Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

University of Nevada, Reno

Policy Year: 2026–2027
Policy Number: 686198
https://www.aetnastudenthealth.com
866-725-4433

University of Nevada, Reno



This is a brief description of the Student Health Plan. The plan is available for University of Nevada Reno students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna) The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **https://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

University of Nevada, Reno Student Health Center

The Student Health Center (SHC) is the University's on-campus health facility. The deductible will be waived and benefits will be paid at 100% for covered medical expenses incurred when treatment is rendered at the UNR Student Health Center (SHC) for the following services: All Services that are not otherwise covered by the University of Nevada – Reno Health Fee.

Please call the Student Health Center at (775) 784-6598 to schedule an appointment Monday through Friday, 8AM-5PM.

Who is eligible?

School of Medicine:
All medical students are automatically enrolled in this insurance plan unless proof of comparable coverage is furnished.

All students who have the student health insurance plan during Spring 2026 term will be covered through July 23rd, 2026, regardless of summer credit hours. This means if you have paid the Spring/Summer student health insurance charge, you will have continuous coverage throughout summer term, regardless of taking classes, traveling, or graduating.

International:
All registered international students are automatically enrolled in this insurance plan, unless proof of comparable coverage is furnished.

All students who have the student health insurance plan during Spring 2026 term will be covered through August 14th, 2026, regardless of summer credit hours. This means if you have paid the Spring/Summer student health insurance charge, you will have continuous coverage throughout summer term, regardless of taking classes, traveling, or graduating.

Post completion Optional Practical Training and Academic Training (OPT/AT) students are not eligible to purchase the UNR student insurance plan.

Graduate Students on Assistantship:
Graduate students who are admitted to an eligible graduate degree program and have a full time Graduate Assistantship (GA) and are enrolled in six (6) or more graduate credit hours at the University of Nevada Reno are automatically enrolled in the student health insurance plan at no charge to the student unless they choose to submit an insurance waiver of comparable coverage.

Graduate students who are admitted to an eligible graduate degree program and have a part time Graduate Assistantship (GA) and are enrolled in six (6) or more graduate credit hours at the University of Nevada Reno are automatically enrolled in the student health insurance plan with half of the insurance premium paid by UNR. Half time GA students who do not submit an insurance waiver of comparable coverage will have their student accounts charged for the remaining half of the insurance premium.

Graduate Students NOT on Assistantship:
All eligible degree-seeking graduate students enrolled in 6 or more credit hours are automatically enrolled in the UNR sponsored student health insurance plan, unless they choose to submit an approved insurance waiver of comparable coverage. Eligible students will be charged a Health Insurance Fee for the Fall and Spring/Summer terms.

All students who have the student health insurance plan during Spring 2026 term will be covered through August 14th, 2026, regardless of summer credit hours. This means if you have paid the Spring/Summer student health insurance charge, you will have continuous coverage throughout summer term, regardless of taking classes, traveling, or graduating.

Dependent Coverage Eligibility
Dependent enrollment in this plan is voluntary. Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

Coverage Dates and Rates
Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

School of Medicine

	Fall	Spring/Summer
Coverage Start Date	**07/24/2026**	**02/01/2027**
Coverage End Date	**01/31/2027**	**07/23/2027**
Student	$2,310.00	$2,081.00
Spouse	$2,310.00	$2,081.00
Per Child (up to 2 children)	$2,310.00	$2,081.00

Enrollment waivers must be submitted by:
08/16/2026 - Fall
02/08/2027 - Spring

International

	Fall	Spring/Summer
Coverage Start Date	**08/15/2026**	**01/15/2027**
Coverage End Date	**01/14/2027**	**08/14/2027**
Student	$1,431.00	$1,984.00
Spouse	$1,431.00	$1,984.00
Per Child (up to 2 children)	$1,431.00	$1,984.00

Enrollment waivers must be submitted by:
09/09/2026 - Fall
02/08/2027 - Spring

Graduate

	Fall	Spring/Summer
Coverage Start Date	**08/15/2026**	**01/15/2027**
Coverage End Date	**01/14/2027**	**08/14/2027**
Student	$1,840.00	$2,551.00
Spouse	$1,840.00	$2,551.00
Per Child (up to 2 children)	$1,840.00	$2,551.00
Enrollment waivers must be submitted by: 09/09/2026 - Fall 02/08/2027 - Spring		

Enrollment

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Important note regarding coverage for a newborn infant or newly adopted child:

Newborn child
Your newborn child is covered on your health plan for the first 31 days from the moment of birth.

- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Adopted child or a child legally placed with you for adoption –
A child that you, or that you and your spouse, or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Dependent coverage due to a court order
If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.

- You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at 866-725-4433.

Termination and Refunds

Withdrawal from Classes – Leave of Absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which premium payment has been received. No premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded.
If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded.
If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

In-network Provider Network

Aetna Student Health offers Aetna's broad network of In-network Providers. You can save money by seeing In-network Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better.

If you need care that is covered under the Plan but not available from an In-network Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Precertification

You need pre-approval from us for some covered services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a $500 penalty for each type of covered service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain [precertification], call [Member Services] at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

Non-emergency admissions	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment is scheduled

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

We will provide a written notification to you and your physician of the precertification decision, where required by state law and within the timeframe specified by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health**:** See the schedule of benefits for more information. Go to CVS.com/virtual-care to register and schedule an appointment.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to **https://www.aetnastudenthealth.com.**

This Plan will pay benefits in accordance with any applicable **Nevada** Insurance Law(s).

	In-network coverage	Out-of-network coverage
Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$350 per policy year	$700 per policy year
Spouse	$350 per policy year	$700 per policy year
Each child	$350 per policy year	$700 per policy year
Family	$700 per policy year	$1,400 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following covered services: • In-network care for Preventive care and wellness, Pediatric Dental Type A services, Pediatric Vision Care Services, and Outpatient Prescription Drugs • In-network care and out-of-network care for Well newborn nursery care		
Individual This is the amount you owe for in-network and out-of-network covered services each policy year before the plan begins to pay for covered services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay forcovered services reaches the policy year deductible, this plan will begin to pay for covered services for the rest of the policy year.		
Family This is the amount you and your covered dependents owe for in-network and out-of-network covered services each policy year before the plan begins to pay for covered services. After the amount you and your covered dependents pay for covered services reaches this family policy year deductible, this plan will begin to pay for covered services that you and your covered dependents incur for the rest of the policy year. To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen: • The combined covered services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year. When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.		
Covered services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Covered services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.		

Maximum out-of-pocket limits		
	In-network coverage	**Out-of-network coverage**
Student	$3,000 per policy year	$6,000 per policy year
Spouse	$3,000 per policy year	$6,000 per policy year
Each child	$3,000 per policy year	$6,000 per policy year
Family	$6,000 per policy year	None
Covered services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and covered services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Covered services	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness **Routine physical exams** Performed at a physician's office		
Routine physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations **Performed in a facility or at a physician's office**		
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Preventive care maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment		

Covered services	In-network coverage	Out-of-network coverage
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Routine cancer maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximums	1 screening every 12 months*	

Covered services	In-network coverage	Out-of-network coverage
Prenatal care (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge)
Family planning services –contraceptives **Counseling services**		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge)
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2	
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge)
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)

The following are not covered under this benefit:

- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms

Covered services	In-network coverage	Out-of-network coverage
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's, or specialist office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

The following are not covered under this benefit:

- Allergy sera and extracts administered via injection

Physician and specialist surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)

The following are not covered under this benefit:

- A stay in a hospital (Hospital stays are covered in the *Covered services and exclusions – Hospital and other facility care* section)
- Services of another physician for the administration of a local anesthetic

Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

The following are not covered under this benefit:

- A stay in a hospital (Hospital stays are covered in the *Covered services and exclusions – Hospital and other facility care* section)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

Covered services	In-network coverage	Out-of-network coverage
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
The following are not covered services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps		
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice-Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice-Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements		

- Pastoral counseling
- Respite care
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Covered services	In-network coverage	Out-of-network coverage
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Emergency room	$200 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.
- [Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment amounts that are different from the emergency room copayment amounts.

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room or an independent freestanding emergency department

Urgent medical care provided by an urgent care provider	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered

The following is not covered under this benefit:

- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Covered services	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	60% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

Pediatric dental care exclusions

The following are not covered under this benefit:

- Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges made for the following are not covered except to the extent listed under the *Covered services* section of the certificate or by amendment attached to the policy. In addition, some services are specifically limited or excluded. This section describes the following expenses that are not covered or subject to special limitations. These dental exclusions are in addition to the exclusions that apply to health coverage.
- Acupuncture, acupressure and acupuncture therapy, except as provided *Covered services and exclusions – Specific conditions* section
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in the plan
- Any instruction for diet, plaque control and oral hygiene
- Charges submitted for services that are not rendered, or not rendered to a person not eligible for coverage under the plan
- Cosmetic services and supplies including:
- Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
- Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Covered services and exclusions* section
- Facings on molar crowns and pontics will always be considered cosmetic
    - Court ordered services, including those required as a condition of parole or release
    - Crown, inlays, onlays, and veneers unless:
        - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
        - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants

- Dental services and supplies that are covered in whole or in part under any other part of this plan
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- Experimental or investigational drugs, devices, treatments or procedures, except as described in *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another medically necessary covered service
- Medicare: payment for that portion of the charge for which Medicare is the primary payer
- Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by us, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dental provider.
- Orthodontic treatment except as covered above and in the [*Pediatric*] *dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Space maintainers except when needed to preserve space resulting from premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies

Covered services	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	80% (of the negotiated charge)	60% (of the recognized charge)
Accidental injury to sound natural teeth	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and Craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Dental implants		
Clinical trials		
Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial		

• Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		
Covered services	**In-network coverage**	**Out-of-network coverage**
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Obesity Surgery - inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Obesity surgery and services The following are not covered services: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis, or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries • Newborn care for a child of a gestational carrier		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Voluntary sterilization for males		
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)

Covered services	In-network coverage	Out-of-network coverage
Abortion		
Inpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing, includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Behavioral Health Treatment		
Inpatient hospital treatment (room and board and other miscellane hospital services and supplies) Inpatient residential treatment facility mental health disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental health disorder room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient treatment office visits (includes telemedicine cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Covered services	In-network coverage (IOE facility)*	Out-of-network coverage* (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services		
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Covered services	In-network coverage	Out-of-network coverage
Infertility services		
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication. See the Covered services and exclusions-Outpatient prescription drugs section for information on coverage of infertility prescription drugs.
- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum

microsurgery).

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as agerelated ovarian insufficiency (e.g., perimenopause, menopause).

Covered services	In-network coverage	Out-of-network coverage
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Covered services	In-network coverage	Out-of-network coverage
Breast cancer screening important note: In-network medically necessary breast imaging and diagnostic imaging will be covered at 100% no deductible consistent with federal and Nevada laws. See your certificate of coverage for more information.		
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services		
Ambulance services		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient services		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators		

- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Covered services	In-network coverage	Out-of-network coverage
Nutritional support	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition		
Prosthetic Devices & Orthotics	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices - Cranial prosthetics (Medical wigs)	80% (of the negotiated charge) per item	80% (of the actual charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids		
Hearing Aids		
Hearing Aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 12 month period • Replacement parts or repairs for a hearing aid • Batteries or cords • Cochlear implants • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist		

Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Covered services	**In-network coverage**	**Out-of-network coverage**
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	 One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Optical devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device	
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs
Copayment/coinsurance waiver for risk reducing breast cancer
The prescription drug copayment will not apply to risk reducing breast cancer prescription drugs filled at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.
Outpatient prescription drug copayment waiver for contraceptives
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at a in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The outpatient prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Covered services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$62.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30 day supply filled at a retail pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

Covered services	In-network coverage	Out-of-network coverage
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies	Not Covered
Important Note: The cost share for anti-cancer drugs taken by mouth will not exceed $100 per supply.		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
Risk reducing breast cancer prescription drugs maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
Tobacco cessation prescription drugs and OTC drugs maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.	
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No copayment or policy year deductible applies	Not Covered
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Not Covered
Outpatient prescription drug exclusions **The following are not covered services:** • Allergy sera and extracts given by injection • Any services related to providing, injecting or application of a drug • Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception • Cosmetic drugs including medication and preparations used for cosmetic purposes • Devices, products and appliances unless listed as a covered service • Dietary supplements including medical foods • Drugs or medications:		

- Administered or entirely consumed at the time and place they are prescribed or provided unless listed in the drug guide or we have approved a medical exception
- Which do not require a prescription by law, even if a prescription is written, unless listed as a covered service or we have approved a medical exception
- That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
- Not approved by the FDA or not proven safe or effective
- Provided under your medical plan while inpatient at a healthcare facility
- Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
- That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a covered service
- That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a covered service
- That are drugs or growth hormones used to stimulate growth and prescribed only to treat idiopathic short stature

• Duplicative drug therapy; for example, two antihistamines for the same condition
• Genetic care including:
- Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service

• Immunizations related to travel or work
• Immunization or immunological agents unless listed as a covered service Implantable drugs and associated devices unless listed as a covered service
• Infertility:
- Prescription drugs used primarily for the treatment of infertility

• Injectables including:
- Any charges for the administration or injection of prescription drugs
- Needles and syringes except for those used for insulin administration
- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting, with the exception of Depo Provera and other injectable drugs for contraception, unless listed in the drug guide or we have approved a medical exception

• Off-label drug use except for indications recognized through peer-reviewed medical literature
• Prescription drugs:
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
- That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
- That are used for the purpose of improving visual acuity or field of vision
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card

• Prescription drugs indicated for the purpose of weight loss.
• Replacement of lost or stolen prescriptions
• Test agents [except diabetic test agents
• Tobacco cessation drugs unless recommended by the USPSTF

- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

Out of Country claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Out-of-network level of benefits.

General Exclusions

The following are not covered services under your plan:

Acupuncture

- Acupuncture
- Acupressure

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

Cosmetic services and plastic surgery

• Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

Court-ordered services and supplies

• This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying or changing containers and clamping tubing)
- Watching or protecting you
- Respite care [except in connection with hospice care], adult or child day care, or convalescent care
- Institutional care including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants except when part of an approved treatment plan for a covered service described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

  This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs whether or not the program is part of a residential treatment facility or otherwise licensed institution
  - Job training
  - Job hardening programs
  - Any services that are schooling related or similar programs
  - Therapeutic programs within a school, vocational, work, or recreational setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental, investigational or unproven

- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gene-based, cellular and other innovative therapies (GCIT)
All services and supplies associated with GCIT including, but not limited to:

- The cost of the GCIT product.
- Any medical, surgical, professional, and facility charges directly related to GCIT. Examples include:
  - Anesthesia
  - Infusion
  - Lab and radiology
  - Nursing
  - Physician or specialist services

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing exams

- Hearing exams performed for the evaluation and treatment of illness, injury or hearing

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Covered services and exclusions –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section in the certificate.

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Non-U.S .citizen

- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

P**rescription or non-prescription drugs and medicines**

- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones, unless we have approved a medical exception
- Drugs or medications recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
- Specialty prescription drugs except as stated in the *Covered services and exclusions* section

Private duty nursing

Routine exams and preventive services and supplies

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Covered services and exclusions* section

School health services

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy

  Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with

- Otherwise designates

Services not permitted by law

- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

- Services provided by a spouse, domestic partner parent, child, step-child, brother, sister, in-law or any household member

Sexual dysfunction and enhancement

- Except where described in the Covered services and exclusions section any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Students in mental health field

- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

Telemedicine

- Services including:
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF) or state law. This also includes:
  - Counseling, except as specifically provided in the *Covered services and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Covered services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, unless coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

Wilderness treatment programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.

Important note:

A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

The University of Nevada Reno Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company Aetna Health and Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna Inc.'s website: https://www.aetnastudenthealth.com

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվձար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၵ်ၵတၢ်ကမ္ၢၢ်ကျိာတၢ်မၤစၵၤအတၢ်ဖံးတၢ်မၤတဖၣ လၵ်ၵတအိာဒီးအပှၤလၵ်ၵနကဘာဘဉာဟ့ဉာအီၤအဂီၢ်ကီးဘာလီတဲစိနီၣ်ဂ်ၢ်လၵ်ၵအအိာလၵ်ၵနခိၣ်ဂီၤ ၈ (ၧ၌) အလိၢ်ဉတက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܬܚܫܒ ܒܫܘܬܐ ܕܠܫܢܐ ܕܠܐ ܡܬܚܠܦ ܠܟ ܒܬܪ ܠܡܒܥܐ ܕܡܠܦܢܐ ܕܒܛܦܣܐ ܕܗܘ ܒܟܪܛܝܣ ܕܗܘܝܬܟ ܥܠ ܕܝܢ ܕܟܬܝܒ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.