$ 51.00	$ 76.00	$ 63.00
		Applicant + Child(ren)	$ 60.00	$ 87.00	$ 72.00
		Applicant + Family	$ 91.00	$ 133.00	$ 110.00
	SELECT	Applicant Only	$ 23.00	$ 33.00	$ 26.00
		Applicant + Spouse	$ 46.00	$ 66.00	$ 56.00
		Applicant + Child(ren)	$ 47.00	$ 68.00	$ 56.00
		Applicant + Family	$ 75.00	$ 108.00	$ 90.00
65 AND OVER	ELITE	Applicant Only	$ 32.00	$ 49.00	$ 40.00
		Applicant + Spouse	$ 67.00	$ 99.00	$ 81.00
	PREMIER	Applicant Only	$ 27.00	$ 41.00	$ 34.00
		Applicant + Spouse	$ 56.00	$ 83.00	$ 68.00
	SELECT	Applicant Only	$ 25.00	$ 36.00	$ 29.00
		Applicant + Spouse	$ 49.00	$ 72.00	$ 61.00
OPTIONAL PREMIER & SELECT VISION COVERAGE FOR ALL AGES		Applicant	$ 5.00	$ 5.00	$ 5.00
		Applicant + Spouse	$ 10.00	$ 10.00	$ 10.00
		Applicant + Child(ren)	$ 10.00	$ 10.00	$ 10.00
		Applicant + Family	$ 13.00	$ 13.00	$ 13.00
OPTIONAL ELITE VISION COVERAGE FOR ALL AGES		Applicant	$ 6.00	$ 6.00	$ 6.00
		Applicant + Spouse	$ 13.00	$ 13.00	$ 13.00
		Applicant + Child(ren)	$ 13.00	$ 13.00	$ 13.00
		Applicant + Family	$ 17.00	$ 17.00	$ 17.00

Call for rates if your permanent address is outside Nevada, or view online at **www.NVStateInsurance.com.**

NEVADA STATE COLLEGE • STUDENT INSURANCE ENROLLMENT CARD 2009-2010 • COMBINED INSURANCE COMPANY OF AMERICA

PLEASE PRINT LEGIBLY

Student's name _____ (First) _____ (M) _____ (Last) Male ☐ Female ☐ School ID No. _____ Social Security Number _____

Date of Birth _____ Telephone No. _____ E-mail _____

Billing Address _____ (Street) _____ (Apt. #) _____ (City) _____ (State) _____ (Zip)

Do you have insurance through another carrier ☐ Yes ☐ No If yes name of Insurance Company _____ Policy Number _____

Spouse's Name _____ Child _____ Child _____ Child _____

Date of Birth ___/___/___ (Month) (Day) (Year) Date of Birth ___/___/___ (Month) (Day) (Year) Date of Birth ___/___/___ (Month) (Day) (Year) Date of Birth ___/___/___ (Month) (Day) (Year)

Social Security Number _____ Social Security Number _____ Social Security Number _____ Social Security Number _____

☐ ***IMPORTANT • • • Please check here if you are an international student or the dependent of an international student.***

SUMMER SESSION • • • Please indicate which summer session you desire your coverage to begin: ☐ Sessions I & II ☐ Session II

QUARTERLY OPTION • • • Please indicate which quarter you desire your coverage to begin: ☐ Quarter I ☐ Quarter II ☐ Quarter III ☐ Quarter IV

I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. PLEASE MAKE SURE TO INDICATE COVERAGE DESIRED ON REVERSE SIDE. My remittance in the amount of $ _____ is enclosed.

Make check or money order payable to Combined Insurance Company of America. Mail this enrollment card along with premium payment to 28085 Ashley Circle, Suite 201, Libertyville, IL 60048

☐ ***Please charge my Student Health Insurance:*** *(Minimum charge of $25)* ***Note: You must re-enroll in the insurance plan each term.***

☐ VISA ☐ DISCOVER *Automatic debit method of payment is available. Please call the administrator at (800) 452-5772 for details and an authorization form.*

☐ MASTERCARD ☐ AMEX Card Number _____ Expiration Date _____ Security Code _____

Print name of cardholder _____ Cardholder phone number _____

Cardholder signature _____ Todays Date _____

(Students must maintain minimum credit hours in order to be eligible)

Please Charge $ _____ for Student Health Insurance.

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at www.associatedinsurancepplans.com/NV_State/.asp

(DO NOT USE)

yes, I wish to participate in the Nevada State College Student Health Insurance Program. My check or money order payable to **COMBINED INSURANCE COMPANY OF AMERICA** for the coverage checked below is enclosed.

**At the time of printing this brochure, the dates of summer sessions had not yet been determined. Please verify at www.NVStateInsurance.com or call (800) 452-5772.*

	Annual 08-24-2009 thru 08-23-2010	Fall Only 08-24-2009 thru 01-18-2010	Spring Only 01-19-2010 thru 05-16-2010	Spring & Summer 01-19-2010 thru 08-23-2010	Quarterly 08-24-2009 thru 11-23-2009 / 11-24-2009 thru 02-23-2010 / 02-24-2010 thru 05-23-2010 / 05-24-2010 thru 08-23-2010	Summer Sessions I & II 05-17-2010 thru 08-23-2010	*Summer Session II 08-24-2010
Student Only	☐ $1,396.00	☐ $ 595.00	☐ $ 451.00	☐ $ 801.00	☐ $ 349.00	☐ $ 350.00	☐ $ 234.00
Student/ Spouse	☐ $5,420.00	☐ $2,285.00	☐ $1,779.00	☐ $3,135.00	☐ $ 1,355.00	☐ $1,356.00	☐ $ 877.00
Student/Child	☐ $2,004.00	☐ $ 852.00	☐ $ 652.00	☐ $1,152.00	☐ $ 501.00	☐ $ 500.00	☐ $ 331.00
Student/2 or more Children	☐ $3,152.00	☐ $,1332.00	☐ $1,030.00	☐ $1,820.00	☐ $ 788.00	☐ $ 790.00	☐ $ 515.00
Student/ Family	☐ $7,176.00	☐ $3,022.00	☐ $2,358.00	☐ $4,154.00	☐ $ 1,794.00	☐ $1,796.00	☐ $1,158.00

NOTE: Renewal premium notices are mailed to the address provided, however, it is your responsibility to submit premium prior to expiration date in order to avoid a lapse in coverage. Premiums shown are inclusive of all administrative fees.

You may enroll "On-line" and pay your premium by electronic check or major credit card at www.NVStateInsurance.com

NEVADA STATE
COLLEGE
at HENDERSON

www.NVStateInsurance.com

Policy Number: CUH201754