



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK
Benefit limitations - Some services or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on the day your plan coverage takes effect (unless otherwise noted). Refer to your plan documents to learn more.	
Deductible (per plan year)	\$2,250 per Individual \$4,500 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.	
Member coinsurance	You pay 30%
Applies to all expenses except as noted.	
Out-of-pocket limit (per plan year)	\$8,000 per Individual \$16,000 per Family
Pharmacy expenses count toward the out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.	
Lifetime maximum	
Unlimited except where otherwise indicated.	
Primary care physician selection	Encouraged
Referral requirement	Not required
Virtual care consultations - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to Aetna.com to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.	
CVS VIRTUAL CARE	IN-NETWORK
CVS Health Virtual Primary Care (VPC) - preventive care consultations	Covered 100%; no deductible
Includes screening and counseling services through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for more information.	
CVS Health Virtual Primary Care (VPC) - consultations	Covered 100%; no deductible
Includes basic medical service consultations through CVS Health Virtual Primary Care for members age 18 and older; refer to Aetna.com for additional information.	
CVS Health Virtual Care (VC) - general medicine	Covered 100%; no deductible
CVS Health Virtual Care (VC) - mental health	Covered 100%; no deductible
PREVENTIVE CARE	IN-NETWORK
Routine adult physical exams/immunizations	Covered 100%; no deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older	



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Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 months to 24 months • 3 exams from age 25 months to 36 months • 1 exam every 12 months thereafter until age 22	Covered 100%; no deductible
Routine gynecological care exams 1 exam and pap smear per year, includes related fees.	Covered 100%; no deductible
Breast cancer screening Recommended: One per year for members age 40 and over	Covered 100%; no deductible
Women's health Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible
Colorectal cancer screening Recommended: For members age 45 and over	Covered 100%; no deductible
Routine eye exams 1 routine exam per 24 months.	Covered 100%; no deductible
Routine hearing screening	Covered 100%; no deductible
PHYSICIAN SERVICES	IN-NETWORK
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	\$40 office visit copay; no deductible
Specialist office visits	\$75 office visit copay; no deductible
Hearing exams 1 routine exam per 24 months.	\$75 copay; no deductible
Walk-in clinics Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services. Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	\$40 copay; no deductible
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	IN-NETWORK
Diagnostic x-ray (Other than complex imaging services) When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	30%; after deductible
Diagnostic laboratory When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	30%; after deductible



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Diagnostic complex imaging	30%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent care provider	\$100 office visit copay; no deductible
Non-urgent use of urgent care provider	Not Covered
Emergency room	30% after \$500 copay; no deductible
Copay waived if admitted	
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	30% after \$200 copay; no deductible
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	IN-NETWORK
Inpatient coverage	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Inpatient maternity coverage	30%; after deductible
(includes delivery and postpartum care)	
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Outpatient hospital	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - hospital	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
Outpatient surgery - freestanding facility	30%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Mental health office visits	\$75 copay; no deductible
Other mental health services	30%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	
SUBSTANCE ABUSE	IN-NETWORK
Inpatient	30%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	
Residential treatment facility	30%; after deductible
When admitted into a facility, cost sharing amount counts toward all covered benefits received.	
Substance abuse office visits	\$75 copay; no deductible
Other substance abuse services	30%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	



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THERAPY SERVICES	IN-NETWORK
Spinal manipulation therapy Limited to 20 visits per year	\$75 copay; no deductible
Outpatient short-term rehabilitation Limited to 60 visits per year Includes physical, occupational, and speech therapies	\$75 copay; no deductible
Habilitative physical therapy	30%; after deductible
Habilitative occupational therapy	30%; after deductible
Habilitative speech therapy	30%; after deductible
Autism related physical therapy	30%; after deductible
Autism related occupational therapy	30%; after deductible
Autism related speech therapy	30%; after deductible
Autism related behavioral therapy These benefits are combined with outpatient mental health visits	\$75 copay; no deductible
Autism related applied behavior analysis Your benefits for these services are the same as any other outpatient mental health other services benefit	30%; after deductible
OTHER SERVICES	IN-NETWORK
Skilled nursing facility Limited to 60 days per year When admitted into a facility, cost sharing amount counts toward all covered benefits received.	30%; after deductible
Home health care Limited to 60 visits per year Private duty nursing not included. Limited to three visits per day by staff from a home health care agency.	30%; after deductible
Hospice care - inpatient When admitted into a facility, cost sharing amount counts toward all covered benefits received.	30%; after deductible
Hospice care - outpatient When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.	30%; after deductible
Private duty nursing Limited to 70 eight hour shifts per year. We count each period of up to 8 hours as one private duty nursing shift.	30%; after deductible
Durable medical equipment	30%; after deductible
Orthotics	30%; after deductible
Diabetic supplies • If not covered under the prescription drug benefit • If covered under the prescription drug benefit	You pay your PCP visit cost sharing amount Applicable prescription drug cost sharing amount applies
Infusion therapy - home/office	\$75 copay; no deductible
Infusion therapy - outpatient hospital/freestanding facility	30%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. \$75 copay; no deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.



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Hearing aids	30%; after deductible
\$2500 maximum per 24 months to age 18	
Transplants	30%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.
Bariatric surgery	Not Covered
Acupuncture	\$40 copay; no deductible
Limited to 10 visits per year	
FAMILY PLANNING	IN-NETWORK
Basic infertility	Your cost sharing amount depends on the type of service and where you receive it. You have coverage for artificial insemination and the diagnosis and treatment of the underlying cause of infertility.
Advanced Reproductive Technology (ART)	Not Covered
Fertility preservation	Not Covered
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.
Tubal ligation	Covered 100%; no deductible
PHARMACY	IN-NETWORK
Pharmacy plan type	Advanced Control Plan - Aetna
Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.
Preferred generic drugs	
	Retail \$10 copay
	Mail order \$25 copay
Preferred brand-name drugs	
	Retail \$35 copay
	Mail order \$87.50 copay
Non-preferred generic and brand-name drugs	
	Retail \$70 copay
	Mail order \$175 copay
Specialty drugs	
	Preferred specialty \$200 copay
	Non-preferred specialty \$200 copay
Pharmacy day supply and requirements	
	Retail You can get up to a 30-day supply from Aetna National Network
Mandatory maintenance choice	Maintenance drugs are prescriptions commonly used to treat conditions that require regular, daily use of medicines. If you take a maintenance drug, you can get two retail fills. Then you must fill a 31-90-day supply of the maintenance drug at CVS Caremark® Mail Service Pharmacy, a designated network pharmacy, or a CVS Pharmacy®.
	If you do not, you will need to pay 100% of the drug cost.
	Opt Out You must notify us if you want to continue to fill the medicine at a network retail pharmacy. Just call the number on the member ID card.
	Specialty You can get up to a 30-day supply of specialty drugs You must fill all specialty drugs through our preferred specialty pharmacy network. Advanced Control Formulary AFA List



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Prescription drug plan also includes:

- Diabetic supplies
- \$25 copay maximum per fill per 30 day supply for formulary insulin drugs
- A limited list of over-the-counter medications when filled with a prescription

Family planning

- Oral fertility drugs included.
- Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

The following are covered 100% in-network:

- Oral chemotherapy drugs
- Seasonal vaccinations
- Preventive vaccinations
- Affordable Care Act (ACA) eligible preventive medications and contraceptives

Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements

Some covered prescription drugs need approval from us before we will cover the drug. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting the plan.

Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy. If you are currently taking one of these drugs when you switch to this plan, you may get one fill of your prescription within the first 90 days of starting this plan.

To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

Choose generics - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS

Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.
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Plans are provided by: Aetna Health Inc. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.



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The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental x-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com**.



Rockport Fulton Independent School District
Effective Date: 09-01-2026
Aetna Open Access® Aetna SelectSM
Aetna Funding Advantage

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Aetna is within the CVS Health family.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**

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