The University of Nevada Las Vegas student health insurance plan is underwritten by Aetna Life Insurance Company (Aetna) and administered by Chickering Claims Administrators, Inc (CCA). Aetna Student Health™ is the brand name for products and services provided by Aetna and CCA and their applicable affiliated companies.
Your student health insurance coverage, offered by Aetna Student Health, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage includes an annual limit of $500,000 on all covered services including Essential Health Benefits. Other internal maximums (on Essential Health Benefits and certain other services) are described more fully in the benefits chart included inside this Plan summary. If you have any questions or concerns about this notice, contact (877) 626-2308. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

When Coverage Begins

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

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

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 Aetna Student Health.

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 and 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 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.

Important

This is just a brief description of your benefits. For a full summary of the plan including refund requests, how to file a claim, mandated benefits and other important information, please visit wjis.wellsfargo.com/UNLV to view the Student Health Insurance brochure specifically designed for your school.
### PLAN COST

#### UNLV UNDERGRADUATE STUDENTS

<table>
<thead>
<tr>
<th>TERMS OF COVERAGE</th>
<th>ANNUAL 8/16/13 - 8/15/14</th>
<th>FALL 8/16/13 - 1/11/14</th>
<th>SPRING 1/12/14 - 5/15/14</th>
<th>SPRING/SUMMER 1/12/14 - 8/15/14</th>
<th>SUMMER* 5/16/14 - 8/15/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Deadline</td>
<td>9/30/13</td>
<td>9/30/13</td>
<td>2/28/14</td>
<td>2/28/14</td>
<td>6/16/14</td>
</tr>
<tr>
<td>Student</td>
<td>$2,340</td>
<td>$955</td>
<td>$795</td>
<td>$1,385</td>
<td>$590</td>
</tr>
</tbody>
</table>

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

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$6,005</td>
<td>$2,452</td>
<td>$2,039</td>
<td>$3,553</td>
<td>$1,514</td>
</tr>
<tr>
<td>Per Child</td>
<td>$2,616</td>
<td>$1,068</td>
<td>$888</td>
<td>$1,548</td>
<td>$660</td>
</tr>
</tbody>
</table>

* Summer term is only available to students who were enrolled in the Spring term, Nursing Program or Physical Therapy Program.

#### UNLV GRADUATE AND INTERNATIONAL STUDENTS

<table>
<thead>
<tr>
<th>TERMS OF COVERAGE</th>
<th>FALL 8/16/13 - 1/11/14</th>
<th>SPRING/SUMMER 1/12/14 - 8/15/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiver Deadline</td>
<td>10/5/13</td>
<td>2/28/14</td>
</tr>
<tr>
<td>Student</td>
<td>$844</td>
<td>$1,224</td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>$2,165</td>
<td>$3,141</td>
</tr>
<tr>
<td>Per Child</td>
<td>$944</td>
<td>$1,368</td>
</tr>
</tbody>
</table>

Rates include premium payable to Aetna Life Insurance Company, as well as administrative fees payable to the University of Nevada, Las Vegas and Wells Fargo Insurance. Rates also include premiums and fees for Accidental Death and Dismemberment, Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through On Call International and its contracted underwriting companies.
HEALTH INSURANCE REQUIREMENT AND ELIGIBILITY

Undergraduate Students

All registered degree seeking University of Nevada, Las Vegas undergraduate students enrolled in 6 or more credit hours are eligible to enroll in this insurance plan. To enroll, contact Wells Fargo Insurance toll free at (800) 853-5899 M-F, 8:00a.m. to 5:00p.m (PST), or visit us online at http://www.unlv.edu/srwc and select “Health Center” then “Fees, Insurance and Payments” from the menu.

International Students

All international students with F-1 visa status on a UNLV I-20 are required to have adequate medical insurance coverage. All international students are automatically enrolled in the UNLV-sponsored Student Health Insurance Plan unless they are eligible and choose to submit an online insurance waiver of comparable coverage. Waivers must be submitted each term. International student accounts will be charged the Student Health Insurance Fee for the Fall and Spring/Summer term.

Graduate Students

All registered degree seeking University of Nevada, Las Vegas graduate students enrolled in 9 or more credit hours and all Graduate Assistantship (GA) students enrolled in 6 or more credit hours are required to have adequate medical insurance coverage. All graduate students are automatically enrolled in the UNLV-sponsored Student Health Insurance Plan unless they are eligible and choose to submit an online insurance waiver of comparable coverage. Students need to submit a waiver once per academic year. Graduate student accounts will be charged the Student Health Insurance Fee for the Fall and Spring/Summer term.

Dependents

Eligible students who enroll may also insure their Dependents. Eligible Dependents are the spouse (or domestic partner), and unmarried 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 student is covered under this plan. Coverage may be continued for that child when Aetna Life Insurance Company is notified in writing within 31 days from the date of birth and by payment of any additional premium. Dependent coverage expires concurrently with that of the Insured Student, and Dependents must re-enroll when coverage terminates to maintain coverage.

To enroll your dependents, contact UNLV’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 recovered within 30 days after the coverage expiration date. It is the student’s responsibility to make timely renewal payment 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, Las Vegas 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 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 31 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.

Home study, correspondence, internet classes and television (TV) courses do also fulfill the eligibility requirements that the student actively attends classes. If the Company discovers the Eligibility requirements have not been met, its only obligation is refund of premium.

Withdrawal From School

If you leave the University of Nevada Las Vegas for reason of a covered accident or sickness, you will be eligible for continued coverage under this Plan for only the first term immediately following your leave, provided you were enrolled in this Plan for the term previous to your leave. Enrollment must be initiated by the student and is not automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium.

Please make sure you understand your school’s credit hour and other requirements for enrollment in this plan. Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school’s eligibility requirements for enrollment, your participation in the plan may be terminated or rescinded in accordance with its terms and applicable law.

INSURANCE WAIVER INFORMATION

IF YOU HAVE INSURANCE that is comparable** to the UNLV Student Health Insurance Plan offered through a different insurance company (i.e. through an employer, spouse, parent/guardian, scholarship, etc.), and DO NOT want to take part in the UNLV Plan, you must complete the online waiver process by the Waiver Deadline or your student account will be charged. International students are required to submit a waiver once per term, Graduate students once per academic year.

IF YOU DO NOT HAVE INSURANCE no action is required. You will automatically be enrolled in the UNLV Aetna Student Health Insurance Plan each term you are eligible, (Fall and Spring/Summer), and your student account will be charged.

**Coverage that may be considered comparable includes (but is not limited to) deductibles of less than $2,500, mental health benefits, in-patient and outpatient services, and prescription medications.

To WAIVE OUT of the insurance plan you must complete the online waiver at wfis.wellsfargo.com/unlv. For more information visit http://www.unlv.edu/srwc/health-center/fees.
CONTINUATION OF COVERAGE PLAN

A 1 term continuation of coverage is offered to students and their dependents who become ineligible to continue the UNLV Student Health Insurance Program due to medical or University approved leave or graduation. The same plan benefits and provisions apply, however cost of continuation coverage is higher. Student must enroll within 30 days of termination of the Student Health Insurance and the entire continuation term requested must be paid in advance.

No renewal of Continuation Benefits will be permitted.

For enrollment and plan/rate information, contact Wells Fargo Insurance at (800) 853-5899.

PREMIUM REFUND

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

1. 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 you 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 coverage will remain in effect until the end of the term for which you have paid the premium.

2. If you enter the armed forces of any country you will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request received by WFIS within 45 days of entry into service.

Refund requests should be directed to Wells Fargo Insurance at (800) 853-5899. Approved refunds will be assessed a $25 processing fee.

PREFERRED PROVIDER NETWORK

Aetna Student Health has arranged for you to access the Aetna preferred provider network. It is to your advantage to utilize a Preferred Care Provider because savings can be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services. Students are responsible for informing their Physicians of potential out-of-pocket expenses for a referral to both a Preferred Care Provider and a Non-Preferred Care Provider. Preferred Care Providers are independent contractors and are neither employees nor agents of University of Nevada, Las Vegas nor Aetna Student Health. To find a preferred provider, you can use Aetna’s online DocFind® service located at www.aetnastudenthealth.com. Click on “Find Your School” and enter your school name. You can use DocFind® to find out whether a specific provider belongs to Aetna’s network or to find preferred providers practicing in your area.

MEMBER WEB: AETNA NAVIGATOR®

Got Questions? Get Answers with Aetna Navigator®

As an Aetna Student Health insurance member, you have access to Aetna Navigator®, your secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into Aetna Navigator®, you can:

• Review who is covered under your plan.
• Request member ID cards.
• View Claim Explanation of Benefits (EOB) statements.
• Estimate the cost of common healthcare services and procedures to better plan your expenses.
• Research the price of a drug and learn if there are alternatives.
• Find healthcare professionals and facilities that participate in your plan.
• Send an e-mail to Aetna Student Health Customer Service at your convenience.
• View the latest health information and news, and more!

How do I register?

• Go to www.aetnastudenthealth.com
• Click on “Find Your School.”
• Enter your school name and then click on “Search.”
• Click on Aetna Navigator® and then the “Access Navigator” link.
• Follow the instructions for First Time User by clicking on the “Register Now” link.
• Select a user name, password and security phrase.

Need help with registering onto Aetna Navigator®

Technical assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1 (800) 225-3375.
**SCHEDULE OF MEDICAL EXPENSE BENEFITS**

<table>
<thead>
<tr>
<th>Aggregate Annual Maximum</th>
<th>$500,000 per Condition per Policy year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Year Deductible*</td>
<td>$300 per Covered Person/$600 per Family</td>
</tr>
<tr>
<td>Health Center Referral Pre-Certification Requirement</td>
<td>Not Required</td>
</tr>
<tr>
<td>Per Condition Stop Loss</td>
<td>After the first $5,000 of covered medical expenses per Condition per Policy Year have been paid by the plan, benefits will then be paid at 100% of Negotiated or Recognized charges incurred for any additional medical expenses up to the $500,000 Aggregate Annual Maximum per Condition.</td>
</tr>
</tbody>
</table>

*Deductible is waived when treatment is rendered at the UNLV Student Health Center

In addition to the Plan’s Aggregate Maximum the Policy may contain benefit level maximums. Please review this Summary of Benefits section for any additional benefit level maximums. If you or your physician have any questions regarding benefits, please contact Aetna Student Health at (877) 626-2308.

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 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 due to an emergency treatment, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when a Non-Preferred Provider is used. Unless indicated otherwise, Non-Preferred will be reimbursed at 50% of Recognized Charge.

Services provided by the University of Nevada, Las Vegas Student Health Center that are otherwise not covered by the University of Nevada, Las Vegas Health Fee, are paid at 100% by the Student Health Insurance Plan. Policy exclusions and limitations apply to those expenses unless otherwise listed in the Schedule of Benefits. Pre-Existing Limitations, Copays and deductible do not apply to the Student Health Center expenses.

After your deductible has been met eligible expenses are payable as follows:

### INPATIENT HOSPITAL EXPENSES

| Room & Board/Hospital Miscellaneous, daily semi-private room rate; general nursing care provided by Hospital Benefit is limited to 30 days max per Policy Year. | 80% of Negotiated Charge | 50% of Recognized Charge |
| Intensive Care Room and Board Expense | 80% of Negotiated Charge | 50% of Recognized Charge |
| Miscellaneous Hospital Expense, includes expenses such as anesthesia and operating room; laboratory tests and x-rays; oxygen tent; and drugs; medicines; and dressings. | 80% of Negotiated Charge | 50% of Recognized Charge |
| Non-surgical Physician Expense, benefits limited to one visit per day; does not apply when related to surgery. | 80% of Negotiated Charge | 50% of Recognized Charge |
| Licensed Nurse Expense | 80% of Negotiated Charge | 50% of Recognized Charge |
| Skilled Nursing/Rehabilitation Facility Expense, when confinement is in lieu of hospital confinement and must be within 24 hours of hospital confinement for same or related cause. Benefits limited to 60 days per Policy Year, combined. | 80% of Negotiated Charge | 50% of Recognized Charge |

### SURGICAL EXPENSES (INPATIENT AND OUTPATIENT)

| Surgical Expense | 80% of Negotiated Charge | 50% of Recognized Charge |
| Anesthetist & Assistant Surgeon Expense | 80% of Negotiated Charge | 50% of Recognized Charge |

### OUTPATIENT EXPENSES

<p>| Physician’s Office Visit Expense | 80% of Negotiated Charge after $15 Copay per visit | 50% of Recognized Charge after $15 Deductible per visit |
| Emergency Room Visit Expense, use of the emergency room and supplies. | 80% of Negotiated Charge after $100 Copay per visit | 80% of Negotiated Charge after $100 Deductible per visit |
| Chemotherapy &amp; Radiation Therapy Expense | 80% of Negotiated Charge after $25 Copay per visit | 50% of Recognized Charge after $25 Copay per visit |
| Ambulatory Surgical Expense | 80% of Negotiated Charge | 50% of Recognized Charge |
| Urgent Care Expense | 80% of Negotiated Charge after $15 Copay per visit | 50% of Recognized Charge after $15 Copay per visit |</p>
<table>
<thead>
<tr>
<th>MENTAL HEALTH AND SUBSTANCE ABUSE EXPENSE</th>
<th>PREFERRED CARE</th>
<th>NON-PREFERRED CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Mental Health Expense</strong>, includes charges made for treatment received during partial hospitalization in a hospital or treatment facility. Prior review and approval must be obtained from Aetna Student Health. When approved, benefits will be payable in place of an inpatient admission, whereby 2 days of partial hospitalization may be exchanged for 1 day of full hospitalization. Limited to 40 days per Policy Year.</td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Expense</strong>, benefits are limited to a maximum of 40 visits per Policy Year, one visit per day.</td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Severe Inpatient/Outpatient Mental Health Expense</strong>, includes schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder. Payable to a maximum of 40 days per Policy Year for Inpatient and up to 40 days maximum per Policy Year for Outpatient.</td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Inpatient Substance Abuse Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Outpatient Substance Abuse Expense</strong>, Preferred and Non-Preferred Substance Abuse Benefits are limited to 20 visits per Policy Year for outpatient counseling for patient or family members.</td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>ADDITIONAL EXPENSES</strong></td>
<td><strong>PREFERRED CARE</strong></td>
<td><strong>NON-PREFERRED CARE</strong></td>
</tr>
<tr>
<td><strong>Women’s Health Care Expense</strong>, includes one baseline mammogram for women Mammogram 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.</td>
<td>100% of Negotiated Charge No Copay (Deductible Waived)</td>
<td>70% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Well Child/Baby Care Expense</strong>, includes routine preventive and primary care services are services rendered to a covered dependent child of a covered 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.</td>
<td>100% of Negotiated Charge No Copay (Deductible Waived)</td>
<td>70% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray and Laboratory Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Acupuncture Expense</strong>, benefit combined with Physical Therapy Maximums.</td>
<td>80% of Negotiated Charge $25 Copay per visit</td>
<td>50% of Recognized Charge after $25 Copay per visit</td>
</tr>
<tr>
<td><strong>Chiropractic Care Expense</strong></td>
<td>80% of Negotiated Charge $25 Copay per visit</td>
<td>50% of Recognized Charge after $25 Copay per visit</td>
</tr>
<tr>
<td><strong>Therapy Expense</strong>, including physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation and cardiac rehabilitation.</td>
<td>80% of Negotiated Charge $25 Copay per visit</td>
<td>50% of Recognized Charge after $25 Copay per visit</td>
</tr>
<tr>
<td><strong>Allergy Testing Expense</strong></td>
<td>Payable as any other condition</td>
<td>Payable as any other condition</td>
</tr>
<tr>
<td><strong>Allergy Serums and Injections</strong></td>
<td>Payable as any other condition</td>
<td>Payable as any other condition</td>
</tr>
<tr>
<td><strong>Outpatient Diabetic Self-Management Education Program Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Maternity Expense</strong>              Covered Medical Expenses include inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.</td>
<td>Payable as any other condition</td>
<td>Payable as any other condition</td>
</tr>
<tr>
<td><strong>Preventative Care Services</strong>, including but not limited to routine physical exams, immunizations and diagnostic X-ray &amp; lab for routine physical exams.</td>
<td>Payable as any other condition</td>
<td>Payable as any other condition</td>
</tr>
<tr>
<td><strong>Diagnostic Testing For Learning Disabilities Expense</strong></td>
<td>Payable as any other condition</td>
<td>Payable as any other condition</td>
</tr>
<tr>
<td><strong>Non-Prescription Enteral Formula Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Elective Abortion Expense</strong></td>
<td>Not covered unless life threatening to mother.</td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Expense</strong>                limited to 100 visits maximum per Policy Year.</td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Home Health Care Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment Expense</strong></td>
<td>80% of Negotiated Charge</td>
<td>50% of Recognized Charge</td>
</tr>
<tr>
<td></td>
<td>PREFERRED CARE</td>
<td>NON-PREFERRED CARE</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Ambulance Expenses</td>
<td>80% of Negotiated Charge</td>
<td>80% of Recognized Charge</td>
</tr>
<tr>
<td>Dental Expenses, made necessary by injury to sound, natural teeth.</td>
<td>80% of Actual Charge</td>
<td>80% of Actual Charge</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV) Vaccine, includes administration of the HPV vaccine to girls ages 11 and older.</td>
<td>100% of Negotiated Charge No Copay (Deductible Waived)</td>
<td>70% of the Recognized Charge</td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUG EXPENSES**

| Prescription Drug Expense: Includes diabetic medication, equipment and testing supplies, prescription contraceptives (including contraceptive devices/aids), prenatal vitamins, smoking deterrents limited to a one time 3 month supply. Medications not covered by this benefit include, but are not limited to: drugs whose sole purpose is to promote or stimulate hair growth, appetite suppression, and non-self-injectibles. Contraceptives (that do not have a generic alternate) covered at 100% at the SHC or Preferred Care Pharmacies. Please Note: You are required to pay in full at the time of service for all Prescriptions dispensed at a Non-Participating Pharmacy. | SHC Pharmacy $20 Copay per prescription, pre-existing and deductible are waived. Non-SHC Pharmacy 25% of Negotiated Charge, subject to pre-existing and deductible | 25% of the Recognized Charge for each Brand Name Prescription and for each Generic Prescription Drug |

*Please note: Once the Prescription Drug Benefit maximum of $500,000 is reached, you are able to obtain prescriptions, at your expense, at the Aetna negotiated charge.*

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**PLEASE READ CAREFULLY BEFORE DECIDING WHETHER THIS PLAN IS RIGHT FOR YOU**

- This plan will not pay more than the overall maximum benefit of $500,000 per Condition per Policy year during the plan year
- Once any of these limits have been reached, the plan will not pay any more towards the cost of the applicable services, and your health provider can bill you for what the plan does not pay. Some illnesses cost more to treat than this plan will cover.

- Please read the University of Nevada Las Vegas brochure located at [https://wfsis.wellsfargo.com/UNLV](https://wfsis.wellsfargo.com/UNLV) carefully before enrolling. While this document and the University of Nevada Las Vegas brochure describe important features of the plan, there may be other specifics of the plan that are important to you and some limit what the plan will pay.
- If you want to look at the full plan description, which is contained in the Master Policy issued to the school, you may view it at Student Wellness or contact us at (800) 853-5899.

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**PRE-EXISTING CONDITION**

If you have a pre-existing condition, this plan may not pay for the coverage of this condition for up to the first six months of coverage. For more information on pre-existing condition limitations and other plan exclusions, limitations and benefit maximums, please refer to the University of Nevada Las Vegas Master Policy. This plan pays benefits only for expenses incurred while the coverage is in force and only for the medically necessary treatment of injury or disease. The coverage displayed in this document reflects certain mandate(s) of the state in which the policy was written. However, certain federal laws and regulations could also affect how this coverage pays. Unless otherwise indicated, all benefits and limitations are per covered person.

The pre-existing condition exclusion does not apply to pregnancy or an insured person who is under age 19.
STATE MANDATED BENEFITS
The Plan will pay benefits in accordance with any applicable Nevada State Insurance Law(s).

SUBROGATION/REIMBURSEMENT RIGHT OF RECOVERY PROVISION
Immediately upon paying or providing any benefit under this Plan, Aetna shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person, due to a Covered Person’s Injuries or illness, to the full extent of benefits provided, or to be provided by Aetna. In addition, if a Covered Person receives any payment from any potentially responsible party, as a result of an Injury or illness, Aetna has the right to recover from, and be reimbursed by the Covered Person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the Covered Person receives, from all potentially responsible parties. A “Covered Person” includes for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or Dependent of any Covered Person, entitled to receive any benefits from this Plan.

As used in this provision, the term “responsible party” means any party possibly responsible for making any payment to a Covered Person or on a Covered Person’s behalf due to a Covered Person’s injuries or illness or any insurance coverage responsible making such payment, including but not limited to:

- Uninsured motorist coverage,
- Underinsured motorist coverage,
- Personal umbrella coverage,
- Med-pay coverage,
- Workers compensation coverage,
- No-fault automobile insurance coverage, or
- Any other first party insurance coverage.

The Covered Person shall do nothing to prejudice Aetna’s subrogation and reimbursement rights. The Covered Person shall, when requested, fully cooperate with Aetna’s efforts to recover its benefits paid. It is the duty of the Covered Person to notify Aetna within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to injuries sustained by the Covered Person.

The Covered Person acknowledges that this Plan’s subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to Aetna before any other claim for the Covered Person’s damages. This Plan shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the Plan will result in a recovery to the Covered Person, which is insufficient to make the Covered Person whole, or to compensate the Covered Person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the Covered Person to pursue the Covered Person’s damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The Covered Person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the Covered Person or for the benefit of the Covered Person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as “pain and suffering” or “non-economic damages” only.

OPTIONAL AETNA DENTAL PPO® PLAN
With our Aetna Dental® PPO plan, you can choose to visit a participating or non-participating dentist for care. Enroll and search dentists online at www.aetnastudenthealth.com. For more information and to enroll, please visit http://www.unlv.edu/srwc and select “Health Center” then “Fees, Insurance and Payments” from the menu.

As an Aetna Dental® PPO Plan participant, you also have access to the following additional benefits and services:

1. Aetna Natural Products and Services ProgramSM 1, 2 Reduced rates for Natural Therapy Professionals and products, including visits to acupuncturists, chiropractors, massage therapists, vitamins and supplements.
3. Fitness Program1: A program that offers discounts on health club memberships and home exercise equipment.

PROGRAM COSTS

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Annual Cost</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Enrollment Deadline</td>
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<tr>
<td>Student only</td>
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<tr>
<td>Spouse only</td>
<td>$ 260</td>
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<tr>
<td>Child (ren)</td>
<td>$ 315</td>
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Fall and Spring/Summer coverage available, for more information call 888-238-4825.

Please Note: Participation in the University of Nevada, Las Vegas Student Health Insurance Plan is NOT required to enroll in the Aetna Dental® PPO Plan. The Aetna Dental PPO insurance plan is underwritten by Aetna Life Insurance Company.

1 Discount program provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discounts are subject to change without notice. Discount programs may not be available in all states. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna.
2 Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other healthcare professionals.
EXCLUSIONS AND LIMITATIONS

This list is only a partial list. Please refer to the School’s Master Policy on file at the school for a complete list of exclusions.

This Policy does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from injury to sound, natural teeth or for extraction of impacted wisdom teeth as provided elsewhere in this Policy.

2. Expense incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or prescriptions or examinations except as required for repair caused by a covered injury or sickness or as provided elsewhere in this policy.

3. Expense incurred as a result of injury due to participation in a riot. “Participation in a riot” means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self defense, so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers’ Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country, the unearned pro rata premium will be refunded to the Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery except as specifically provided elsewhere in this Policy and performed while this Policy is in effect.

9. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, except to the extend needed to:

   Improve the function of a part of the body that:
   - is not a tooth or structure that supports the teeth, and
   - is malformed:
     - as a result of a severe birth defect, including harelip, webbed fingers, or toes, or as direct result of:
       - disease, or
       - surgery performed to treat a disease or injury.

   Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy) which occurs while the covered person is covered under this Policy. Surgery must be performed:

   in the calendar year of the accident which causes the injury, or in the next calendar year.

10. Expense covered by any other valid and collectible medical, health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

11. Expense incurred as a result of preventive medicines; sera or vaccines unless otherwise provided in the policy.

12. Expense incurred as a result of commission of a felony.

13. Expense incurred for voluntary or elective abortions unless otherwise provided in this Policy.

14. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits Provision.

15. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

16. Expense incurred for any services rendered by a member of the covered person’s immediate family or a person who lives in the covered person’s home.

17. Expense incurred for injury resulting from the play or practice of collegiate or intercollegiate sports; including collegiate or intercollegiate club sports and intramurals.

18. Expense incurred for which no member of the covered person’s immediate family has any legal obligation for payment.

19. Expense incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:
   - by whom they are prescribed; or
   - by whom they are recommended; or
   - by whom or by which they are performed.

20. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

21. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices.

22. Expenses incurred for or in connection with: procedures; services; or supplies that are; as determined by Aetna; to be experimental or investigational. A drug; a device; a procedure; or treatment will be determined to be experimental or investigational if:

   There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature; to substantiate its safety and effectiveness; for the disease or injury involved; or

   If required by the FDA; approval has not been granted for marketing; or

   A recognized national medical or dental society or regulatory agency has determined; in writing; that it is experimental; investigational; or for research purposes; or

   The written protocol or protocols used by the treating facility; or the protocol or protocols of any other facility studying substantially the same drug; device; procedure; or treatment; or the written informed consent used by the treating facility; or by another facility studying the same drug; device; procedure; or treatment; states that it is experimental; investigational; or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease; if Aetna determines that:

   The disease can be expected to cause death within one year; in the absence of effective treatment; and

   The care or treatment is effective for that disease; or shows promise of being effective for that disease; as demonstrated by scientific data. In making this determination; Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

   Also, this exclusion will not apply with respect to drugs that

   Have been granted treatment investigational new drug (IND); or Group C/treatment IND status; or

   Are being studied at the Phase III level in a national clinical trial; sponsored by the National Cancer Institute;

   If Aetna determines that available; scientific evidence demonstrates that the drug is effective; or shows promise of being effective; for the disease.
EXCLUSIONS AND LIMITATIONS (CONT’D)

23. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except for medically necessary surgical treatment of morbid obesity.


25. Expenses incurred for gynecomastia (male breasts).

26. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person’s home country; if the covered person’s home country has a socialized medicine program.

27. Expense incurred for; or related to; services; treatment; testing; educational testing or training for Attention Deficit Disorder; Attention Deficit Hyperactive Disorder; or Learning Disabilities; or other developmental delays.

28. Expense incurred for acupuncture; unless services are rendered for anesthetic purposes.

29. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy.

30. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary; because the covered person is diabetic; or suffers from circulatory problems.

31. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

32. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

33. Expense incurred for hearing aids; the fitting; or prescription of hearing aids.

34. Expenses incurred for hearing exams not performed in conjunction with a routine physical exam.

35. Expense for transplants; other than cornea and kidney.

36. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

37. Expense for telephone consultations; charges for failure to keep a scheduled visit; or charges for completion of a claim form.

38. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

39. Expense for services or supplies provided for the treatment of obesity and/or weight control, except for medically necessary surgical treatment for morbid obesity.

40. Expense for incidental surgeries; and standby charges of a physician.

41. Expense for treatment and supplies for programs involving cessation of tobacco use, unless specifically provided for in this Policy.

42. Expense for contraceptive methods; devices or aids; and charges for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; elective sterilization or its reversal; or elective abortion; unless specifically provided for in this Policy.

43. Expenses incurred for massage therapy.

44. Expense incurred for; or related to; sex change surgery; or to any treatment of gender identity disorder.

45. Expense for charges that are not recognized charges; as determined by Aetna; except that this will not apply if the charge for a service; or supply; does not exceed the recognized charge for that service or supply; by more than the amount or percentage; specified as the Allowable Variation.

46. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

47. Expenses arising from a pre-existing condition. The pre-existing condition exclusion does not apply to pregnancy or an insured person who is under age 19.

48. Expense incurred for a treatment; service, or supply, which is not medically necessary, as determined by Aetna; for the diagnosis care or treatment of the sickness or injury involved. This applies even if they are prescribed; recommended; or approved; by the person’s attending physician; or dentist. In order for a treatment; service, or supply, to be considered medically necessary; the service or supply must:

   • be care; or treatment; which is likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the sickness or injury involved; and the person’s overall health condition,

   • be a diagnostic procedure which is indicated by the health status of the person; and be as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than; any alternative service or supply; both as to the sickness or injury involved; and the person’s overall health condition;

   • be diagnostic; care; and treatment; be no more costly (taking into account all health expenses incurred in connection with the treatment; service, or supply); than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration: information relating to the affected person’s health status; reports in peer reviewed medical literature; reports and guidelines published by nationally recognized health care organizations that include supporting scientific data; generally recognized professional standards of safety and effectiveness in the United States for diagnosis; care; or treatment; the opinion of health professionals in the generally recognized health specialty involved; and any other relevant information brought to Aetna’s attention.

In no event will the following services or supplies be considered to be medically necessary:

   • those that do not require the technical skills of a medical; a mental health; or a dental professional; or

   • those furnished mainly for the personal comfort or convenience of the person; any person who cares for him or her; or any persons who is part of his or her family; any healthcare provider; or healthcare facility; or

   • those furnished solely because the person is an inpatient on any day on which the person’s sickness or injury could safely; and adequately; be diagnosed; or treated; while not confined; or those furnished solely because of the setting; if the service or supply could safely and adequately be furnished in a physician’s or a dentist’s office; or otherwise other less costly setting.

49. Expense for the contraceptive methods; devices or aids; and charges for or related to artificial insemination; in-vitro fertilization; or embryo transfer procedures; elective sterilization or its reversal; or elective abortion unless specifically provided for in this Policy.
**COORDINATION OF BENEFITS**

If the Covered Person is insured under more than one group health plan, the benefits of the plan that covers the insured student will be used before those of any other plan that provides coverage as a dependent. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy.

**EXTENSION OF BENEFITS**

If a Covered Person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement, shall be payable in accordance with the policy, but only while they are incurred during the 30 day period, following such termination of insurance.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in the Policy; or coverage of the charges is required under any law that applies to the coverage.

**HOW DO I FILE A CLAIM?**

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by:

Aetna Student Health  
P.O. Box 981106, El Paso, TX 79998  
(877) 626-2308 (toll-free)

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m. (PST), Monday through Friday, for any questions.

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.
4. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to Aetna Student Health within 180 days from the date appearing on the Explanation of Benefits (EOB).
5. You will receive an “Explanation of Benefits” when your claims are processed. The Explanation of Benefits will explain how your claim was processed; according to the benefits of your Student Accident and Sickness Insurance Plan.

**HOW TO APPEAL A CLAIM**

In the event a Covered Person disagrees with how a claim was processed, he/she may request a review of the decision. The Covered Person’s requests must be made in writing within one hundred eighty (180) days of receipt of the Explanation of Benefits (EOB). The Covered Person’s request must include why he/she disagrees with the way the claim was processed. The request must also include any additional information that supports the claim (e.g., medical records, Physician’s office notes, operative reports, Physician’s letter of medical necessity, etc.). Please submit all requests to:

Aetna  
P.O. Box 14464  
Lexington, KY 40512

**PRESCRIPTION DRUG CLAIM PROCEDURE**

When obtaining a covered prescription, please present your ID card to a Preferred Pharmacy, along with your applicable copay. The pharmacy will bill Aetna for the cost of the drug, plus a dispensing fee, less the copay amount. When you need to fill a prescription, and do not have your ID card with you, you may obtain your prescription from an Aetna Preferred Pharmacy, and be reimbursed by submitting a completed Aetna Prescription Drug claim form. You will be reimbursed for covered medications, less your copay. For an Aetna Prescription claim form go to www.aetnastudenthealth.com. Find your school, then click “Prescription” to obtain an RX claim form. Prescriptions from a Non-Preferred Pharmacy must be paid for in full at the time of service and submitted for reimbursement.

**NOTICE**

Aetna considers non-public personal member information (“NPI”) confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health Plan, or other related activities, we use NPI internally, share it with our affiliates, and disclose it to healthcare providers (doctors, dentists, pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep NPI confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. To obtain a copy of our notice describing in greater detail our practices concerning use and disclosure of NPI, please call the tollFree Customer Services number on your ID card or visit Aetna Student Health on the internet at: www.aetnastudenthealth.com.
As a member of the Plan, you can also take advantage of the following services, discounts, and programs. These are not underwritten by Aetna and are NOT insurance. The member is responsible for the full cost of the discounted services. Please note that these programs are subject to change without notice. To learn more about these additional services and search for providers visit, www.aetnastudenthealth.com.

Aetna FitnessSM discount program: Access to preferred rates on gym memberships and discounts on at-home weight loss programs, home fitness options and one-on-one health coaching services through GlobalFit®.

Aetna HearingSM discount program: Offers members and their families access to savings on hearing exams, hearing aids and other hearing services. Members can choose between two great offers at no additional premium cost, Hearing Care Solutions and HearPO®.

Aetna Natural Products and ServicesSM discount program: Access to savings on complementary health care products and services, including online consultations, not traditionally covered by their health benefits plan. All products and services are provided through the ChooseHealthy® program* and Vital Health Network (VHN).

*The ChooseHealthy program is made available through American Specialty Health Networks, Inc. (ASH Networks) and Healthyroads, Inc. subsidiaries of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Aetna VisionSM discount program: Access to discounts on vision exams, lenses and frames when a member utilizes a provider participating in the EyeMed Select Network.

Aetna Weight Management discount program: Access to discounts on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs and Nutrisystem® weight loss meal plans.

Oral Health Care discount program: Access to discounts on oral health care products. Save on xylitol mints, mouth rinses, gum, candies and toothpaste from Epic. Additionally, receive exclusive savings on Waterpik® dental water jets and sonic toothbrushes.

Aetna Specialty Pharmacy: provides specialty medications and support to members living with chronic conditions and illnesses. These medications are usually injected or infused, or some may be taken by mouth. For compounded medications, Aetna Specialty Pharmacy will coordinate getting your prescription to the compounding pharmacy that will be able to fill your prescription. For additional information please go to www.AetnaSpecialtyRx.com.

Quit Tobacco Cessation Program: Say good-bye to tobacco and hello to a healthier future! The one-year Quit Tobacco program is provided by Healthyroads, a leading provider of tobacco cessation programs. You’ll get personal attention from health professionals that can help find what works for you.

Beginning Right® Maternity Program: Make healthy choices for you and your baby. Learn what decisions are good ones for you and your baby. Our Beginning Right maternity program helps prepare you for the exciting changes pregnancy brings.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Discount programs may be offered by vendors who are independent contractors and not employees or agents of Aetna or their affiliates. Aetna may receive a percentage of the fee you pay to the discount vendor.

Aetna’s Informed Health® Line*: Call our toll-free number to talk to registered nurses. They can share information on a range of healthy topics**. The nurses can help you:
- Learn about medical procedures and treatment options.
- Improve how you talk with your doctor and other health care providers.
- Find out how to describe your symptoms better.
- Ask the right questions.
- Tell your doctor about your eating, exercise and lifestyle habits.

Call anytime. (United States only). Nurses are available 24-hours a day, To reach a nurse, call 1-800-556-1555. TDD for hearing and speech-impaired people only: 1-800-270-2386. Or reach them through E-mail. You can send an e-mail to IHL2@aetna.com for links to health information about your questions. Nurses reply within 24 hours. Note: Due to security reasons, the Informed Healthline will not open any attachments sent by e-mail. Or listen to the Audio Health Library*. It explains thousands of health conditions in English and Spanish. Transfer easily to a registered nurse at any time during the call.

*While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

** Not all topics may be covered expenses under your plan.

Use the Healthwise® Knowledgebase to find out more about a health condition you have or medications you take. It explains things in terms that are easy to understand.

Get to it through your secure Aetna Navigator® member website, at www.aetnastudenthealth.com.
On Call International
Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Covered Persons with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits. A brief description of these benefits is outlined below.

Accidental Death and Dismemberment (ADD) Benefits
These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following: Benefits are payable for the Accidental Death and Dismemberment of Covered Persons, up to a maximum of $10,000.

Medical Evacuation and Repatriation (MER) Benefits
The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist Covered Persons when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion
- $2,500 Return of Traveling Companion
- $2,500 Bereavement Reunion - in the event of a Covered Person’s death, On Call will fly a family member to identify the remains and accompany the remains back to the deceased’s home country
- $2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or spouse

Natural Disaster and Political Evacuation Services (NDPE)
The following benefits are underwritten by United States Fire Insurance Company (USFIC), with security assistance services provided by On Call. If a Covered Person requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then to the his/her home country. If a Covered Person requires emergency evacuation due to a natural disaster, which makes his/her location uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home. Benefits are payable up to $100,000 per event per person.

Worldwide Emergency Travel Assistance (WETA) Services
On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at www.aetnastudenthealth.com or (800) 966-7772.

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Covered Person’s student health insurance plan (the “Plan”), neither On Call nor its contracted insurance providers provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes.

To file a claim for ADD benefits, or to obtain MER, WETA or NDPE benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Covered Persons when they enroll in the Plan: Toll Free at (866) 525-1956 or Collect at (603) 328-1956. All Covered Persons should carry their On Call ID card when traveling.

CCA and On Call are independent contractors and not employees or agents of the other. CCA provides access to ADD, MER, WETA and NDPE benefits/services through a contractual arrangement with On Call. However, neither CCA nor any of its affiliates provides or administers ADD, MER, WETA or NDPE benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call, USFIC, VSC or CV.
1. Medical treatment which an insured receives as part of a clinical trial or study if: (a) the medical treatment is provided in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome; (b) the clinical trial or study is approved by: (1) an agency of the National Institutes of Health; (2) a cooperative group; (3) the FDA as an application for a new investigational drug; (4) the U.S. Department of Veterans Affairs; or (5) the U.S. Department of Defense; (c) the medical treatment is provided by a provider of health care and the facility and personnel have the experience and training to provide the treatment in a capable manner; (d) there is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study; (e) there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; (f) the clinical trial or study is conducted in this state; and (g) the insured has signed, before his participation in the clinical trial or study, a statement of consent indicating that he has been informed of, without limitation: (1) the procedure to be undertaken; (2) alternative methods of treatment; and (3) the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. The coverage for medical treatment described above is limited to: (a) coverage for any drug or device that is approved for sale by the FDA without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured; (b) the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in the clinical trial or study or as a result of any complication arising out of the medical treatment provided in the clinical trial or study, to the extent that such health care services would otherwise be covered under group health policy; (c) the initial consultation to determine whether the insured is eligible to participate in the clinical trial or study; (d) health care services required for the clinically appropriate monitoring of the insured during the clinical trial or study. The services provided pursuant to this paragraph 2(b) and (d) must be covered only if the services are provided by a provider with whom the insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described above and provided to an insured is not required to be covered if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the group health policy.

4. The coverage for medical treatment required by this section does not include: (a) any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry; (b) coverage for a drug or device described in 2(a) above which is paid for by the manufacturer, distributor or provider of the drug or device; (c) health care services that are specifically excluded from coverage under the insured’s policy of group health insurance, regardless of whether such services are provided under the clinical trial or study; (d) health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study; (e) extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur; (f) any expenses incurred by a person who accompanies the insured during the clinical trial or study; (g) any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured; (h) any costs for the management of research relating to the clinical trial or study.

5. Coverage required by this section shall be subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the policy.

6. An insurer who issues group health insurance specified in subsection 1 is immune from liability for: (a) any injury to the insured caused by: (1) any medical treatment provided to the insured in connection with his participation in a clinical trial or study described in this section; or (2) an act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his participation in a clinical trial or study described in this section; (b) any adverse or unprecedented outcome arising out of an insured’s participation in a clinical trial or study described in this section.

Coinsurance: The percentage of Covered Medical Expenses payable by Aetna under this Accident and Sickness Insurance Plan.

Copay: This is a fee charged to a person for Covered Medical Expenses. For Prescribed Medicines Expense, the copay is payable directly to the pharmacy for each: prescription, kit, or refill, at the time it is dispensed. In no event will the copay be greater than the pharmacy’s charge per: prescription, kit, or refill.

Covered Medical Expense: Those charges for any treatment, service or supplies covered by this Policy which are:

- not in excess of the recognized and customary charges, or
- not in excess of the charges that would have been made in the absence of this coverage, and
- incurred while this Policy is in force as to the covered person except with respect to any expenses payable under the Extension of Benefit Provisions.

Covered person: A covered student and any covered dependent while coverage under this Policy is in effect.

Deductible: The amount of Covered Medical Expenses that are paid by each covered person during the policy year before benefits are paid.

Emergency Medical Condition: This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury, is of such a nature that failure to get immediate medical care could result in:

- Placing the person’s health in serious jeopardy, or
- Serious impairment to bodily function, or
- Serious dysfunction of a body part or organ, or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.
**DEFINITIONS (CONTINUED)**

**Generic Prescription Drug or Medicine:** A prescription drug which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

**Home Health Care:** “Agency to provide nursing in the home” means any person or governmental organization which provides in the home, through its employees or by contractual arrangement with other persons, skilled nursing and assistance and training in health and housekeeping skills. The term does not include a provider of supported living arrangement services during any period in which the provider of supported living arrangement services is engaged in providing supported living arrangement services.

1. “Agency to provide personal care services in the home” means any person, other than a natural person, which provides in the home, through its employees or by contractual arrangement with other persons, nonmedical services related to personal care to elderly persons or persons with disabilities to assist those persons with activities of daily living, including, without limitation:
   - (a) The elimination of wastes from the body;
   - (b) Bathing and undressing;
   - (c) Grooming;
   - (d) The preparation and eating of meals;
   - (e) Laundry;
   - (f) Shopping;
   - (g) Cleaning;
   - (h) Transportation; and
   - (j) Any other minor needs related to the maintenance of personal hygiene.

2. The term does not include: (a) An independent contractor who provides nonmedical services specified by subsection 1 without the assistance of employees; (b) An organized group of persons composed of the family or friends of a person needing personal care services that employs or contracts with persons to provide services specified by subsection 1 for the person if:
   - The organization of the group of persons is set forth in a written document that is made available for review by the Health Division upon request; and
   - The personal care services are provided to only one person or one family who resides in the same residence; or
   (c) An intermediary service organization.

**Hospice:** 1. “Hospice care” means a centrally administered program of palliative services and supportive services provided by an interdisciplinary team directed by a physician. The program includes the provision of physical, psychological, custodial and spiritual care for persons who are terminally ill and their families. The care may be provided in the home, at a residential facility or at a medical facility at any time of the day or night. The term includes the supportive care and services provided to the family after the patient dies.

2. As used in this section: (a) “Family” includes the immediate family, the person who primarily cared for the patient and other persons with significant personal ties to the patient, whether or not related by blood.

   (b) “Interdisciplinary team” means a group of persons who work collectively to meet the special needs of terminally ill patients and their families and includes such persons as a physician, registered nurse, social worker, clergyman and trained volunteer.

**Injury:** Bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

**Medically Necessary:** A service or supply that is: necessary, and appropriate, for the diagnosis or treatment of a sickness, or injury, based on generally accepted current medical practice.

In order for a treatment, service, or supply to be considered medically necessary, the service or supply must:

- Be care or treatment which is likely to produce as significant positive outcome as any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition.

- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely as possible to result in information that could affect the course of treatment as any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person’s overall health condition.

- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information relating to the affected person’s health status,
- reports in peer reviewed medical literature,
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data,
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment,
- the opinion of health professionals in the generally recognized health specialty involved, and
- any other relevant information brought to Aetna’s attention.

In no event will the following services or supplies be considered to be medically necessary:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional, or
- Those furnished mainly for: the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility, or
- Those furnished solely because the person is an inpatient on any day on which the person’s sickness or injury could safely and adequately be diagnosed or treated while not confined, or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished, in a physician’s or a dentist’s office, or other less costly setting.

**Negotiated Charge:** The maximum charge a Preferred Care Provider or Designated Provider has agreed to make as to any service or supply for the purpose of the benefits under this Policy.
DEFINITIONS (CONTINUED)

Non-Preferred Care: A health care service or supply furnished by a health care provider that is not a Designated Care Provider, or that is not a Preferred Care Provider, if, as determined by Aetna:

- the service or supply could have been provided by a Preferred Care Provider, and
- the provider is of a type that falls into one or more of the categories of providers listed in the directory.

Non-Preferred Care Provider:

- a health care provider that has not contracted to furnish services or supplies at a negotiated charge, or

Pharmacy: An establishment where prescription drugs are legally dispensed.

Physician: (a) legally qualified physician licensed by the state in which he or she practices, and (b) any other practitioner that must by law be recognized as a doctor legally qualified to render treatment.

Pre-Existing Condition: Any injury, sickness, or condition that was diagnosed or treated, or would have caused a prudent person to seek diagnosis or treatment, within six months prior to the covered person’s effective date of insurance.

Preferred Care: Care provided by

- a covered person’s primary care physician, or a preferred care provider of the primary care
- physician, or
- a health care provider that is not a Preferred Care Provider for an emergency medical condition when travel to a Preferred Care Provider, is not feasible, or
- a Non-Preferred Urgent Care Provider when travel to a Preferred Urgent Care Provider for treatment is not feasible, and if authorized by Aetna.

Preferred Care Provider: A health care provider that has contracted to furnish services or supplies for a negotiated charge, but only if the provider is, with Aetna’s consent, included in the directory as a Preferred Care Provider for:

- the service or supply involved, and
- the class of covered persons of which you are member.

Preferred Pharmacy: A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Policy, but only:

- while the contract remains in effect, and
- while such a pharmacy dispenses a prescription drug, under the terms of its contract with Aetna.

Prescription: An order of a prescriber for a prescription drug. If it is an oral order, it must be promptly put in writing by the pharmacy.

Recognized Charge: Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- The provider’s usual charge for furnishing it, and
- The charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made, and
- The charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, Aetna may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the recognized charge is the rate established in such agreement.

In determining the recognized charge for a service or supply that is:

- Unusual, or
- Not often provided in the area, or
- Provided by only a small number of providers in the area.

Aetna may take into account factors, such as:

- The complexity,
- The degree of skill needed,
- The type of specialty of the provider,
- The range of services or supplies provided by a facility, and

The prevailing charge in other areas.

The Company: is Wells Fargo Insurance, which administers the Plan.
WELLS FARGO INSURANCE 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 non-public 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 non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at (800) 853-5899 or by visiting us at studentinsurance.wellsfargo.com.

CLAIMS ADMINISTERED BY: Aetna Student Health
Claims and Coverage Questions
P.O. Box 981106
El Paso, TX 79998
(877) 626-2308 (Toll-Free)
wfis.wellsfargo.com/UNLV

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PRESCRIPTIONS: Aetna Pharmacy Management
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THE PLAN ADMINISTERED BY: Wells Fargo Insurance
Student Insurance Division
Eligibility, Enrollment and General Questions
NV License No. 9191
10940 White Rock Road, 2nd Floor
Rancho Cordova, CA 95670
(800) 853-5899
Fax: (877) 612-7966
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This material is for information only. Health/Dental insurance plans contain exclusions, benefit maximums and limitations. The plan will pay benefits in accordance with any applicable Nevada insurance law. If any discrepancy exists between this pamphlet and the Master Policy/Group Agreement, the Master Policy/Group Agreement will govern and control the payment of benefits. Information is believed to be accurate as of the production date; however, it is subject to change. Policy forms issued in OK include: GR-96134.

NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IMPORTANT NOTE

Please keep this Brochure; as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policy. If any discrepancy exists between this Brochure and the Policy; the Master Policy will govern and control the payment of benefits.