UNLV

UNIVERSITY OF NEVADA LAS VEGAS

STUDENT ACCIDENT AND SICKNESS INSURANCE PLAN FOR DOMESTIC AND INTERNATIONAL STUDENTS

2008 - 2009

Policy Number CUH201480

Direct all inquiries regarding enrollment to:

ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC.
28085 Ashley Circle, Suite 201
Post Office Box 189
Libertyville, Illinois 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.
OR
www.UNLVINSURANCE.com

PRE-CERTIFICATION IS NOT REQUIRED

The plan is insured by
Combined Insurance Company of America, Chicago, Illinois
and is administered by
Associated Insurance Plans International, Inc., Libertyville, Illinois
Policy benefits are not guaranteed
Limitations in this Policy should be carefully noted

Detach and retain.

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

_____
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 12:00 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: University of Nevada Las Vegas
CUH201480
Payor #: 22384

Office visits: $15.00 co-pay
Please keep card in your possession at all times. Pre-Certification is not required.

ATTENTION

The Preferred Provider Network is Beech Street Corporation. When choosing your network provider, confirm if the provider is a member when you make your appointment. You must obtain a referral for treatment from the Student Health Center in order to receive the 80% reimbursement.

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 Obtain ID Card and Verify Coverage. 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.

Student Insurance Identification Card 2008-2009

University Of Nevada Las Vegas

Policy Number: CUH201480

Beech Street
A VIANT NETWORK

Direct all claim inquiries and correspondence to:

Payor Number: 22384
Administrative Concepts, Inc.
994 Old Eagle School Rd., Suite 1005
Wayne, PA 19087-1802
800-452-5772
5:00 a.m. - 5:00 p.m. Pacific Time

HOW THE UNLV PLAN WORKS

Seek treatment from the Student Health Center (SHC) first! Use the resources of the SHC first where treatment will be administered and, if necessary, a referral will be made to a specialty provider. The following rules apply to services and supplies provided at the SHC:

- **Pre-existing conditions are waived. Referrals for treatment outside of the SHC will be subject to the Pre-existing limitation. See pages 16 and 17.**
- **No deductible or co-pays (except for pharmacy) apply at the SHC, benefits are payable at 80%.**
- **$20.00 co-payment per prescription (birth control included).**
- **$1,500 maximum benefit per Policy Year for pharmacy charges on Formulary.**
- **A referral from the Student Health Center to an *In-Network* provider will result in a larger reimbursement (see Schedule of Benefits). In-Network benefits without a referral from the Student Health Center will be reimbursed at 50% (see schedule of benefits).**

If you are a:

1. **Student**, and the SHC is closed, use UMC Quick Care facilities or other Beech Street Preferred Provider Network providers. Deductible and coinsurance apply to the charges.
2. **Dependent,** use any UMC Quick Care facility or other Beech Street Preferred Provider Network provider for treatment. Deductible and coinsurance apply to the charges.

It is important for students to have current registration and enrollment status EACH semester and have paid the SHC health fee for the semester (including Summer) in order to receive SHC services.

NON-RETURNING STUDENTS

Only one "follow up visit" is available at the Student Health Center. Because you are no longer a student, after this "follow up visit", you are ineligible to utilize the Student Health Center. Reimbursement for eligible expenses will be based on "Out of Network Provider" (see pages 8 and 9).

CLAIM PROCEDURES

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

1. If you are a student, seek treatment from the UNLV Student Health Center if the situation is non-life threatening.

2a. If the Student Health Center is closed, you may use a UMC Quick Care facility or other Beech Street Preferred Provider Network provider. (In the event of a life threatening emergency, you should go to the nearest emergency room.)

2b. If the Student Health Center is open and you prefer to go to a Beech Stret Provider, please visit the Student Health Center **first** to request a referral so that you receive the higher reimbursement for your Network Provider.

3. Obtain itemized bills from your physician or provider.
4. Please make certain all medical bills submitted show your name, student ID number, social security number (if applicable), school name, and description of medical condition.
5. Send your itemized medical bills (and the explanation of benefits paid by your primary insurance company if you have other health insurance) as soon as possible to:

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

Please call weekdays from 5:00 a.m. to 5:00 p.m. Pacific Time.

6. You may check the status of a claim you have already filed at **www.UNLVINSURANCE.com** and click "Check Claims Online".

POLICY TERM

The Annual Policy under UNLV's Student Health Insurance Plan is effective 12:00 a.m. Pacific Time on August 16, 2008. An eligible student's coverage becomes effective on that date or the date the application and annual premium are postmarked and received by the Company or the Plan Administrator, whichever is later. The Annual Policy terminates at 11:59 p.m. on the last date for which premium has been paid. Coverage is effective 24 hours a day on a worldwide basis.

PERIODS OF COVERAGE

If paying premiums other than Annual, coverage will be in effect as shown below. Please see premiums on page 21 of the brochure.

Full Policy Year Enrollment ends	August 16, 2008 through August 15, 2009 September 30, 2008
Fall Semester Enrollment ends	August 16, 2008 through January 11, 2009 September 30, 2008
Spring Semester Enrollment ends	January 12, 2009 through May 10, 2009 February 28, 2009
Spring & Summer Semesters Enrollment ends	January 12, 2009 through August 15, 2009 February 28, 2009
No New Enrollment Except International Students	
Summer I, II, III Enrollment Ends	May 11, 2009 through August 15, 2009 May 25, 2009
Summer II, III Enrollment Ends	June 1, 2009 through August 15, 2009 June 15, 2009
Summer III Enrollment Ends	July 6, 2009 through August 15, 2009 July 20, 2009
Quarterly Payment Option Enrollment Ends	**Initial payment due August 16, 2008, subsequent payments due the 16th of November 2008, February 2009 and May 2009.** September 30, 2008

You must meet the eligibility requirements listed in the eligibility section to continue insurance coverage. (To avoid a lapse in coverage, your insurance payment must be received within 14 days after the date your coverage terminates, based on the insurance payment method you selected.) It is your 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.

LATE ENROLLMENT

Eligible students and their dependents will not be allowed to enroll in the Policy after September 30, 2008 for Fall Semester, or February 28, 2009 for Spring Semester, unless proof is furnished that the eligible student or dependent became ineligible for coverage under another insurance Policy during the thirty (30) days immediately preceding the date of the request for late enrollment in the University's Policy. In such cases, the cost will be the same as it would have been at the beginning of that period, but the effective date will be the date the payment is received. The deadlines shown above are ABSOLUTE deadlines. The 14-day grace period does not apply here.

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.

ELIGIBILITY

UNLV Undergraduate students formally admitted to a UNLV program, 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.** Registered International Students (F-1 Visas) are required to purchase this plan regardless of the number of credit hours maintained.

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, quarterly or summer), shall not be covered under the Policy and a full refund of the cost of insurance will be made, but only if no claim has been 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.**

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.

ENROLLMENT PROCESS FOR DOMESTIC STUDENTS ONLY

Enrollment applications may be obtained from the Student Health Insurance Information Internet Site **www.UNLVINSURANCE.com** or from the Student Health Center.

1. You may enroll on-line at **www.UNLVINSURANCE.com** with an electronic-check or major credit card.
2. Application and insurance payment may be mailed directly to:

   STUDENT INSURANCE PLAN
   Post Office Box 189
   Libertyville, Illinois 60048
   (800) 452-5772 **www.UNLVINSURANCE.com**
3. You may call and enroll over the telephone using a Major Credit Card or Electronic Check (800) 452-5772.
4. You can email questions on our website at : **www.UNLVINSURANCE.com**

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

NOTE: Renewal notices will be mailed to the address provided. However, it is your responsibility to submit insurance payments prior to expiration date in order to avoid a lapse in coverage. You must re-enroll in the insurance plan.

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

ENROLLMENT PROCESS FOR INTERNATIONAL STUDENTS ONLY

All F-1 International students enrolled at UNLV are required to purchase the Student Health Insurance. Premiums are collected by the Cashier's office with tuition during registration. Coverage is also available to dependents of International students on a voluntary basis. **International students may not enroll on a quarterly basis.** See definition of Eligible Dependent on page 5.

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 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. 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.

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.

CONTINUATION OF COVERAGE

Continuation of coverage is offered to students and their dependents for up to 9 months should they become ineligible to continue the UNLV Student Health Insurance Program. The benefits and Provisions will be similar to the Student Health Insurance Program, but cost of insurance will be higher. Application must be made within 31 days of termination of the Student Health Insurance and the entire term requested must be paid in advance. No renewal of Continuation Benefits will be permitted. Please contact (800) 452-5772 for information.

COST OF INSURANCE REFUND POLICY

There is no provision for refunds upon 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 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., 28085 Ashley Circle, Suite 201, 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, **or without a Referral from the Student Health Center,** expenses will be payable at 50% of the covered Reasonable and Customary Expenses.

Assignment of a network doctor does not guarantee eligibility or the right to health benefits under this policy.

To use the services of a participating provider, you must present your Student Insurance Identification Card. To obtain your Identification Card please see page 5 of this brochure.

You should always ask the provider when making an appointment if they are a preferred provider with Beech Street.

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.**

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

After the Deductible is satisfied, the Plan will pay 80% of the Preferred Allowance for Network Providers (you must obtain a referral from the Student Health Center in order to receive the higher reimbursement) and 50% of the Reasonable and Customary Expenses incurred for Non-Network Providers incurred for the first $5,000 of such covered medical expenses, and then 100% of covered charges incurred for any additional covered medical expenses, up to the $100,000 per Condition Aggregate Lifetime Maximum. Benefits are subject to a $300.00 per Insured Person, per Policy Year deductible; $600.00 per Family, per Policy Year. **(Deductible is waived for covered medical treatment received at the Student Health Center.)**

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.

DEDUCTIBLE

The deductible per Insured Person is $300.00 per Policy Year. If you have dependent coverage, the deductible maximum will be $600.00 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. **(Deductible is waived for covered medical treatment received at the Student Health Center.)**

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.

SPECIFIC CO-PAYS

$100 co-pay for Emergency Room Treatment
$25 co-pay for Outpatient Therapy Services
$15 co-pay for Physician's Visits
$20 co-pay for Pharmacy per prescription

STOP LOSS

After the Deductible is satisfied, the Plan will pay 80% of the Preferred Allowance for Network Providers and 50% for Non-Network Providers of the Reasonable and Customary Expense incurred for the first $5,000 of such Covered Medical Expenses and then 100% of Covered Charges incurred for any of the Additional Covered Medical Expense, up to $100,000 Per Condition Aggregate Lifetime Maximum.

Important Note: You must obtain a referral from the Student Health Center in order to receive the higher reimbursement when you receive treatment from a Preferred Provider.

ACCIDENTAL DEATH AND DISMEMBERMENT EXPENSE BENEFIT

If 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"

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**.

With SHC Referral: After the Deductible is applied, Covered Medical Expenses are payable at 80% of PPO Allowance In-Network, not to exceed the Maximum Policy benefit of $100,000 per Injury or Sickness. Deductible applies unless otherwise specified.

Without SHC Referral: After the deductible is applied, Covered Medical Expenses are payable at 50% of Reasonable & Customary Charges (R&C) not to exceed the Maximum Policy Benefit of $100,000 per Injury or Sickness. Deductible applies unless otherwise specified.

COVERED MEDICAL EXPENSES	Network With Student Health Center Provider Referral	Out-of-Network or Without Student Health Center Referral
INPATIENT HOSPITAL SERVICES		
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%
OUTPATIENT HOSPITAL SERVICES		
Day Surgery and Medical Services: Surgery and medical services, Physician's Visits (limited to one visit per day) subject to a in network $15 co-pay, Surgical Assistant Consultation, Obstetrical, Anesthesia	80%	50%
Outpatient Hospital Services and Emergency Room Care	80%	50%
Outpatient Diagnostic Services: Radiology, Ultrasound, Nuclear Medicine, Laboratory, Pathology, ECG, EEF and other Electronic Diagnostic Medical Procedures.	80%	50%
Outpatient 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: Refer to Page 12	80%	50%
Outpatient Prescription Medication (including birth control) (For information on "approved drugs", contact the Claim Department at (866) 317-9040.)		
At SHC Pharmacy: $20 co-pay per prescription. The Company pays up to $1,500 maximum benefit per policy year, for pharmacy charges on Formulary (Student Health Center approved prescription list). The remaining charges after the co-pay are billed directly to the Insurance Company and are limited to $1500 per policy year	n/a	n/a
Outside SHC Pharmacy: 25% of charges to SHC "approved drug list" subject to pre-existing condition limitation, and/or the deductible	n/a	25%

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		
Inpatient: Same as In-patient Hospital Services. Not to exceed 40 days per policy year. In network co-pay applies.	80%	50%
Outpatient: $75 per visit, not to exceed a maximum of 40 visits per policy year. All visits limited to one per day.	80%	50%
Alcohol and Chemical Dependency		
Inpatient: Treatment for a patient admitted to a facility up to a maximum benefit of $9,000 per policy year.	80%	50%
Outpatient: Counseling: For a person, group, or family who is not admitted to a facility up to a maximum benefit of $2,500 per policy year.	80%	50%
Treatment for Withdrawal: From the physiological effects of alcohol or drugs up to a maximum benefit of $1,500 per policy year.	80%	50%
OTHER SERVICES		
Ambulance Service: Limited to $400 for air ambulance and $150 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 (Referral Required). Annual exams for women 40 and over.	80%	50%
Cytologic Screening	80%	50%

SPECIFIC CO-PAYS

$100 co-pay for Emergency Room Treatment • $25 co-pay for Outpatient Therapy Services
$15 co-pay for Physician's Visits • $20 co-pay for Pharmacy per prescription

STOP LOSS

After the Deductible is satisfied, the Plan will pay 80% of the Preferred Allowance for Network Providers and 50% for Non-Network Providers of the Reasonable and Customary Expense incurred for the first $5,000 of such Covered Medical Expenses and then 100% of Covered Charges incurred for any of the Additional Covered Medical Expense, up to $100,000 Per Condition Aggregate Lifetime Maximum.

Important Note: You must obtain a referral from the Student Health Center in order to receive the higher reimbursement when you receive treatment from a Preferred Provider. It is important for students to have paid the Student Health Center access fee EACH semester (including Summer) in order to receive the higher level of reimbursement. Questions should be directed to the Student Health Center at (702) 895-3370.

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. You must first seek approval from the Company's 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 $10,000. You must first seek approval from the Company's Claim Office, (800) 452-5772.

STATE MANDATED BENEFITS

This Plan also covers all mandated benefits as required by the state of Nevada.

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.

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 / 50% 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.

Charges for such services are not subject to the Deductible.

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.

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, 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 temporomandibular 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;

EXCLUSIONS (CONTINUED)

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 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;
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 lasix 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;
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. 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;

EXCLUSIONS (CONTINUED)

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, 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;
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.

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.

PRE-EXISTING CONDITIONS LIMITATION (CONTINUED)

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 the 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.

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 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 form used to submit medical expenses for services received from a Medical Provider or Facility. Claim forms are available online at **www.UNLVInsurance.com** or at the UNLV Student Health Center.

Coinsurance 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.

DEFINITIONS (CONTINUED)

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.

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.

Policy Year: August 16, 2008 through August 15, 2009.

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

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. Pacific time.

Referral means a form to be obtained from the Student Health Center. A referral is not necessary if you are using an In-Network Provider.

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.

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. Send your written requests to AIP International, Inc. Post Office Box 189, Libertyville, IL 60048 Attn: Claims Review Committee. You may also email us at office@aipinternational.com.

The Plan is Underwritten by:

COMBINED INSURANCE

Policy Number: CUH201480

Plan Administrator:

ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

Post Office Box 189
Libertyville, IL 60048
(800) 452-5772
Fax (847) 281-8813

(Weekdays from 5:00 a.m. to 5:00 p.m. Pacific Time) or
e-mail 24 hours office@AIPInternational.com
Visit us on the web at:
www.UNLVINSURANCE.com

For a list of Beech Street Preferred Providers call (800) 432-1776 or go to www.UNLVINSURANCE.com and click on "Preferred Provider"

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. This notice is available online at **www.UNLVINSURANCE.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 or call (800) 225-4500, select HIPAA.

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.

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	**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

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

	Annual 8-16-2008 to 8-15-2009	Fall Only 8-16-2008 to 1-11-2009	Spring Only 1-12-2009 to 5-10-2009	Spring & Summer 1-12-2009 to 8-15-2009	Quarterly 8-16-2008 to 11-15-2008 11-16-2008 to 2-15-2009 2-16-2009 to 5-15-2009 5-16-2009 to 8-15-2009
Student Only	☐ $1,491.00	☐ $ 636.00	☐ $ 482.00	☐ $ 855.00	☐ $ 373.00
Student/ Spouse	☐ $5,788.00	☐ $2,441.00	☐ $1,900.00	☐ $3,347.00	☐ $1,447.00
Student/ Child	☐ $2,142.00	☐ $ 910.00	☐ $ 696.00	☐ $1,232.00	☐ $ 536.00
Student/ Children	☐ $3,365.00	☐ $1,423.00	☐ $1,100.00	☐ $1,942.00	☐ $ 842.00
Student/ Family	☐ $9,335.00	☐ $3,744.00	☐ $3,257.00	☐ $5,591.00	☐ $2,334.00

NEW INTERNATIONAL STUDENTS ONLY

Summer Session I, II, III 5-11-2009 to 8-15-2009	*Summer Sessions II & III 6-1-2009 to 8-15-2009	*Summer Session III 7-6-2009 to 8-15-2009
☐ $ 373.00	☐ $ 250.00	☐ $108.00
☐ $1,447.00	☐ $ 937.00	☐ $387.00
☐ $ 536.00	☐ $ 354.00	☐ $150.00
☐ $ 842.00	☐ $ 550.00	☐ $230.00
☐ $2,334.00	☐ $1,505.00	☐ $618.00

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.UNLVINSURANCE.com

UNIVERSITY OF NEVADA LAS VEGAS • STUDENT INSURANCE ENROLLMENT CARD 2008-2009 • 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 ___/___/___ Date of Birth ___/___/___ Date of Birth ___/___/___

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

Please check all that apply: ☐ GRAD ☐ INTERNATIONAL ☐ LAW ☐ RESIDENCE HALL

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

QUARTERLY OPTION • • • Please indicate which quarter you desire your coverage to begin: ☐ Quarter I ☐ Quarter II ☐ Quarter III ☐ Quarter IV (This does not apply to international students.)

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 P.O. Box 189, Libertyville, Illinois 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 (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**

UNIVERSITY OF NEVADA LAS VEGAS • STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2008-2009

I request and authorize Combined Insurance Company of America 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 effect until September 1, 2009.**

DRAFT DATE:_____ **(Quarterly enrollments will be debited on the 16th of each month shown on pg 3)** 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 charge my credit card a one time payment of:*** _____

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

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)

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_____