2015-2016 Student Injury & Sickness Insurance Plan

University of Nevada, Reno

wfis.wellsfargo.com/UNR

Underwritten by:
UnitedHealthcare Insurance Company
Policy #2015-524-1
BR-NV(09) (524)
WHEN COVERAGE BEGINS

Coverage under the Plan once premium has been collected 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 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.

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.

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: wfs.wellsfargo.com/UNR or call 800-853-5899 to request a paper copy free of charge.
**HEALTH INSURANCE REQUIREMENT AND ELIGIBILITY**

**Undergraduates**
All registered undergraduate students enrolled in 9 or more credit hours and who have paid the health service fee are eligible to enroll in this insurance plan on a voluntary basis.

**Graduate Specials**
Any Grad Special students taking 6 or more credit hours are eligible to enroll in this insurance plan.

To enroll in the Student Injury and Sickness Plan, log on to your MyNEVADA account and select ‘Purchase Items’ under the “Other Financial” drop down under the Finances section. Purchase item fees must be paid at the time of selection.

**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.

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 during school authorized breaks or in case of a medical withdrawal, approved by your school and any applicable regulatory authority. Please contact your school or Wells Fargo insurance for details. Home study, correspondence and online courses do not fulfill the eligibility requirements that the student actively attend classes.

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

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**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.

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**PLAN COST MASTER POLICY #2015-524-1**

<table>
<thead>
<tr>
<th>TERMS OF COVERAGE</th>
<th>ANNUAL 8/15/15 - 8/14/16</th>
<th>FALL 8/15/15 - 1/14/16</th>
<th>SPRING/SUMMER 1/15/16 - 8/14/16</th>
<th>SPRING 1/15/16 - 5/31/16</th>
<th>SUMMER 6/1/16 - 8/14/16</th>
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</thead>
<tbody>
<tr>
<td>Enrollment Deadline</td>
<td>9/7/15</td>
<td>9/7/15</td>
<td>2/1/16</td>
<td>2/1/16</td>
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<td>$1,045.56</td>
<td>$1,456.67</td>
<td>$943.33</td>
<td>$512.22</td>
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<tr>
<td>Spouse only</td>
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<td>$1,045.56</td>
<td>$1,456.67</td>
<td>$943.33</td>
<td>$512.22</td>
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<td>Single Child only</td>
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<td>$1,045.56</td>
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<tr>
<td>Two or More Children only</td>
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<td>$2,091.11</td>
<td>$2,913.33</td>
<td>$1,886.67</td>
<td>$1,024.44</td>
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</tbody>
</table>

**NOTE:** Costs below are in addition to the student premium. 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 UnitedHealthcare Global and its contracted underwriting companies.
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.uhcsr.com/unr to download the 2015-2016 University of Nevada Reno certificate which contains additional information about the UHCP network pharmacy benefits and exclusions.

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.

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.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the 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 FOR HOME HEALTH CARE

Benefits shall be paid for Covered Medical Expenses arising from care at home or health supportive services if that care or service is prescribed by a Physician and would have been covered by the Master Policy if performed in a medical facility or facility for the Dependent as defined in chapter 449 of NRS. Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the Master Policy.

NURSELINE AND STUDENT ASSISTANCE

Insureds have immediate access to nurse advice, a health information library, and counseling support 24 hours a day by calling the toll-free number listed on their medical ID card. NurseLine is staffed by both English and Spanish speaking Registered Nurses who can provide health information, support, and guidance on when to seek medical care. The Student Assistance Program coordinates services using a network of resources. Services available include financial and legal advice, as well as mediation. Counseling is also available by Licensed Clinicians who can provide insureds with someone to talk to when everyday issues become overwhelming. Translation services are available in over 170 languages for most services. Insureds also have access to LiveAndWorkWell.com where they can take health risk assessments, use health estimators to calculate things like their target heart rate and BMI, and participate in personalized self-help programs. More information about these services is available by logging into My Account at www.uhcsr.com/MyAccount.
**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.

**CONGENTIAL 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.

Covered Medical Expenses will be deemed “incurred” only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

**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; and,
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 the Named Insured’s sole spousal equivalent and shares a common residence with the Named Insured. A domestic partner relationship may be demonstrated by providing documentation prescribed by the state of Nevada declaring the domestic partnership agreement.

**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.

Habilitative services do not include services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Insured Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

**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 by reason of an Injury or Sickness for which benefits are payable.

**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
DEFINITIONS (CONTINUED)

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.
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.
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/MEDICALLY NECESSARY 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.
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.
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 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 on the date the adoption becomes effective; and 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 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.

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) administered by a Physician.

Continued on next page
DEFINITIONS (CONTINUED)

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 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.

THE COMPANY means UnitedHealthcare Insurance Company

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 the lesser of the actual charge or 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 where service is rendered. 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.

WHERE DO I GO FOR SERVICE?

When you need care, consider the UNR Student Health Center (SHC) as your first stop. They can provide many of the routine health services you need. Most services obtained at the UNR SHC are covered at no charge or at a highly reduced charge. Plan deductibles, coinsurance and copays are waived when services are received at the SHC. For more information on services covered at the UNR SHC please visit http://www.unr.edu/shc/.

You may visit any licensed health care provider directly for covered services, except for specific Plan restrictions on certain services. However, when you visit a Preferred Provider, you’ll generally have less out of pocket expense for your care. To find a Preferred Provider, call the UnitedHealthcare Choice Plus Network at (800) 828-7716, or visit www.uhcsrc.com/unr.
### SCHEDULE OF MEDICAL EXPENSE BENEFITS SUMMARY

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metallic Tier</td>
<td>Gold</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Deductible* (per Policy Year)</td>
<td>$250 per Insured/ $500 per family</td>
<td>$500 per Insured/ $1,000 per family</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum (per Policy Year)</td>
<td>$6,000 per Insured/ $12,000 per family</td>
<td>$12,000 per Insured</td>
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*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. 13 and 14 of this Brochure for more detailed information on excluded 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 50% 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. The Routine/Preventive Exclusion will be waived for treatment rendered at the Student Health Center. Quantiferon Gold TB testing is covered at the Student Health Center only.

Covered Medical Expenses are payable as follows:

<table>
<thead>
<tr>
<th>INPATIENT HOSPITAL EXPENSES</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room &amp; Board/Hospital Miscellaneous</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Intensive Care Room and Board Expense</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Non-surgical Physician Expense</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
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<tr>
<td>Registered Nurse Expense</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>

Continued on next page
**SCHEDULE OF MEDICAL EXPENSE BENEFITS (CONTINUED)**

<table>
<thead>
<tr>
<th>SURGICAL EXPENSES (INPATIENT AND OUTPATIENT)</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense, Physician’s fees for surgery 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>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT EXPENSES</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>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>

| Emergency Room Visit Expense for a Medical Emergency, facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits | 70% of Preferred Allowance after $100 Copay per visit | 70% of Usual & Customary Charges after $100 Deductible per visit |

| Chemotherapy & Radiation Therapy Expense | 70% of Preferred Allowance | 50% of Usual & Customary Charges |

| Day Surgery Miscellaneous, Facility charge and the charge for services and supplies in connection with outpatient day surgery, excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician’s office; or clinic. Usual and Customary Charges for Day Surgery Misc. are based on the Outpatient Surgical Charge Index. | 70% of Preferred Allowance | 50% Usual & Customary Charges |

| 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. | 70% of Preferred Allowance after $50 Copay per visit | 50% of Usual & Customary Charges |

| 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. | 70% of Preferred Allowance | 50% of Usual & Customary Charges |

| Diagnostic X-Ray and Laboratory Expense | 70% of Preferred Allowance | 50% of Usual & Customary Charges |

<table>
<thead>
<tr>
<th>MENTAL HEALTH AND SUBSTANCE USE EXPENSE</th>
<th>PREFERRED PROVIDERS</th>
<th>OUT-OF-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient/Outpatient Mental Illness Treatment, services received on an Inpatient and outpatient basis, including partial hospitalization/day treatment received at a Hospital and intensive outpatient treatment. 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>

| Substance Use Disorder Treatment, services received on an Inpatient and outpatient basis, including partial hospitalization/day treatment received at a Hospital and intensive outpatient treatment. 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. | Paid as any other Sickness | Paid as any other Sickness |

<table>
<thead>
<tr>
<th>ADDITIONAL EXPENSES</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 Preventive Services please see page 12.</td>
<td>100% of Preferred Allowance Deductible waived</td>
<td>Paid as any other Sickness</td>
</tr>
</tbody>
</table>

| Well Child/Baby Care Expense, includes routine preventive 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 Preventive Services please see page 12. | 100% of Preferred Allowance Deductible waived | Paid as any other Sickness |

| 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 12. | 100% of Preferred Allowance Deductible waived | Not Covered |

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>Acupuncture Expense, benefit combined with Physiotherapy (Outpatient) Maximums.</td>
<td>Paid under Physiotherapy</td>
<td>Paid under Physiotherapy</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Expense, in conjunction with Inpatient or outpatient surgery.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Physiotherapy (Outpatient), 60 visits of any combination of physical therapy, occupational therapy, speech therapy and cardiac rehabilitation therapy.</td>
<td>70% of Preferred Allowance</td>
<td>50% 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>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Medical Foods, Enteral formulas and special food products which are ordered or prescribed by a Physician for the medically necessary treatment of inherited metabolic diseases.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Routine Screening For Sexually Transmitted Disease Expense, 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>Vision Care Exam, except as specifically provided for Pediatric Vision Services, benefits are limited to 1 visit Per Policy Year. Benefits limited to charges for a complete routine eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Elective Abortion Expense, benefits limited to $150.</td>
<td>70% of Preferred Allowance</td>
<td>70% 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>70% of Preferred Allowance</td>
<td>50% 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. Benefits also include Private Duty Nursing services when Medically Necessary and the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider.</td>
<td>70% of Preferred Allowance</td>
<td>50% 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, braces that stabilize an injured body part and braces to treat curvature of the spine and orthotic devices that straighten or change the shape of a body part.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Ambulance Expenses</td>
<td>70% of Preferred Allowance</td>
<td>70% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Dental Expenses, made necessary by injury to sound, natural teeth and removal of teeth to perform radiation therapy only.</td>
<td>70% of Usual &amp; Customary Charges</td>
<td>70% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Transplantation Services, organ and tissue transplants when ordered by a Physician. Travel expenses and transplants involving permanent mechanical or animal organs are not covered.</td>
<td>Paid as any other Sickness</td>
<td>Paid as any other Sickness</td>
</tr>
<tr>
<td>Consultant Physician Fees, services on an Inpatient or outpatient basis.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>
### ADDITIONAL EXPENSES (CONTINUED)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility</strong>, while confined as an Inpatient in a Skilled Nursing Facility in lieu of Hospital Confinement as a full-time inpatient or within 24 hours following a Hospital Confinement for the same or related cause. 100 days maximum Per Policy Year.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Facility</strong>, while confined as an Inpatient in a licensed Inpatient Rehabilitation Facility within 24 hours of and for the same or related cause as a Hospital Confinement or Skilled Nursing Facility confinement. 60 days maximum Per Policy Year.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Infertility Services</strong>, limited to Medically Necessary laboratory studies, diagnostic procedures and six (6) cycles per Insured Person for Artificial Insemination.</td>
<td>Paid as any other sickness</td>
<td>Paid as any other sickness</td>
</tr>
<tr>
<td><strong>Hospital Outpatient Facility or Clinic</strong>, benefits are limited to the facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Genetic Testing</strong>, benefits are limited to genetic testing when ordered by a Physician, determined to be Medically Necessary and which meets additional criteria specified in the Master Policy.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong>, when prescribed by a Physician and used for the treatment of a covered Injury or Sickness. The written prescription must accompany the claim when submitted. Benefits are limited to a 31-day supply per purchase.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Approved Clinical Trials</strong>, benefits are payable for the treatment of cancer, chronic fatigue syndrome or other life-threatening conditions for Covered Medical Expenses incurred which are typically provided absent a clinical trial and not excluded in the policy.</td>
<td>Paid as any other sickness</td>
<td>Paid as any other sickness</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong>, required for the correction of a hearing impairment and with the written recommendation of a Physician. Benefits are limited to one hearing aid per hearing impaired ear every 36 months for a hearing aid that meets the minimum specifications for the Insured’s needs.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Ostomy Supplies</strong>, limited to pouches, face plates and belts; irrigation sleeves, bags and ostomy irrigation catheters; and skin barriers.</td>
<td>70% of Preferred Allowance</td>
<td>50% of Usual &amp; Customary</td>
</tr>
<tr>
<td><strong>Pediatric Dental and Vision Services</strong>, Refer to the Master Policy or Certificate for details (age limits apply).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reconstructive Breast Surgery Following Mastectomy</strong>, In connection with a covered mastectomy for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and physical complications of mastectomy, including lymphedemas.</td>
<td>Paid as any other sickness</td>
<td>Paid as any other sickness</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUG EXPENSES

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Preferred Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
</table>
| **Prescription Drug Expense**: Includes prenatal vitamins. 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. | UnitedHealthcare Pharmacy (UHCP)  
$15 Copay per prescription for Tier 1  
$30 Copay per prescription for Tier 2  
$70 Copay per prescription for Tier 3 up to a 31 day supply per prescription | Not Covered |
| **UnitedHealthcare Pharmacy (UHCP) Mail Order Prescription Drug Expense**: 90 day supply.  
UnitedHealthcare Pharmacy (UHCP) Mail Order is a pharmacy that works through the mail. It can send you up to a 90-day supply at 2.5 times the retail Copay. You have access to this pharmacy as part of your UnitedHealthcare StudentResources pharmacy benefits plan. Learn more online.  
Visit 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)  
2.5 times the retail Copay up to a 90 day supply | Not Covered |
PREVENTIVE 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 Preventive 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 Master Policy benefits if all other policy provisions have been met.

Initial screening at first visit:
- Pregnancy test: urine human chorionic gonadotropin (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
- Cystic fibrosis screening

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), non-invasive fetal aneuploidy DNA testing
- 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.

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.
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 or improved 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 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.


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.
EXCLUSIONS AND LIMITATIONS (cont’d)

25. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems. 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. Speech therapy, except as specifically provided in the policy. 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).


EXCLUSIONS AND LIMITATIONS (cont’d)

MEDICAL 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, SR ID Number (insured's insurance company ID 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

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.

IMPORTANT NOTICE FOR

Nevada Consumers of Health Care, you may contact:

The Department of Business and Industry Division of Insurance
Monday through Friday 8am-5pm (PST)

Call toll-free at
1-888-872-3234

Carson City residents call
1-702-687-4270

Las Vegas residents call
1-702-486-4009
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
Email: claims@uhcsr.com

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 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
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 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 would be significantly less effective is 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 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 discharged from a facility.

Continued on next page
HOW TO APPEAL A CLAIM (CONTINUED)

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

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

PREMIUM REFUND/CANCELLATION

A refund of premium will be granted for the reasons listed below only. No other refunds will be granted.
1. 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 45 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 45 days of the coverage period, your dependent’s 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 studentinsurance@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 a prorata 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.
UnitedHealthcare Global: Global Emergency Services

If you are a member insured with this insurance plan, you and your insured spouse or Domestic Partner and insured minor child(ren) are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

Domestic students, insured spouse or Domestic Partner and insured minor child(ren): you are eligible for UnitedHealthcare Global 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.

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 UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center.

UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:
- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccines
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to $5,000.00 payment (when included with your enrollment in a UnitedHealthcare StudentResources health insurance policy)
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global 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 assistance@UHCGlobal.com.

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

UnitedHealthcare Global 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 UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in My Account at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.
IMPORTANT NOTICE
FOR NEVADA CONSUMERS
OF HEALTH CARE:
The Dept. of Business and Industry Division of Insurance
Monday through Friday, 8am-5pm (PST)
Call toll-free: 1-888-872-3234
Carson City residents call 1-702-687-4270
Las Vegas residents call 1-702-486-4009

CLAIMS AND COVERAGE QUESTIONS:
UnitedHealthcare StudentResources
P.O. Box 809025
Dallas, Texas 75380-9025
(800) 767-0700
Claims@uhcsr.com
CustomerService@uhcsr.com

EMERGENCY TRAVEL ASSISTANCE:
(Provide this information to your
Emergency Contact)
UnitedHealthcare Global
(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 assistance@UHCGlobal.com.

TO FIND A DOCTOR OR PREFERRED PROVIDER:
UnitedHealthcare Choice Plus Network
(800) 767-0700
www.uhcsr.com/unr

PRESCRIPTIONS:
UnitedHealthcare Pharmacies
(855) 828-7716
www.uhcsr.com/unr

ELIGIBILITY, ENROLLMENT, AND GENERAL QUESTIONS:
Wells Fargo Insurance
Student Insurance
(800) 853-5899 • Fax: (877) 612-7966
Email: studentinsurance@wellsfargo.com
studentinsurance.wellsfargo.com

IMPORTANT NOTE
This brochure highlights some of the features of the University of Nevada, Reno injury and sickness insurance plan underwritten by UnitedHealthcare Insurance Company and based on policy number 2015-524-1 (undergraduate and graduate special plan). Please go to www.uhcsr.com/unr to download the Student Injury and Sickness certificate which contains additional essential information about the Master Policy and plan features. The master policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of the insurance benefits. If there is a discrepancy between this document and the master policy, the master policy will prevail.

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.

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.