UNLV

UNIVERSITY OF NEVADA LAS VEGAS

SCHOOL OF DENTAL MEDICINE
STUDENTS AND RESIDENTS
STUDENT ACCIDENT AND SICKNESS INSURANCE

2008 - 2009

Policy Number DSP0004708

Direct all inquiries regarding enrollment to:

ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC.
Post Office Box 189
Libertyville, Illinois 60048
(800) 452-5772 • Fax (847) 281-8813

OR

Student Insurance Information Internet Site:
www.UNLVINSURANCE.com
Please contact between the hours of 5:00 a.m. to 5:00 p.m. Pacific time.

Pre-Certification for Hospital Stays is Required
Policy Benefits are not Guaranteed
Limitations in this Policy should be Carefully Noted

THE COMPANY

The plan is insured by Delos Insurance Company,
and is administered by
Associated Insurance Plans International, Inc., Libertyville, Illinois

Detach and retain.

Student Insurance Identification Card 2008-2009
University Of Nevada Las Vegas School of Dental Medicine
NOTE: In a life threatening emergency, please go to the nearest emergency room for treatment.
www.UNLVINSURANCE.com

_____
Print name and school ID number

is entitled to the benefits provided under the policy issued by Delos Insurance Company, for the entire period for which premium has been paid, 24 hours per day, anywhere in the world. Coverage expires at 11:59 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, or www.UNLVINSURANCE.com.

Policy Number: DSP0004708

Beech Street
A VIANT NETWORK

Direct all claim inquiries and correspondence to:
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
800-468-4343
www.PIACLAIMS.com
Office visits: $25.00 co-pay

medco®
Medco Prescription Services $10/20
Grp# UNLV001
Pharmacy Locations/
Questions (800) 400-0136

Please keep card in your possession at all times. Pre-Certification is required.

Student Health Center (SHC)

(702) 895-3370

Location

You may access the Health Center by using University Road from Maryland Parkway. We are located behind the Dining Commons.

Important Note:
You must pay the Student Health fee each Semester (including summer) to access the services of the Student Health Center.

Regular Hours of Operation

Monday-Thursday: 8am-8pm
Friday: 9am-5pm
Closed holidays and weekends

Services Provided

- Treatment of minor illness and injury;
- Early detection and referral for care of chronic illness for coordination of ongoing care;
- Immediate first aid and blood pressure checks;
- Fitness screening and exercise prescriptions;
- Screening tests for hearing and vision;
- Contraception evaluation and pregnancy testing;
- Acute management and referral for sexual assault;
- Evaluation, continuing treatment, or referral for initial allergy antigen testing;
- Onsite licensed lab offers a variety of tests with licensed practitioner's order;
- Standard prescription and nonprescription medications are available through our licensed pharmacy;
- Free health information and health education programs available upon request

Insurance Plan Highlights

- You are covered anywhere in the world
- No deductible
- $250,000 benefit per condition, per policy year
- Prescription Drug Card
- National Preferred Provider Network
- Continuation available for one year
- Repatriation, Medical Evacuation, and Accidental Death benefits

Dear Student:

The School of Dental Medicine, University of Nevada, Las Vegas (UNLV), while primarily concerned with academic pursuits, is aware of the varied needs of students in other areas. Therefore, the Student Health Insurance Plan was developed and serves UNLV School of Dental Medicine students. This program has been designed to ensure the availability of quality health care at the least possible cost.

POLICY TERM

The insurance under UNLV, School of Dental Medicine Student Health Insurance Plan for the Annual Policy is effective 12:00 a.m., Pacific Time as shown below. An eligible student's coverage becomes effective on that date.

PERIODS OF COVERAGE

Coverage will be in effect as shown below. Please see premiums on page 23 of the brochure.

	*Deadline for Waiver Submission	Enrollment for Dependents Ends
Orthodontic Residents: 7/1/2008 to 7/1/2009	8/6/2008	8/15/2008
Pediatric Residents: 8/1/2008 to 7/31/2009	8/6/2008	9/15/2008
DMD Students: 8/25/2008 to 8/24/2009	8/6/2008	10/15/2008

*Waiver form may be completed online at www.UNLVInsurance.com. Students with comparable health insurance coverage may elect to waive these benefits. If you have received Pharmacy or Medical benefits prior to submission of your "Waiver" you will be charged for this insurance and coverage will remain in effect.

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 30 day period following such termination of insurance.

COST OF INSURANCE

Student Only	**Annual**
Residents or DMD Students	$1,442

ELIGIBILITY

All School of Dental Medicine students enrolled at UNLV who cannot show proof of existing insurance coverage, will be required to purchase the Student Health Insurance coverage. Premiums are collected by the Cashier's office with tuition during registration. Coverage is also available to dependents of Insured students on a voluntary basis. See definition of Eligible Dependent below.

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, but only if no claim has been made, shall not be covered under the Policy and a full refund of the cost of insurance 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 the cost of insurance has been paid and no refund will be available, except for active participation in the armed forces.**

ELIGIBILITY (CONTINUED)

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 as of the date requirements were not met, appropriate cost of insurance will be refunded, and claims cannot be considered.

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 student. 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 directly to the Administrator.**

Coverage becomes effective on that date or the date application and full premium for the term of coverage you have selected is received by the company (or its authorized representative), whichever is later.

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. Dependent coverage becomes effective the date payment is received by the Company.

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.

CONTINUATION OF COVERAGE AFTER GRADUATION OR TERMINATION

If a student who has been insured under this program graduates, leaves, or terminates enrollment at the School, he/she, and their previously insured dependents, may continue to be covered under this plan for the remainder of the policy year at the cost of insurance shown. If continuous coverage is maintained you can re-enroll in the Insurance Plan for up to 12 months at a higher cost, provided application is made within 30 days of the policy expiration date. The cost of insurance for the Continuation Plan must be paid in advance for the entire continuation period selected, either 3,6,9, or 12 months. No re-enrollment is permitted once the original term of coverage selected has expired. Please contact Associated Insurance Plans at (800) 452-5772. International Students (F-1 and J-1 non-immigrant visa holders) who are authorized for optional practical training or academic training are eligible to extend coverage by completing an insurance request form and returning the form to the International Affairs office. You will be billed accordingly.

COST OF INSURANCE 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 shall not be covered under the Policy and a full refund of the insurance payment will be made, but only if no claim has been made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which the insurance 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.**

CERTIFICATION OF HEALTH PLAN COVERAGE

If your coverage terminates, the Insured should request a Certificate 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.UNLVINSURANCE.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 60048, (800) 452-5772.

PREFERRED PROVIDER NETWORK

Persons insured under this Plan may choose to be treated within, or outside 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 the PPO Allowance. However, when treatment is rendered by providers outside the Beech Street Preferred Provider Network, expenses will be payable at 60% of the covered Reasonable and Customary Expenses.

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 Delos Insurance Company Medical Identification Card that is provided to all students insured under the School of Dental Medicine 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 is available on the web at: **www.UNLVINSURANCE.com.** or by calling the **Beech Street Preferred Provider Network (800) 432-1776.**

Eligible treatment received from the Student Health Service will be covered the same as if received from a Beech Street Preferred Provider Network provider.

COVERED MEDICAL EXPENSES - SCHEDULE OF BENEFITS

$250,000 PER CONDITION

OUT-OF-POCKET MAXIMUM PER POLICY YEAR: $1,250 per Insured Person for In-Network providers; $2,500 per Insured Person for Non-Network providers. Additional Covered Medical Expenses incurred wil be paid at 100%. (Co-payments are not applied to the out-of-pocket maximum.)

	*SHC OR IN-NETWORK PROVIDER	OUT-OF NETWORK (ANY PROVIDER)
STUDENT HEALTH CENTER		
STUDENT HEALTH CENTER – Covered medical expenses for treatment received	80%	N/A
STUDENT HEALTH CENTER PHARMACY BENEFIT ($10 generic/$20 brand co-pay applies per prescription, to the $10,000 aggregate maximum benefit for Medco Drug Card and UNLV SHC Pharmacy expenses.)	N/A	N/A
MEDCO PRESCRIPTION BENEFIT		
Prescription Drug Card: (MEDCO) - $10,000 per Policy Year – $10 co-payment for generic medications, $20 co-payment for Brand Medications. Prescriptions filled at the Student Health Center are also covered.	N/A	N/A
IN-PATIENT HOSPITAL SERVICES		
Inpatient Hospital Services: Daily charge for Semi-Private Room, general Nursing Services and Ancillary Services	80%	60%
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%	60%
Psychiatric and Counseling Services, Alcoholism & Chemical Dependency – Limited to 1 visit per day, 40 days per policy year.	80%	60%
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 $25 co-pay; Surgical Assistant Consultation; Obstetrical; Anesthesia.	80%	60%

Out-Patient Hospital Services and Emergency Room/Urgent Care (Emergency Room/Urgent Care Center subject to $100 co-pay).	80%	60%
Out-Patient Diagnostic Services: Radiology; Ultrasound; Nuclear Medicine; Laboratory; Pathology; ECG; EEF and other Electronic Diagnostic Medical Procedures.	80%	60%
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%	60%
Home Health Care: 100 visits per calendar year.	80%	60%
Maternity Care Services: Same as In-patient, Out-patient Hospital Services, and Surgical Medical Services. (Note: Abortion is not covered, except in circumstances that are life-threatening to a mother.)	80%	60%
Psychiatric and Counseling Services, Alcohol and Chemical Dependency: (Limited to 1 visit per day, 40 visits each Policy Year).	80%	60%
OTHER SERVICES		
Ambulance Service: Limited to $400 for air ambulance and $150 for ground ambulance per condition.	80%	60%
Skilled Nursing Facility Services: Same as Inpatient Hospital Services	80%	60%
Dental Services: Relating to injury to sound, natural teeth only.	80%	60%
Durable Medical Equipment, Prosthetic Appliances and Medical Supplies: Only when determined to be medically necessary.	80%	60%
Hospice Care: Payable to a lifetime maximum benefit of $4,000.	80%	60%
Well Child Care, including immunizations and age appropriate screening tests:	80%	60%
Preventative Mammography: One Baseline Mammogram for women ages 35-39. Annual exams for women 40 and over.	80%	60%
Wellness: One Annual Exam, Including Cost of Recommended Laboratory testing, not to exceed $500 per policy year.	80%	60%

*SHC = Student Health Center

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

The Plan will pay 80% of the Preferred Allowance for Network Providers and 60% of the usual and customary expenses incurred for Non-Network Providers up to $250,000 per condition, per policy year. When the insured incurs $1,250 in out-of-pocket expenses for Network Providers, or $2,500 in out-of-pocket expense for Non-Network Providers each policy year, additional covered medical expenses incurred during the policy year will be paid at 100%.

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; (o) inpatient facility medical expenses for psychiatric and counseling services, alcoholism and chemical dependency are limited to 40 days per policy year; (p) outpatient service for psychiatric and counseling services, alcoholism and chemical dependency are limited to 40 visits per policy year. The first eligible expense must be incurred within 90 days from the date of accident.

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***.

NEWBORN CHILDREN

In the event of the birth of a child to an insured person, the child will automatically be a covered dependent from the moment of birth. Coverage will continue for 31 days. 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.

MEDCO HEALTH - PRESCRIPTION DRUG CARD

Prescriptions purchased from the Medco Health Network of pharmacies will be covered. For a complete list of pharmacy providers, please visit www.UNLVInsurance.com. Prescriptions filled at the Student Health Center are also covered, the same as if a Medco Health Network pharmacy is used.

****NOTE: The prescription drug benefit is through the MEDCO Pharmacy Program. The MEDCO Pharmacy Network includes national chains such as CVS and Walgreens, as well as local pharmacies. When you need to have a prescription filled, present your insurance ID card at a participating pharmacy. You will pay a co-payment for your medications. The pharmacy will submit additional charges to the Insurance Company. The plan pays a maximum of $10,000.00 per policy year towards prescription medications.**

$10.00 co-pay generic medications, $20.00 co-pay brand medications. Co-payments are for a 30 day supply only.

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.

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

(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) For expenses for which a contributing cause was the 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) While the Insured Person is legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor.

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.
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.UNLVINSURANCE.com
Click on " On Call International"

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 $10,000, upon approval from the Company's Claim Office, (800) 468-4343.

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 $10,000. You must first seek approval from the Company's Claim Office, (800) 468-4343.

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 Doctor.

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.

STATE MANDATED BENEFITS (CONTINUED)

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 calender year or in any continuous period of 12 months. Covered Charges are subject to 80% in network/60% out of network 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.

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

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.

EXCESS PROVISION

No benefit 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.

EXCLUSIONS

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

1. Preventative medicines, serums, immunizations or vaccines, except as specifically provided;
2. Routine periodic physical examinations and routine chest x-rays, 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;

EXCLUSIONS (CONTINUED)

16. Expenses incurred for treatment of Temporomandibular joint dysfunction and association myofacial pain;
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;
21. For services or supplies rendered by a close relative of the Insured Person. 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;
27. Services or supplies primarily for educational, vocational or training purposes, except the initial visit to diagnose and determine if a medical condition is causing a learning disability;
28. 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 Lasik or other vision procedures except as required for repair caused by a covered Injury;
29. Well baby care, including routine exams and immunizations, except as specifically provided;
30. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
31. Expenses for any service or supply not specified in this Policy as a covered service;
32. An amount of a charge in excess of the Reasonable and Customary Expense;

EXCLUSIONS (CONTINUED)

33. Elective Treatment or elective surgery, except as specifically provided;
34. Services not Medically Necessary;
35. Treatment of mental or nervous disorders, except as specifically provided;
36. Treatment of alcohol and substance abuse except as specifically provided;
37. Expenses incurred for: 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;
38. Voluntary or elective abortion;
39. 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, except as noted, 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; Doctor prescribed Viagra will be limited to six (6) tablets per month;
40. 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;
41. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
42. Expenses incurred for replacement braces and appliances, except for repair or replacement that is required by a changed condition due to Sickness or Injury;
43. Services, supplies and facilities that are provided primarily for rest care, maintenance or custodial care;
44. Any treatment, service or supply in excess of the maximum benefit specified in this Policy;
45. Care, treatment or supplies furnished by a program or agency funded by any government;
46. 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;
47. Alternative health care, including but not limited to acupuncture, except as specifically provided, acupressure, biofeedback, reflexology, and rolfing type services;
48. Treatment of obesity, including any care which is primarily dieting or exercise for weight loss, except for surgical treatment of morbid obesity;
49. 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.
50. Expenses incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a doctor.

PRE-EXISTING CONDITIONS LIMITATION

"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 twelve (12) 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 accord 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 provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.

(d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the Insured Person held Creditable Coverage, and the medical advice, 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.

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;

PRE-EXISTING CONDITIONS LIMITATION (CONTINUED)

(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 University of Nevada Las Vegas 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. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Plan. Also, the total amount of benefits payable for Injury or Sickness under this Plan and the Prior Plan cannot exceed the Per Condition Aggregate Maximum.

DEFINITIONS

Claim Form. A submission of a claim form is not required. If additional information is needed to process your medical bills, you will be contacted by the Claim Office.

Coinsurance Claims 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.

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.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

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.

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 throughout 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.

Out-of-Pocket Maximum means the maximum dollar amount an Insured Person is responsible to pay during a Policy Term. After an Insured Person has reached the Out-of-pocket Maximum, the Plan will cover benefits at 100% for the remainder of the Policy Term. The Out-of-pocket Maximum is met by accumulated deductible, coinsurance and copayments. Penalties and amounts above the Reasonable and Customary Expense do not count toward the Out-of-Pocket Maximum. The Out-of-pocket Maximum is shown on page 5.

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.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.

DEFINITIONS (CONTINUED)

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) 468-4343 between the hours of 5:00 a.m. to 5:00 p.m. Pacific time.

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 Delos Insurance Company.

You, Your or Yours means the Insured Student.

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.

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.

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.

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 the University of Nevada Las Vegas, School of Dental Medicine.

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.UNLVINSURANCE.com.

ANNUAL PREMIUMS Dental/Vision/Pharmacy	**Credit Card or Internet Payment**	**Check by mail**
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

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.UNLVINSURANCE.com**. Click on "Print ID Card". You will need to provide your name, Student Identification Number, and your birthdate. 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 be mailed to you.

HOW CAN 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: office@AIPInternational.com. We appreciate hearing from you with your comments, questions and concerns.

TO OBTAIN A LIST OF BEECH STREET PREFERRED PROVIDERS

call (800) 432-1776

Or, use the website: **www.UNLVINSURANCE.com** and click on "Preferred Provider"

HOW DO I FILE MY CLAIM UNDER THE STUDENT INSURANCE PROGRAM?

1. Secure the necessary medical treatment. A listing of Preferred Providers is available at: **www.UNLVINSURANCE.com**
2. Obtain itemized bills from your Doctor or provider.
3. Complete a claim form. A claim form is available at: **www.UNLVINSURANCE.com**
   If your provider has already mailed the bills to the Insurance Company, you may complete the claim form and email it to the Insurance Company. If you have not yet mailed the medical bills to the Insurance Company, print a claim form, complete it, and mail the completed claim form along with your medical bills to the Insurance Company at:

   Personal Insurance Administrators, Inc.
   P.O. Box 6040
   Agoura Hills, CA 91376-6040
   800-468-4343
   www.PIACLAIMS.com

   Written notice of claim must be given within 30 days after the occurrence, or commencement of any loss covered by the Policy. Bills for which benefit is to be paid must be submitted within 90 days of the date of treatment.
4. Any additional medical bills submitted for reimbursement by the Insurance Company must show your name, student identification number, name of college or university, and description of medical condition.
   Only one claim form, per condition, needs to be completed.
5. You may check the status of a claim you have already filed at **www.UNLVINSURANCE.com** and click "Check Claims Online."

HOW DO I ENROLL?

1. **Unless you provide proof of existing insurance, prior to the date you must return your waiver form, you will be automatically enrolled in the Student Insurance Program.**

2. To purchase coverage for Dependents:
   a) You may enroll your Dependents via the Internet at **www.UNLVINSURANCE.com** or you may call us at (800) 452-5772 to enroll your dependents and pay by phone.

   or

   b) You may enroll your dependents by completing the attached application, along with your credit card number and expiration date, or you may include a check/money order made payable to:

STUDENT INSURANCE PLAN
Post Office Box 189
Libertyville, IL 60048
800-452-5772
www.UNLVINSURANCE.com

The Plan is Underwritten by:

Delos Insurance Company
Policy Number: DSP0004708

Plan Administrator:

Associated Insurance Plans International, Inc.
Post Office Box 189
Libertyville, IL 60048
(800) 452-5772
Fax (847) 281-8813

Please contact us between the hours of
5:00 a.m. to 5:00 p.m. Pacific Time.
Email us at: office@AIPInternational.com
Visit us on the web at:
www.UNLVINSURANCE.com

This brochure is a brief description of the Plan Benefits. The exact provisions governing the insurance are contained in the Master Policy issued to University of Nevada, Las Vegas, School of Dental Medicine.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

This is your Health Information Privacy Notice from DELOS INSURANCE COMPANY (referred to as We or Us). This notice is effective April 14, 2003. This notice provides you with information about the way in which We protect Personal Health Information ("PHI") that We have about you. PHI includes individually identifiable information which relates to your past, present or future health, treatment or payment for health care services. This notice also explains your rights with respect to PHI. The Health Insurance Portability and Accountability Act ("HIPAA") requires Us to: Keep PHI about you private; provide you this notice of our legal duties and privacy notices with respect to your PHI; and follow the terms of the notice that are currently in effect.

Use and Disclosure of PHI

We obtain PHI in the course of providing and/or administering health insurance benefits for you. In administering your benefits, We may use and/or disclose PHI about you and your dependents. The following are some examples, however, not every use or disclosure in a category will be listed:

- **For Health Care Payment Purposes:** For example, We may use and disclose PHI to administer and process payment of benefits under your insurance coverage, determine eligibility for coverage, claims or billing information, conduct utilization reviews, or to another entity or health care provider for its payment purposes.
- **For Health Care Operations Purposes:** For example, We may use and disclose PHI for underwriting and rating of the plan, audits of your claims, quality of care reviews, investigation of fraud, care coordination, investigate and respond to complaints or appeals, provider treatment review and provision of services.
- **For Treatment Purposes.** For example, We may use and disclose PHI to health care providers to assist in their treatment of you. We do not provide health care treatment to you directly.
- **For Health Services.** For example, We may use your medical information to contact you to give you information about treatment alternatives or other health related benefits and services that may be of interest to you as part of large case management or other insurance related services.
- **For Data Aggregation Purposes.** For example, We may combine PHI about many insureds to make plan benefit decisions, and the appropriate premium rate to charge.
- **To You About Dependents.** For example, We may use and disclose PHI about your dependents for any purpose identified herein. We may provide an explanation of benefits for you or any of your dependents to you.
- **To Business Associates.** For example, We may disclose PHI to administrators who are contracted with Us who may use the PHI to administer health insurance benefits on our behalf and such administrators may further disclose PHI to their contractors or vendors as necessary for the administration of health insurance benefits.

If your state has adopted a more stringent standard regarding any of the above uses or disclosures of your PHI, those standards will be applied.

Additional Uses or Disclosures. We may also disclose PHI about you for the following purposes:

• To comply with legal proceedings, such as a court or administrative order, subpoena or discovery requests.

• To law enforcement officials for limited law enforcement purposes.

• To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plan to do this.

• To your personal representatives appointed by you or designated by applicable law.

• For research purposes in limited circumstances.

• To a coroner, medical examiner, or funeral director about a deceased person.

• To an organ procurement organization in limited circumstances.

• To avert a serious threat to your health or safety or the health or safety of others.

• To a governmental agency authorized to oversee the health care system or government programs.

• To the Department of Health and Human Services for the investigation of compliance with HIPAA or to fulfill another lawful request.

• To federal officials for lawful intelligence, counterintelligence, national security purposes and to protect the president.

• To public health authorities for public health purposes.

• To appropriate military authorities, if you are a member of the armed forces.

• In accordance with a valid authorization signed by you.

Your Rights Regarding PHI That We Maintain About You

You have various rights as a consumer under HIPAA concerning your PHI. You may exercise any of these rights by writing to Us in care of Associated Insurance Plans International, Inc., 28085 Ashley Circle, Suite 201, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

• You have the right to inspect and copy your PHI. If you request a copy of the information, We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

• You have the right to ask Us to amend the PHI that is contained in a "designated record set", e.g., information used to make enrollment, eligibility, payment, claims adjudication and other decisions. You have the right to request an amendment for as long as we maintain the PHI. Requests must be made in writing and include the reason for the request. We may deny the request if the PHI is accurate and complete or if we did not create the PHI.

• You have the right to request a list of our disclosures of the PHI. Your request must state a time period, may not include dates before April 14, 2003 and may not exceed a period of six years prior to the date of your request. If you request more than one list in a year, We may charge you the cost of providing the list. We will notify you of the cost and you may withdraw or modify your request before any costs are incurred. Any list of disclosures provided by Us will not include disclosures made for payment, treatment or healthcare operations; made to you or persons involved in your care; incidental disclosures, authorized disclosures, for national security or intelligence purposes or to correctional institutions.

• You have the right to request to restrict the way We use or disclose PHI regarding treatment, payment or health care operations. You also have the right to request to restrict the PHI We disclose about you to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If We do agree, We

will comply with your request unless the information is needed to provide you emergency treatment. Your request must be in writing and state (1) what information you want to restrict; (2) whether you want to restrict our use, disclosure or both; and (3) to whom you want the restrictions to apply.

• Uses and disclosures of your PHI, other than those listed above, require prior written authorization from you. You may revoke that authorization at any time by writing to Us at the address at the end of this notice.

• You have the right to request that We communicate personal information to you in a certain way or at a certain location. Your request must specify how or where you wish to be contacted. We will comply with reasonable requests.

• You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. You may request a paper copy of this notice by calling Us at 800-452-5772 or submitting the request to DELOS INSURANCE COMPANY, c/o Associated Insurance Plans International, Inc., Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Us. When filing a complaint, include your name, address and telephone number and We will respond. All complaints must be submitted in writing to DELOS INSURANCE COMPANY, c/o Associated Insurance Plans International, Inc.,Post Office Box 189, Libertyville, IL 60048, Attn: HIPAA Privacy Office. You may also contact the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Changes To This Notice

We reserve the right to modify this Privacy Notice and our privacy policies at any time. If We make any modifications, the new terms and policies will apply to all PHI before and after the effective date of the modifications that We maintain. If We make material changes, We will send a new notice to insureds.

If you have any questions regarding this notice, please call 800-452-5772 or send your written questions to the address at the end of this notice. Please include your name, the name of your insurance plan, your policy/ID number or copy of ID card, your address and telephone number and We will respond.

ALL QUESTIONS AND REQUESTS REGARDING YOUR RIGHTS UNDER THIS NOTICE SHOULD BE SENT TO:
DELOS INSURANCE COMPANY
c/o Associated Insurance Plans International, Inc.
Post Office Box 189, Libertyville, IL 60048
Attn: HIPAA Privacy Office

UNLV

UNIVERSITY OF NEVADA LAS VEGAS

SCHOOL OF DENTAL MEDICINE

Policy Number: DSP0004708

www.UNLVINSURANCE.com

yes

I wish to enroll my Dependents in the University of Nevada Las Vegas School of Dental Medicine, Student Health Insurance Program. My check or money order payable to **DELOS INSURANCE COMPANY** for the coverage checked below is enclosed.

	Annual Cost	Monthly Cost
Additional/ Spouse	☐ $2,883	☐ $251
Add for Child	☐ $2,163	☐ $191
Add for More Than One Child	☐ $4,326	☐ $371

* Cost will be debited from your account on the 1st of the month, every month, through the Policy expiration date for dependents of Residents or DMD Students.

PLEASE NOTE: Monthly payment option is available on an automatic debit base only for the entire policy year. Refunds and cancellation are permitted ONLY upon entry into the Armed Forces. Please complete automatic debit authorization form.

You may enroll for coverage for your Dependents "On-line" and pay by electronic check or major credit card at www.UNLVInsurance.com

UNLV SCHOOL OF DENTAL MEDICINE • INSURANCE ENROLLMENT CARD FOR DEPENDENT COVERAGE 2008-2009 • DELOS INSURANCE COMPANY

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 ___/___/___ Date of Birth ___/___/___ Date of Birth ___/___/___

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

SESSION **• • • Please indicate which session you desire your coverage to begin: ☐ Residents ☐ DMD Students (Please see page 1 for coverage dates.)**

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 Student Insurance Plan. Mail this enrollment card along with premium payment to: Post Office Box 189, Libertyville, Illinois 60048

☐ ***Please charge my Student Health Insurance:*** ***Note: You must re-enroll in the insurance plan each term.***

☐ VISA ☐ DISCOVER ***Automatic debit method of payment is available. Use the attached authorization form & submit your payment.***

☐ MASTERCARD ☐ AMEX Card Number _____ Expiration Date _____ Security Code (3 Digit) _____

Print name of cardholder _____ Cardholder phone number _____

Cardholder signature _____ Todays Date _____

Please Charge $ _____ for Student Health Insurance. (Students must maintain minimum credit hours in order to be eligible)

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

UNLV SCHOOL OF DENTAL MEDICINE • STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2008-2009

I request and authorize Delos Insurance Company and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. **This Authorization will remain in force throughout the Policy Period for the 2008/2009 school year.** No cancellation will be permitted except upon entry into the Armed Forces.

DRAFT DATE:_____ **(Will be debited on the 1st of each month)** DRAFT AMOUNT: _____ Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

ADDRESS OF BANK

CITY STATE ZIP CODE

NAME OF INSURED, APPLICANT (PRINT) NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED RELATIONSHIP TO INSURED

DEPOSITOR SOCIAL SECURITY NUMBER DEPOSITOR DRIVERS LICENSE NUMBER DEPOSITOR STATE

SIGNATURE OF DEPOSITOR DATE

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT REQUIRES A COPY OF A VOIDED CHECK (PLEASE DO NOT SEND A DEPOSIT SLIP)

☐ ***Please automatically charge my Student Insurance premiums to my credit card for this entire policy year. (Premiums will be charged on the date due as specified in the brochure).***

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

Card Number_____ Expiration Date _____

Last 3 numbers on the reverse side of the credit card. Located within the signature box._____ ***(For Authorization Purpose)***

Print name of cardholder _____ Cardholder phone number _____

Amount authorized to debit _____ for Student Health Insurance. Cardholder signature _____ Today's Date_____