UNIVERSITY OF NEVADA, RENO
SCHOOL OF MEDICINE

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: wfis.wellsfargo.com/UNR or call 800-853-5899 to request a paper copy free of charge.

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

BR-NV(09) (524-3)
WHEN COVERAGE BEGINS

Insurance under the Master Policy will become effective at 12:01 a.m. on the later of:

- The Master Policy effective date;
- The beginning date of the term for which premium has been paid;
- The day the Enrollment Form (if applicable) and premium payment are received by the Company, Authorized Agent or University.

IMPORTANT NOTICE - Premiums will not be pro-rated if the Insured enrolls past the first date of coverage for which he or she is applying. Final decisions regarding coverage effective dates are made by UnitedHealthcare Insurance Company.

The below enrollments will be allowed a 30 day grace period from the term start date to enroll whereby the effective date will be backdated a maximum of 30 days. No policy shall ever start prior to the term start date:

1. All hard-waiver mandatory (insurance is required as a condition of enrollment on campus) insurance programs.
2. All re-enrollments into the same exact policy if re-enrollment occurs within 30 days of the prior policy termination date.

WHEN COVERAGE ENDS

Insurance of all Insured Persons terminates at 11:59 p.m on the earlier of:

- Date the Master Policy terminates for all Insured Persons; or
- End of the period of coverage for which premium has been paid; or
- Date the Insured Person ceases to be eligible for the insurance; or
- Date the Insured Person enters military service.

Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage. NO notification of plan expiration or renewal will be sent.

The Master Policy is a Non-Renewable One Year Term Policy.

<table>
<thead>
<tr>
<th>TERMS OF COVERAGE</th>
<th>FALL</th>
<th>SPRING/SUMMER</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1/14 - 1/31/15</td>
<td>8/31/14</td>
<td></td>
</tr>
<tr>
<td>2/1/15 - 7/31/15</td>
<td>1/31/15</td>
<td></td>
</tr>
</tbody>
</table>

Waiver & Enrollment Deadline

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$1,398.89</td>
</tr>
<tr>
<td>Dependent</td>
<td>$3,446.11</td>
</tr>
<tr>
<td>All Children</td>
<td>$2,431.67</td>
</tr>
</tbody>
</table>

Dependents must be enrolled for the same term of coverage as student.

Rates include premium payable to UnitedHealthcare, as well as administrative fees payable to Wells Fargo Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through FrontierMEDEX and its contracted underwriting companies.

ONLINE ACCESS TO ACCOUNT INFORMATION

UnitedHealthcare StudentResources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging into My Account at www.uhcsr.com/myaccount. Insured students who don’t already have an online account may simply select the “create My Account Now” link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare StudentResources’ environmental commitment to reducing waste, we’ve introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student’s personal health information.

My Account has been enhanced to include Message Center - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student’s email address. Please note, all ID cards, EOBs and correspondence will only be sent electronically. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.
HEALTH INSURANCE REQUIREMENT AND ELIGIBILITY

All registered University of Nevada, Reno medical students are required to have insurance and will automatically be enrolled in the plan and charged the health insurance fee unless they choose to submit an insurance waiver of comparable coverage. Eligible students will be charged a Health Insurance Fee for the Fall and Spring/Summer terms. Waiver of insurance must be submitted each semester online at wfs.wellsfargo.com/UNR. Waiver announcements will be sent to the SOM email address and it is the student’s responsibility to submit a waiver during the open waiver period.

Dependents
Eligible students who enroll may also insure their Dependents. Eligible Dependents are the legal spouse (or domestic partner), and their children under 26 years of age. A “Newborn” will automatically be covered for Injury or Sickness from birth until 31 days old, providing that the Insured Person, who is the parent, is covered under this plan. Coverage may be continued for that child when Wells Fargo Insurance is notified in writing within 31 days from the date of birth and by payment of any additional premium. Dependent eligibility expires concurrently with that of the Insured Student, and Dependents must re-enroll when coverage terminates to maintain coverage.

To enroll your dependents contact UNR’s student health insurance brokers, Wells Fargo Insurance at (800) 853-5899, M-F, 8:00am-5:00pm (PST).

Eligibility Requirement
You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 30 days after the coverage expiration date. It is the student’s responsibility to make timely premium payments to avoid a lapse in coverage.

Eligible students who involuntarily lose coverage under another group insurance plan are also eligible to purchase the University of Nevada, Reno Student Health Insurance Plan. These students must provide Wells Fargo Insurance with proof that they have lost insurance through another group (certificate and letter of ineligibility) within 30 days of the qualifying event. The effective date would be the later of: a) term effective date, or b) the day after prior coverage ends if enrollment request is received by Wells Fargo Insurance within 30 days from loss of prior coverage.

To be an Insured under the Master Policy, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer. All students must actively attend classes for the first 45 consecutive days following their effective date for the term purchased, and/or pursuant to their visa requirements for the period for which coverage is purchased, except in the case of medical withdrawal or during school authorized breaks.

If the Company discovers the Eligibility requirements have not been met, its only obligation is refund of premium.

PREFERRED PROVIDER NETWORK

“Preferred Providers” are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are: UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at (800) 767-0700 and/or by asking the provider when making an appointment for services.

“Preferred Allowance” means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

“Out of Network” providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured’s responsibility. Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Hospital Expenses
PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (800) 767-0700 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses
Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses
Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

UNITEDHEALTHCARE PHARMACY BENEFITS (UHCP)

Go to www.uhcrs.com/unr to download the 2014-2015 University of Nevada Reno certificate which contains additional information about the UHCP network pharmacy benefits and exclusions.
DEFINITIONS

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition which requires Hospital Confinement for medical treatment and: 1) if the pregnancy is not terminated, is caused by an Injury or Sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or 2) if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the Master Policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the Master Policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

CUSTODIAL CARE means services that are any of the following:
1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the legal spouse or Domestic Partner of the Named Insured and their dependent children. Children shall cease to be dependent at the end of the month in which they attain the age of 26 years.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:
1) Incapable of self-sustaining employment by reason of mental retardation or physical handicap;
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company:
1) by the Named Insured; and, 2) within 31 days of the child’s attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child’s attainment of the limiting age.

If a claim is denied under the Master Policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be handicapped as defined by subsections (1) and (2). DOMESTIC PARTNER means a person who is neither married nor related by blood or marriage to the Named Insured but who is: 1) the Named Insured’s sole spousal equivalent; 2) lives together with the Named Insured in the same residence and intends to do so indefinitely; and 3) is responsible with the Named Insured for each other’s welfare. A domestic partner relationship may be demonstrated by any three of the following types of documentation: 1) a joint mortgage or lease; 2) designation of the domestic partner as beneficiary for life insurance; 3) designation of the domestic partner as primary beneficiary in the Named Insured’s will; 4) domestic partnership agreement; 5) powers of attorney for property and/or health care; and 6) joint ownership of either a motor vehicle, checking account or credit account.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:
1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

HABILITATIVE SERVICES means outpatient occupational therapy, physical therapy and speech therapy prescribed by the Insured Person’s treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.

HOSPITAL means a licensed or properly accredited general hospital which:
1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental Illness and Substance Use Disorder.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital reason of an Injury or Sickness for which benefits are payable.

Continued on next page
DEFINITIONS

**INJURY** means bodily injury which is all of the following: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Insured Person is covered under this policy. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy’s Effective Date will be considered a Sickness under this policy.

**INPATIENT** means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this policy.

**INPATIENT REHABILITATION FACILITY** means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

**INSURED PERSON** means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term “Insured” also means Insured Person.

**INTENSIVE CARE** means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and, 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and, 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care;
2) Sub-acute intensive care;
3) Intermediate care units;
4) Private monitored rooms;
5) Observation units; or
6) Other facilities which do not meet the standards for intensive care.

**MEDICAL EMERGENCY** means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1) Death;
2) Placement of the Insured’s health in jeopardy;
3) Serious impairment of bodily functions;
4) Serious dysfunction of any body organ or part; or
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for “Medical Emergency” will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

**MEDICAL NECESSITY** means those services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1) Essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
2) Provided for the diagnosis, or the direct care and treatment of the Sickness or Injury;
3) In accordance with the standards of good medical practice;
4) Not primarily for the convenience of the Insured, or the Insured’s Physician; and,
5) The most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being confined as an Inpatient means that both: 1) the Insured requires acute care as a bed patient; and, 2) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

**MENTAL ILLNESS** means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the Master Policy, all mental health or psychiatric diagnoses are considered one Sickness.

**NAMED INSURED** means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and, 2) the appropriate premium for coverage has been paid.

**NEWBORN INFANT AND ADOPTED CHILD** means: 1) a newly born child of the Insured from the moment of birth provided that the Insured is insured under this policy; 2) an adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption, provided the person adopting the child is insured under this policy; 3) a child placed with the Insured for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement provided the person adopting the child is insured under this policy on the date the child is placed with the Insured. Such child will be covered under the Master Policy for the first 31 days after: 1) birth of the newly born child; 2) the effective date of adoption of the child; or 3) the date of placement of the child for adoption. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child’s parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the

Continued on next page
DEFINITIONS (CONTINUED)

date of birth, adoption, or placement for adoption: 1) apply to us; and 2) pay the required additional premium for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child’s birth, adoption, or placement for adoption.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person’s immediate family.

The term “member of the immediate family” means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services).

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

PRESCRIPTION DRUGS means: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person’s immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy’s Effective Date will be considered a sickness under this policy.

SKILLED NURSING FACILITY means a hospital or nursing facility that is licensed and operated as required by law.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person’s health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

USUAL AND CUSTOMARY CHARGES means a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality of the Policyholder. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.
This is just a brief description of your benefits. For information regarding the full Master Policy (which includes plan benefits, exclusions and limitations, and information about refund requests, how to file a claim, mandated benefits and other important information) please call UnitedHealthcare at 800-767-0700 or email claims@uhcsr.com. You will be able to obtain a copy of the full Master Policy as soon as it is available.

### SUMMARY OF SCHEDULE OF MEDICAL EXPENSE BENEFITS

<table>
<thead>
<tr>
<th>Benefit Maximum</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible* (per Policy Year)</td>
<td>Unlimited</td>
<td>$250 per Insured/$500 per family</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (per Policy Year)</td>
<td>After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.</td>
<td>$1,800 per Insured/$3,600 per family</td>
</tr>
</tbody>
</table>

*Deductible is waived when treatment is rendered at the UNR Student Health Center (Reno)

Please review this Summary of Benefits section for any benefit maximums or limits that may apply. Please refer to the Exclusions and Limitations listed on p. 12 and 13 of this Brochure for more detailed information on covered benefits. The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be reviewed at the Student Health Center during business hours. If you or your physician have any questions regarding benefits, please contact UnitedHealthcare Insurance Company at (800) 767-0700. If care is received from a Preferred Provider, any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If Covered Medical Expenses are incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out of Network Provider is used. Unless indicated otherwise, Out-of-Network Providers will be reimbursed at 60% of Usual & Customary Charges.

Services provided by the University of Nevada, Reno Student Health Center that are otherwise not covered by the University of Nevada, Reno Health Fee, are paid at 100% of billed charges by the Student Health Insurance Plan. Policy exclusions and limitations apply to those expenses unless otherwise listed in the Schedule of Benefits. Deductible does not apply to these expenses. For medical students in Las Vegas, the policy Deductible will be waived for services rendered at UNLV Student Health Center.

Benefits are provided at the University of Nevada, Reno Health Center, UNLV Student Health Center in Las Vegas or any Preferred Provider for the following Immunizations and Titters required of Medical Students: T-DAP, MMR (Mumps, Rubella, and Rubeola), Varicella, Hepatitis A, Hepatitis B, and Twinrix. The following tests will be covered at the University of Nevada, Reno Health Center or the UNLV Student Health Center only: 2 Step PPD, Yearly PPD, and Quantiferon TB Gold.

Fluid exposures (needle sticks, face splashes, etc.) experienced by students while engaging in school related activities in a clinical setting shall be covered at 100%. Deductible does not apply to Fluid Exposures. The exclusion for obesity will be waived and hernia resulting from obesity will be covered the same as any other Sickness. Benefits will be paid up to the Maximum Benefits for each service scheduled below. After your Deductible has been met, Covered Medical Expenses are payable as follows:

### INPATIENT HOSPITAL EXPENSES

<table>
<thead>
<tr>
<th>Description</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board/Hospital Miscellaneous, daily semi-private room rate when confined as an Inpatient general nursing care provided by Hospital. Hospital Miscellaneous Expenses such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Intensive Care Room and Board Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care, while Hospital Confined; and routine nursery care provided immediately after birth for an Inpatient stay for at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending Physician may discharge the newborn earlier.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Non-surgical Physician Expense, benefits do not apply when related to surgery.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Registered Nurse Expense, private duty nursing care.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Pre-Admission Testing, must occur within 7 days prior to admission.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
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**SURGICAL EXPENSES (INPATIENT AND OUTPATIENT)**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense, If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>

**OUTPATIENT EXPENSES**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Office Visit Expense, benefits do not apply when related to surgery or physiotherapy.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Emergency Room Visit Expense for a Medical Emergency, use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of injury or first onset of sickness.</td>
<td>80% of Preferred Allowance</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Chemotherapy &amp; Radiation Therapy Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous, facility charge for related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines and supplies. Usual and Customary Charges for Day Surgery Misc. are based on the Outpatient Surgical Charge Index.</td>
<td>80% of Preferred Allowance</td>
<td>60% Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Urgent Care Expense, benefits are limited to the urgent care clinic fee billed by the clinic/hospital. All other services rendered during the visit are payable as specified in the schedule.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Tests and Procedures, diagnostic services and medical procedures performed by a Physician other than Physician’s Visits, Physiotherapy, X-rays and Laboratory Procedures. The following therapies will be paid under this benefit: inhalation therapy; infusion therapy, pulmonary therapy and respiratory therapy.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Laboratory Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH AND SUBSTANCE USE EXPENSE**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Illness Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered unless treatment is rendered from a United Behavioral Health provider.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis. Institutions specializing in or primarily treating Mental Illness and Substance Use Disorders are not covered unless treatment is rendered from a United Behavioral Health provider.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>

**ADDITIONAL EXPENSES**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Health Care Expense, includes one baseline mammogram for women 35-40. Women 40 and older have coverage for a Mammogram annually. Covered medical expenses include an annual Pap Smear screening for women 18 and older. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. For a full description of Preventative Services please see page 10.</td>
<td>100% of Preferred Allowance Deductible waived</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Well Child/Baby Care Expense, includes routine preventative and primary care services which are services rendered to a covered Dependent child of an Insured Person; from the date of birth through the attainment of two (2) years of age. Services include: initial hospital check-ups; other hospital visits; physical examinations; including routine hearing and vision examinations; medical history; developmental assessments; and materials for the administration of appropriate and necessary immunizations and laboratory tests; when given in accordance with the prevailing clinical standards of the American Academy of Pediatrics. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. For a full description of Preventative Services please see page 10.</td>
<td>100% of Preferred Allowance Deductible waived</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>

Continued on next page
<table>
<thead>
<tr>
<th>ADDITIONAL EXPENSES (CONTINUED)</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Services, No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. For a full description of Preventive Services please see page 10.</td>
<td>100% of Preferred Allowance Deductible waived</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Non-Prescription Enteral Formula Expense, when ordered or prescribed by a Physician for the medically necessary treatment of inherited metabolic diseases.</td>
<td>80% of Preferred Allowance</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Acupuncture Expense, benefit combined with Physical Therapy Maximums.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy (Outpatient), Review of Medical Necessity will be performed after 12 visits per Injury or Sickness. 60 visits of any combination of physical therapy, occupational therapy, speech therapy and cardiac rehabilitation therapy.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Allergy Testing Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Diabetes Services, In connection with the treatment of diabetes for Medically Necessary: 1) outpatient self-management training, education and medical nutrition therapy service when ordered by a Physician and provided by appropriately licensed or registered healthcare professionals; and 2) Prescription Drugs, equipment, and supplies including insulin pumps and supplies, blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Maternity, benefits will be paid for an Inpatient stay of at least 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If the mother agrees, the attending physician may discharge the mother earlier.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Diagnostic Testing For Learning Disabilities Expense</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Routine Screening For Sexually Transmitted Disease Expense, except as provided in the Preventative Care Services benefit. Benefits payable for routine screening, except as specifically provided in the Preventive Care Services benefit.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion Expense, benefits limited to $150 per occurrence.</td>
<td>80% of Preferred Allowance</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Hospice Expense, services received from a licensed hospice agency and when recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Home Health Care Expense, services received from a licensed home health agency that are ordered by a Physician, provided or supervised by a Registered Nurse in the Insured Person's home, and pursuant to a home health plan as mandated by the State of Nevada.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment Expense, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. Durable Medical Equipment includes external prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Ambulance Expenses</td>
<td>80% of Preferred Allowance</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Dental Expenses, made necessary by injury to sound, natural teeth.</td>
<td>80% of Usual &amp; Customary Charges</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Transplantation Services</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Consultant Physician Fees, when requested and approved by the attending Physician.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Skilled Nursing Facility, 100 days maximum Per Policy Year.</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Continued on next page
**PRESCRIPTION DRUG EXPENSES**

UnitedHealthcare Pharmacy (UHCP) Mail Order Prescription Drug Expense: UnitedHealthcare Pharmacy (UHCP) Mail Order is a pharmacy that works through the mail. It can send you up to a 90-day supply at a 75-day supply copay. You have access to this pharmacy as part of your UnitedHealthcare StudentResources pharmacy benefits plan. Learn more online. Visit [www.uhcsr.com/unr](http://www.uhcsr.com/unr) and log in to your online account or call 1-855-828-7716. Contraceptives (that do not have a generic alternate) covered at 100%. UnitedHealthcare Pharmacy (UHCP) $20 Copay per prescription for Tier 1 $40 Copay per prescription for Tier 2/up to a 90 day supply per prescription

**Prescription Drug Expense:** Includes diabetic testing supplies, prescription contraceptives, prenatal vitamins. Medications not covered by this benefit include, but are not limited to: allergy sera, drugs whose sole purpose is to promote or stimulate hair growth, appetite suppression, smoking deterrents, and non-self-injectibles. Tier 1 contraceptives are covered at 100%

**Please Note:** You are required to pay in full at the time of service for all Prescriptions dispensed at an Out of Network Pharmacy and are not eligible for reimbursement. You may be eligible to obtain up to a 90 day supply of covered Prescription Drugs from Campus Pharmacy. For more information, please call (775) 784-6799.

<table>
<thead>
<tr>
<th>Inpatient Rehabilitation Facility</th>
<th>80% of Preferred Allowance</th>
<th>60% of Usual &amp; Customary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services</td>
<td>Paid as any other sickness</td>
<td>Paid as any other sickness</td>
</tr>
<tr>
<td>Hospital Outpatient Facility or Clinic</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary</td>
</tr>
<tr>
<td>Medical Supplies, Benefits are limited to a 31-day supply per purchase.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>Paid as any other sickness</td>
<td>Paid as any other sickness</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary</td>
</tr>
<tr>
<td>Ostomy Supplies</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary</td>
</tr>
</tbody>
</table>
PREVENTATIVE CARE SERVICES

Medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventative Services Task Force; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3) with respect to infants, children, and adolescents, evidence-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4) with respect to women, such additional preventative care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider.

MATERNITY TESTING

This policy does not cover all routine, preventative, or screening examinations or testing. The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:
- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) (first trimester only)
- Free beta human chorionic gonadotrophin (hCG) (first trimester only)
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis
- Once every trimester: Hematocrit and Hemoglobin
- Once during first trimester: Ultrasound
- Once during second trimester
  - Ultrasound (anatomy scan)
  - Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a
- Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)
- Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)
- Once during third trimester: Group B Strep Culture

For additional information regarding Maternity Testing, please call the Company at 1-800-767-0700.

PRE-ADMISSION NOTIFICATION

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone (877) 295-0720 at least five working days prior to the planned admission.

2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient’s representative, Physician or Hospital should telephone (877) 295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department’s voice mail after hours by calling (877) 295-0720.

**IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the Master Policy; however, pre-notification is not a guarantee that benefits will be paid.
GENERAL PROVISIONS

SUBROGATION: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for benefits made by the Company to or for benefit of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company.

RIGHT OF RECOVERY: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms, or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

COORDINATION OF BENEFITS

Benefits will be coordinated with any other eligible medical, surgical or hospital plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for Covered Medical Expenses.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under this policy ceases on the Termination Date. However, if an Insured is Hospital Confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date. The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this “Extension of Benefits” provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made. Benefits are provided for Home Health Care as mandated by the state of Nevada. A detail of the benefits may be found in the master policy on file with the University.

OPTIONAL DENTAL AND VISION PLANS

Fully insured dental and vision coverage is also available for eligible students and their dependents. To learn more about the benefits offered, or to enroll online, go to www.uhcsr.com/unr. Participation in the University of Nevada Reno Student Health Insurance Plan is NOT required to enroll in the dental or vision coverage.

PREMIUM REFUND/CANCELLATION

A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.

1. All hard-waiver and mandatory (insurance is required as a condition of enrollment on campus) enrollments will NOT receive a refund of your insurance premium after the Drop Deadline of the term has passed. For dependent enrollments made directly with Wells Fargo Insurance that are paid using a credit card or check: if you withdraw from school within the first 31 days of the coverage period, you will receive a full refund of the insurance premium provided that your dependent did not file a medical claim during this period. Written proof of withdrawal from the school must be provided. If you withdraw after 31 days of the coverage period, your dependents coverage will remain in effect until the end of the term for which you have paid the premium. Refund requests for these enrollments should be directed to Wells Fargo Insurance at (800) 853-5899 or via email at studentinsuranc@wellsfargo.com.

2. If you or your insured dependents enter the armed forces of any country you and your insured dependents will not be covered under the Master Policy as of the date of such entry. If you or your dependents enter the armed forces the policy will be cancelled as of the date of such entry. If your dependent enters the armed forces, a pro-rata refund of premium will be made for such person, upon written request received by Wells Fargo Insurance Services within 31 days of entry into service.

3. Refunds will be granted for insured dependents in case of a qualifying event such as legal separation, divorce or death within 31 days of the occurred event, provided that your insured dependents did not file a medical claim during the insured period. Written proof of such qualifying event must be submitted. Refunds will not be prorated.

INSURANCE PAYMENTS WITH PERSONAL CHECK

For direct enrollments of dependents with Wells Fargo Insurance: If you make your or your dependents’ insurance payment via personal check payable to Wells Fargo Insurance and we are unable to process the check (due to insufficient funds, closure of account, etc.), your dependents insurance coverage will be terminated retroactive to the effective date of the enrolled term.
No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:


2. Biofeedback.

3. Cosmetic procedures, except reconstructive procedures to:
   - Correct an Injury or treat a Sickness for which benefits are otherwise payable under this policy. The primary result of the procedure is not a changed, improved or physical appearance.
   - Correct a congenital malformation which causes a functional impairment.
   - Treat or correct Congenital Conditions of a Newborn or adopted Infant.

4. Custodial Care.
   - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
   - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.

5. Dental treatment, except:
   - For accidental Injury to Sound, Natural Teeth.
   - As specifically provided in the Schedule of Benefits.
   - As described under Dental Treatment in the policy. This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.

6. Elective Surgery or Elective Treatment.

7. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.

8. Foot care for the following: Flat foot conditions; Supportive devices for the foot; Fallen arches; Weak feet; Chronic foot strain; Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

   This exclusion does not apply to preventive foot care for Insured Persons with diabetes.

9. Genetic testing, except as specifically provided in the policy.

10. Health spa or similar facilities. Strengthening programs.

11. Hearing examinations. Hearing aids, except as specifically provided for in the policy. Other treatment for hearing defects and hearing loss. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

   This exclusion does not apply to:
   - Hearing defects or hearing loss as a result of an infection or Injury.
   - A bone anchored hearing aid for an Insured Person with: a) craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or b) hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
   - Benefits specifically provided in the policy.


13. Hypnosis.

14. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.

15. Injury or Sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation.

16. Injury or Sickness outside the United States and its possessions, except for a Medical Emergency when traveling for academic study abroad programs, business, or pleasure.

17. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.

18. Injury sustained while:
   - Participating in any intramural, club, intercollegiate, or professional sport, contest or competition.
   - Traveling to or from such sport, contest or competition as a participant.
   - Participating in any practice or conditioning program for such sport, contest or competition.

19. Investigational services.

20. Lipectomy.

21. Participation in a riot or civil disorder. Commission of or attempt to commit a felony.

22. Prescription Drugs, services or supplies as follows:
   - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
   - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
   - Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs.
   - Products used for cosmetic purposes.
   - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
   - Anorectics - drugs used for the purpose of weight control.
   - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
   - Growth hormones.
   - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

23. Reproductive/Infertility services including but not limited to the following:
   - Procreative counseling.
   - Genetic counseling and genetic testing, except as specifically provided in the policy.
   - Cryopreservation of reproductive materials. Storage of reproductive materials.
   - Fertility tests, except as specifically provided in the policy.
   - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the policy.
   - Premarital examinations.
   - Impotence, organic or otherwise.
   - Reversal of sterilization procedures.
   - Sexual reassignment surgery.

24. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy.


Continued on next page
EXCLUSIONS AND LIMITATIONS (CONTINUED)

This exclusion does not apply as follows:
- When due to a covered Injury or disease process.
- To benefits specifically provided in Pediatric Vision Services.
- To benefits specifically provided in the policy.
- To one pair of eyeglasses or set of contact lenses following cataract surgery.
26. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the policy.
27. Preventive care services, except as specifically provided in the policy, including:
   - Routine physical examinations and routine testing.
   - Preventive testing or treatment.
   - Screening exams or testing in the absence of Injury or Sickness.
28. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
29. Naturopathic services.
30. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional.
31. Supplies, except as specifically provided in the policy.
32. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the policy.
33. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.
34. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).

CLAIM PROCEDURE

In the event of Injury or Sickness, students should:
1. Report the Student Health Service for treatment or referral, or when not in school, to their Physician or Hospital.
2. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, social security number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn’t provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700
claims@uhcsr.com
NOTICE OF APPEAL RIGHTS

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company’s denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person’s Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company’s Adverse Determination.

The written Internal Appeal request should include:
1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person’s Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider’s name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at (800) 767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to:

UnitedHealthcare StudentResources
PO Box 809025 • Dallas, TX 75380-9025

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

An Urgent Care Request means a request for services or treatment where the time period for completing a standard Internal Appeal:
1. Could seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
2. Would, in the opinion of a Physician with knowledge of the Insured Person’s medical condition, subject the Insured Person to severe pain that cannot be adequately managed without the requested health care service or treatment.

To request an Expedited Internal Appeal, please contact Claims Appeals at (888) 315-0447. The written request for an Expedited Internal Appeal should be sent to:

Claims Appeals, UnitedHealthcare StudentResources
PO Box 809025 • Dallas, TX 75380-9025

Right to External Independent Review

After exhausting the Company’s Internal Appeal process, the Insured Person, or the Insured Person’s Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:
1. Is a Covered Medical Expense under the Master Policy; and
2. Is not covered because it does not meet the Company’s requirements for Medical Necessity, appropriateness, health care setting, level or care, or effectiveness.

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company’s Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:
1. The Insured Person or the Insured Person’s Authorized Representative has received an Adverse Determination, and a. The Insured Person, or the Insured Person’s Authorized Representative, has submitted a request for an Expedited Internal Appeal; and b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or
2. The Insured Person or the Insured Person’s Authorized Representative has received a Final Adverse Determination, and a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

Standard Experimental or Investigational External Review

An Insured Person, or an Insured Person’s Authorized Representative, may submit a request for an Experimental or Investigational External Review when the denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational.

A request for a Standard Experimental or Investigational External Review must be submitted in writing within 4 months of receiving a notice of the Company’s Adverse Determination or Final Adverse Determination.

Expedited Experimental or Investigational External Review

An Insured Person, or an Insured Person’s Authorized Representative, may submit an oral request for an Expedited Experimental or Investigational External Review when:
1. The Insured Person or the Insured Person’s Authorized Representative has received an Adverse Determination, and a. The Insured Person, or the Insured Person’s Authorized Representative, has submitted a request for an Expedited Internal Appeal; and b. Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly; or
2. The Insured Person or the Insured Person’s Authorized Representative has received a Final Adverse Determination, and a. The Insured Person has a medical condition for which the time frame for completing an External Independent Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person’s ability to regain maximum function; or b. The Final Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the Insured Person’s treating Physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not initiated promptly.

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Where to Send External Review Requests
All types of External Review requests shall be submitted to the Office of Consumer Health at the following address:

Office of the Governor
Consumer Health Assistance
555 East Washington Avenue #4800
Las Vegas, NV 89101
(702) 486-3587
(888) 333-1597
http://dhhs.nv.gov
cha@govcha.nv.gov

Questions Regarding Appeal Rights
Contact Customer Service at (800) 767-0700 with questions regarding the Insured Person’s rights to an Internal Appeal and External Review. Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state

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Consumer Health Assistance
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PRESCRIPTION DRUG CLAIM PROCEDURE
When obtaining a covered prescription, please present your ID card to a UnitedHealthcare Pharmacy, along with your applicable Copay. When you need to fill a prescription at a network pharmacy, and do not have your ID card with you, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, please visit www.uhcsr.com/unr and log in to your online account or call (855) 828-7716.

Prescriptions from an Out-of-Network pharmacy must be paid for in full at the time of service and are not eligible for reimbursement.

COLLEGIATE ASSISTANCE PROGRAM
Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

PRIVACY POLICY
We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at (800) 767-0700 or visiting us at www.uhcsr.com/unr.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
Loss of Life, Limb or Sight
If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of:
Life .................................................................................................................. $10,000
Two or More Members .............................................................................. $10,000
One Member ........................................................................................ $5,000
Thumb or Index Finger ............................................................................ $2,500

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.
If you are a student insured with this insurance plan, you and your insured spouse/Domestic Partner and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

FrontierMEDEX includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:
- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Medication, Vaccine and Blood Transfers
- Transfer of Medical Records
- Dispatch of Doctors/Specialists
- Worldwide Medical and Dental Referrals
- Facilitation of Hospital Admission Payments
- Emergency Medical Evacuation
- Transportation After Stabilization
- Transportation to Join a Hospitalized Participant
- Emergency Travel Arrangements
- Continuous Updates to Family and Home Physician
- Replacement of Corrective Lenses and Medical Devices
- Replacement of Lost or Stolen Travel Documents
- Hotel Arrangements for Convalescence
- Return of Dependent Children
- Repatriation of Mortal Remains
- Legal Referrals
- Transfer of Funds
- Message Transmittals
- Translation Services

Please visit [www.uhcsr.com/frontiermedex](http://www.uhcsr.com/frontiermedex) for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:
- (800) 527-0218 Toll-free within the United States
- (410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX Operations Center, please be prepared to provide:
1. Caller’s name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient’s name, age, sex, and FrontierMEDEX ID Number as listed on your Medical ID Card;
3. Description of the patient’s condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at [www.uhcsr.com/MyAccount](http://www.uhcsr.com/MyAccount) for additional information, including limitations and exclusions.