

# UNLV

UNIVERSITY OF NEVADA LAS VEGAS

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

# 2007 - 2008

Policy Number CUH201291

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) 537-6958

OR

Student Insurance Information Internet Site:

[www.UNLVINSURANCE.com](http://www.UNLVINSURANCE.com)

Please contact between the hours of 7:00 a.m. to 3:00 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 Combined Insurance Company of America,  
Chicago, Illinois and is administered by  
Associated Insurance Plans International, Inc., Libertyville, Illinois

#### Student Insurance Identification Card 2007-2008

University Of Nevada Las Vegas

NOTE: In a life threatening emergency, please go to the nearest emergency room for treatment.

[www.UNLVINSURANCE.com](http://www.UNLVINSURANCE.com)

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](http://www.UNLVINSURANCE.com).

Policy Number: University of Nevada Las Vegas

CUH201291

Direct all claim Administrative Concepts, Inc. Payor: #22384

inquiries and 997 Old Eagle School Rd., Suite 215

correspondence to: Wayne, PA 19087-1706

9:00 a.m. - 5:00 p.m. Eastern Time

Phone: 866-317-9040

Office visits: \$15.00 co-pay

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

Beech Street  
A CONCENTRA COMPANY

medco®

Medco Prescription Services \$10/20

Grp# UNLVDEN

Pharmacy Locations/

Questions (800) 400-0136

Detach and retain.

# 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.

## 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

### **Important Note:**

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

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's Student Health Insurance Plan for the Annual Policy is effective 12:01 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 20 of the brochure.

		<b>*Deadline for Waiver Submission</b>	<b>Enrollment for Dependents Ends</b>
Residents	7-1-2007 to 7-1-2008	8-6-2007	8-15-2007
DMD Students	9-1-2007 to 9-1-2008	9-14-2007	10-15-2007

\*Waiver form may be completed online at [www.UNLVInsurance.com](http://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**

<b>Student Only</b> Residents or DMD Students	<b>Annual</b> \$2,016
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### **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](http://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, 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 Combined Insurance Company of America 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](http://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.

## UTILIZATION REVIEW

### CERTIFICATION OF IN-NETWORK HOSPITAL ADMISSIONS

**Pre-admission Certification** - Pre-Admission Certification must be obtained for every in-network Hospital admission. This Pre-Admission Certification provision does not apply to Maternity and Medical Emergency admissions. These admissions have separate certification requirements. All Plan provisions apply. *Pre-certification does not guarantee benefits.*

To obtain Pre-Admission Certification, the Insured Person must: provide Beech Street with the information necessary to make decisions regarding the Medical Necessity of the admission; and contact Beech Street no less than 48 hours prior to a Hospital admission. Refer to the following sections for descriptions of the certification provisions for Maternity Admissions and Medical Emergency admissions.

Notice may be given by calling Beech Street at 1-877-323-6127.

**Certification of Maternity Admissions** – Maternity patients are admitted to Hospitals expressly for giving birth, when the Insured Person is actually admitted to the Hospital. Notify Beech Street of admission no later than one (1) day following the admission date. Beech Street may be notified by the Hospital, admitting Doctor, the Insured Person, or family members of the Insured Person

**Certification of Medical Emergency Admissions** – If an Insured Person is admitted to a Hospital for a Medical Emergency admission, notice of admission must be provided to Beech Street no later than one (1) day following the date of admission. Such notice may be given by the Hospital, admitting Doctor, Insured Person, or family members of the Insured Person.

When Pre-Admission Certification is provided to Insured Persons, a certain number of inpatient Hospital days for the stays are assigned. If Beech Street is not informed of admissions within the required period of time, payment of benefits for admitting Doctors and Hospital charges is reduced by 20%. This is referred to as a “penalty”. This penalty will not be applied toward any Deductibles, Coinsurance, or the Out-of-Pocket Maximum.

### DEDUCTIBLE

The deductible is \$250 per Insured for Network Providers per Policy Year and \$500 per Insured per Policy Year for Non-Network Providers. If two or more covered members of a family are injured in the same Accident, only one deductible will be charged each Policy Year against their combined eligible expenses due to the Accident.

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

### ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT

After the deductible has been satisfied, 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 the aggregate lifetime Maximum Benefit of \$1,000,000. 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%.

## **ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFIT (CONTINUED)**

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](http://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.

**\*\*It will NOT be possible to fully utilize the benefits of the Prescription Drug Card until the list of insureds is received from UNLV School of Dental Medicine.** Until the list of insureds is received from UNLV School of Dental Medicine, you will need to use one of the following options to obtain your medication:

- 1) Obtain medication at the UNLV Student Health Center by showing your Student ID and paying the applicable co-pay.
- 2) You may purchase your medication at a Pharmacy of your choice and submit the receipts to the Medco Health Network for reimbursement.

Claim forms are available online at [www.UNLVInsurance.com](http://www.UNLVInsurance.com).

**SCHEDULE OF BENEFITS**

**\$1,000,000 AGGREGATE LIFETIME MAXIMUM BENEFIT**

**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 during the policy year will be paid at 100%.

	*SHC OR	OUT-OF NETWORK	ANY PROVIDER
<b>COVERED MEDICAL EXPENSES</b>			
<b>STUDENT HEALTH CENTER PHARMACY BENEFIT</b> (\$10 generic/\$20 brand co-pay applies per prescription, deductible waived to \$10,000 aggregate maximum benefit for all Medco and UNLV SHC pharmacy expenses)	N/A	N/A	N/A
<b>STUDENT HEALTH CENTER</b> – covered medical expenses for treatment received (deductible applies)	80%		N/A
<b>IN-PATIENT HOSPITAL SERVICES</b>			
<b>Inpatient Hospital Services:</b> Daily charge for semi-private room, general nursing services and ancillary services \$50 co-pay for emergency room treatment or Urgent Care Center, if not admitted	80%		60%
<b>Surgical/Medical Services:</b> Pre-admission Testing, Surgery and Medical Services, Physician's Visits (limited to one visit per day), Surgical Assistant Consultation, Obstetrical, Anesthesia	80%		60%
<b>Psychiatric and Counseling Services, Alcoholism &amp; Chemical Dependency</b> – Limited to 1 visit per day, 40 days per policy year	80%		60%
<b>OUT-PATIENT HOSPITAL SERVICES</b>			
<b>Day Surgery and Medical Services:</b> Surgery and medical services, Physician's Visits (limited to one visit per day) subject to an in-network \$15 co-pay, Surgical Assistant Consultation, Obstetrical, Anesthesia	80%		60%
<b>Out-Patient Hospital Services and Emergency Room Care</b> (Emergency Room/Urgent Care Center subject to \$50 co-pay)	80%		60%
<b>Out-Patient Diagnostic Services:</b> Radiology, Ultrasound, Nuclear Medicine, Laboratory, Pathology, ECG, EEF and other Electronic Diagnostic Medical Procedures.	80%		60%

\*SHC = Student Health Center



<b>Out-Patient Therapy Services:</b> 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%
<b>Home Health Care:</b> 100 visits per calendar year	80%	60%
<b>Maternity Care Services:</b> 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%	60%
<b>Psychiatric and Counseling Services, Alcohol and Chemical Dependency:</b> (Limited to 1 visit per day, 40 visits each Policy Year)	80%	60%
<b>Prescription Drug Card:</b> (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, the same as if a Medco Health Network pharmacy is used.		
<b>OTHER SERVICES</b>	N/A	N/A
<b>Ambulance Service:</b> Limited to \$400 for air ambulance and \$150 for ground ambulance per Condition	80%	60%
<b>Skilled Nursing Facility Services:</b> Same as Inpatient Hospital Services	80%	60%
<b>Dental Services:</b> Relating to injury to sound, natural teeth only	80%	60%
<b>Durable Medical Equipment, Prosthetic Appliances and Medical Supplies:</b> Only when determined to be medically necessary	80%	60%
<b>Hospice Care:</b> Payable to a lifetime maximum benefit of \$4,000	80%	60%
<b>Well Child Care,</b> including immunizations and age appropriate screening tests:	80%	60%
<b>Preventative Mammography:</b> One Baseline Mammogram for women ages 35-39. Annual exams for women 40 and over	80%	60%
<b>Wellness:</b> One Annual Exam, Including Cost of Recommended Laboratory Work, Up to \$500 per policy year	80%	60%

## **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:

<u>For Loss Of:</u>	<u>Amount</u>
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](http://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 Claim Office, (866) 317-9040.

## 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 Claim Office, (866) 317-9040.

## 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 calendar 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.

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"** 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, eye-glasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or Lasic or other vision procedures except as required for repair caused by a covered Injury;
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; submucous 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 facility that are provided mainly 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) Health insurance coverage;
- c) Part A or Part B of Title XVIII of the Social Security Act;
- d) Title XIX of the Social Security Act other than coverage consisting solely of benefits under Sec. 1928 of that Title;
- e) The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, Chapter 55 of title 10, U.S.C.;
- f) A medical care program of the Indian Health Service or of a tribal organization;
- g) A State health benefit risk pool;
- h) A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, under chapter 89 of title 5, U.S.C.;
- i) A public health plan as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Health Service Act, 42 U.S.C. Sec. 300gg(c)(1)(I);
- j) A health benefit plan under Sec. 5(e) of the Peace Corps Act, 22 U.S.C. Sec. 2504(e).



## 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

## DEFINITIONS (CONTINUED)

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 4.

**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.

**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, (866) 317-9040 between the hours of 9:00 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 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.

**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](http://www.UNLVINSURANCE.com).**

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

**The Plan is Underwritten by:**  
Combined Insurance Company of America  
Policy Number: CUH201291

**Plan Administrator:**

Associated Insurance Plans International, Inc.  
28085 Ashley Circle, Suite 201  
Post Office Box 189  
Libertyville, IL 60048  
(800) 452-5772  
Fax (847) 537-6958

Please contact us between the hours of  
7:00 a.m. to 3:00 p.m. Pacific Time.  
Email us at: [office@UNLVINSURANCE.com](mailto:office@UNLVINSURANCE.com)  
Visit us on the web at:  
[www.UNLVINSURANCE.com](http://www.UNLVINSURANCE.com)

**TO OBTAIN A LIST OF BEECH STREET  
PREFERRED PROVIDERS**

**call (800) 432-1776**

Or, use the website: [www.UNLVINSURANCE.com](http://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](http://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.

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.

**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](http://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 9:00 a.m. to 5:00 p.m. Central Time, or email us: [office@AIPInternational.com](mailto:office@AIPInternational.com). We appreciate hearing from you with your comments, questions and concerns.

## 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](http://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](http://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:

**Administrative Concepts, Inc.**  
**997 Old Eagle School Road, Suite 215**  
**Wayne, PA 19087-1706**  
**(866) 317-9040**

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](http://www.UNLVInsurance.com) and click "Claims 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](http://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  
28085 Ashley Circle, Suite 201  
Post Office Box 189  
Libertyville, IL 60048

# yes!

I wish to participate in the School of Dental Medicine, 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	*Monthly Auto Debit
Additional/ Spouse	<input type="checkbox"/> \$4,178	<input type="checkbox"/> \$359.00
Add for Child	<input type="checkbox"/> \$3,053	<input type="checkbox"/> \$265.00
Add for More Than One Child	<input type="checkbox"/> \$6,536	<input type="checkbox"/> \$555.00
Add for Family	<input type="checkbox"/> \$10,714	<input type="checkbox"/> \$903.00

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

**NOTE: Premiums shown are inclusive of all administrative fees.**

**You may enroll for coverage for your Dependents "On-line" and pay your premium by electronic check or major credit card at [www.UNLVInsurance.com](http://www.UNLVInsurance.com)**

**PLEASE NOTE: Monthly payment option is available on an automatic debit base only. Please complete automatic debit authorization form.**

PLEASE PRINT LEGIBLY

Student's name \_\_\_\_\_ (First) \_\_\_\_\_ (Last) \_\_\_\_\_ Male  Female  School ID No. \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Telephone No. \_\_\_\_\_ E-mail \_\_\_\_\_

Billing Address \_\_\_\_\_ (Street) \_\_\_\_\_ (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 \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ (Month) / \_\_\_\_\_ (Day) / \_\_\_\_\_ (Year) Date of Birth \_\_\_\_\_ (Month) / \_\_\_\_\_ (Day) / \_\_\_\_\_ (Year)

Social Security Number \_\_\_\_\_ 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: 28085 Ashley Circle, Suite 201, 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 \_\_\_\_\_ Today's 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](http://www.UNLVInsurance.com)

**SCHOOL OF DENTAL MEDICINE, UNLV • STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2007-2008**

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 force throughout the Policy Period for the 2007/2008 school year.**

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 \_\_\_\_\_