



NONPROFIT EMPLOYEE BENEFITS TRUST DBA COMMUNITY ACCESS UNLIMITED, INC.

Effective Date: 01-01-2026  
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit limitations</b> - Some service 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 January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
<b>Deductible</b> (per calendar year)	None Individual None Family	\$1,000 per Individual \$3,000 per Family
You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. 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.		
<b>Member coinsurance</b>	Covered 100%	You pay 50%
Applies to all expenses except as noted.		
<b>Out-of-pocket limit</b> (per calendar year)	\$5,500 per Individual  \$11,000 per Family	\$5,500 per Individual  \$11,000 per Family
Covered expenses add up toward both your in-network and out-of-network out-of-pocket limit at the same time. Your pharmacy expenses count toward your 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. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply.		
<b>Lifetime maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for out-of-network care**</b>	Does not apply	Professional: Prevailing Charges Facility: Facility Charge Review
<b>Primary care physician selection</b>	Encouraged	Does not apply
<b>Precertification requirements</b> - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by \$400. Refer to your plan documents for a full list of services that need this approval.		
<b>Referral requirement</b>	Not required	None
<b>Telehealth consultations</b> - You can access covered services for telehealth visits from different kinds of providers in your network. Log on to <b>Aetna.com</b> to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
<b>Virtual care consultations</b> - You can access covered services for virtual care visits from different kinds of providers in your network. Log on to <b>Aetna.com</b> to see a list of virtual care providers. You'll also find more about your options, including cost share amounts.		



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<b>CVS VIRTUAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>CVS Health Virtual Care (VC) - general medicine</b>	Covered 100%	Not applicable
<b>CVS Health Virtual Care (VC) - mental health</b>	Covered 100%	Not applicable
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine adult physical exams/immunizations</b>	Covered 100%	50%; after deductible
1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older		
<b>Routine well child exams/immunizations</b>	Covered 100%	50%; after deductible
• 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		
<b>Routine gynecological care exams</b>	Covered 100%	50%; after deductible
1 exam and pap smear per year, includes related fees.		
<b>Routine mammogram</b>	Covered 100%	50%; after deductible
Recommended: One per year for members age 40 and over		
<b>Women's health</b>	Covered 100%	50%; after deductible
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.		
<b>Pre-natal maternity</b>	Covered 100%	50%; after deductible
<b>Routine digital rectal exam</b>	Covered 100%	50%; after deductible
Recommended: For members age 40 and over		
<b>Prostate-specific antigen test</b>	Covered 100%	50%; after deductible
Recommended: For members age 40 and over		
<b>Colorectal cancer screening</b>	Covered 100%	50%; after deductible
Recommended: For members age 45 and over		
<b>Routine eye exams</b>	Covered 100%	50%; after deductible
1 routine exam per 12 months.		
<b>Routine hearing screening</b>	Covered 100%	50%; after deductible
<b>Medications</b>	Certain over-the-counter preventive medications covered 100% in network.	



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<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office visits to primary care physician (PCP)</b> Includes services of an internist, general physician, family practitioner or pediatrician.	\$20 office visit copay	50%; after deductible
<b>Telehealth consultation with non-specialist</b>	\$20 office visit copay	50%; after deductible
<b>Specialist office visits</b>	\$20 office visit copay	50%; after deductible
<b>Telehealth consultation with specialist</b>	\$20 office visit copay	50%; after deductible
<b>Hearing exams</b>	Not Covered	Not Covered
<b>Walk-in clinics</b> <b>Designated Walk-in clinics</b> Covered 100%	\$20 copay	50%; after deductible
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.		
<b>Allergy testing</b>	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
<b>Allergy injections</b>	Your cost sharing amount depends on the type of service and where you receive it. Covered 100% when an office visit charge is not applicable.	Your cost sharing amount depends on the type of service and where you receive it.
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (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.	Covered 100%	50%; after deductible
<b>Diagnostic laboratory</b> When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%	50%; after deductible
<b>Diagnostic complex imaging</b> When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	Covered 100%	50%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent care provider</b>	\$20 office visit copay	50%; after deductible
<b>Non-urgent use of urgent care provider</b>	\$20 office visit copay	50%; after deductible
<b>Emergency room</b> Copay waived if admitted	\$150 copay	Same as in-network care
<b>Non-emergency care in an emergency room</b>	Not Covered	Not Covered
<b>Emergency use of ambulance</b>	Covered 100%	Same as in-network care
<b>Non-emergency use of ambulance</b>	Not Covered	Not Covered



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<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient coverage</b>	\$200 copay	50% after \$200 per visit deductible; after plan deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Inpatient maternity coverage</b> (includes delivery and postpartum care)	\$200 copay	50% after \$200 per visit deductible; after plan deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Outpatient hospital</b>	Covered 100%	50%; 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.		
<b>Outpatient surgery - hospital facility</b>	Covered 100%	50%; 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.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	\$200 copay	50% after \$200 per visit deductible; after plan deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Mental health office visits</b>	\$20 copay	50%; after deductible
<b>Mental health telehealth consultations</b>	\$20 office visit copay	50%; after deductible
<b>Other mental health services</b>	Covered 100%	50%; 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.		
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	\$200 copay	50% after \$200 per visit deductible; after plan deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Residential treatment facility</b>	\$200 copay	50% after \$200 per visit deductible; after plan deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Substance abuse office visits</b>	\$20 copay	50%; after deductible
<b>Substance abuse telehealth consultations</b>	\$20 office visit copay	50%; after deductible
<b>Other substance abuse services</b>	Covered 100%	50%; 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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<b>THERAPY SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Spinal manipulation therapy</b> Limited to 25 visits per year	\$20 copay	50%; after deductible
<b>Outpatient rehabilitative physical and occupational therapy</b>	\$20 copay	50%; after deductible
<b>Outpatient rehabilitative speech therapy</b>	\$20 copay	50%; after deductible
<b>Habitative physical therapy</b>	Covered 100%	50%; after deductible
<b>Habitative occupational therapy</b>	Covered 100%	50%; after deductible
<b>Habitative speech therapy</b>	Covered 100%	50%; after deductible
<b>Autism related physical therapy</b>	Covered 100%	50%; after deductible
<b>Autism related occupational therapy</b>	Covered 100%	50%; after deductible
<b>Autism related speech therapy</b>	Covered 100%	50%; after deductible
<b>Autism related behavioral therapy</b>	\$20 copay	50%; after deductible
These benefits are combined with outpatient mental health visits		
<b>Autism related applied behavior analysis</b>	Covered 100%	50%; after deductible

Your benefits for these services are the same as any other outpatient mental health other services benefit

<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled nursing facility</b> Limited to 90 days per year	Covered 100%	Covered 100%; no deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
<b>Home health care</b> Limited to 100 visits per year Private duty nursing not included.	Covered 100%	Covered 100%; no deductible
Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.		
<b>Hospice care - inpatient</b> When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.	Covered 100%	Covered 100%; no deductible
<b>Hospice care - outpatient</b> 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.	Covered 100%	Covered 100%; no deductible
<b>Private duty nursing</b> Limited to 70 eight hour shifts per year. We count each period of up to 8 hours as one private duty nursing shift.	Covered 100%	50%; after deductible
<b>Durable medical equipment</b>	Covered 100%	50%; after deductible
<b>Orthotics</b>	Covered 100%	50%; after deductible
<b>Diabetic supplies</b>		
• If not covered under the prescription drug benefit	You pay your PCP visit cost sharing amount	You pay your PCP visit cost sharing amount
• If covered under the prescription drug benefit	You pay your applicable prescription drug cost sharing amount	You pay your applicable prescription drug cost sharing amount
<b>Infusion therapy - home/office</b>	\$20 copay	50%; after deductible
<b>Infusion therapy - outpatient hospital/freestanding facility</b>	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.



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<b>Gene-based, Cellular, and other Innovative Therapies (GCIT™)</b>	Your cost sharing amount depends on the type of service and where you receive it. \$50 copay In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
<b>Vision eyewear</b>	Covered 100% up to \$300 every 24 months; not subject to any plan deductible, if applicable	
<b>Transplants</b>	\$200 copay  In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.	50% after \$200 per visit deductible; after plan deductible  Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility.
<b>Bariatric surgery</b>	Not Covered	Not Covered
<b>Acupuncture</b>	Not Covered	Not Covered
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Basic Infertility</b>	Your cost sharing amount depends on the type of service and where you receive it.  You have coverage for the diagnosis and treatment of the underlying cause of infertility. Does not include artificial insemination (AI).	Your cost sharing amount depends on the type of service and where you receive it.
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Fertility preservation</b>	Not Covered	Not Covered
<b>Vasectomy</b>	Covered 100%	50%; after deductible
<b>Tubal ligation</b>	Covered 100%	50%; after deductible



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**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.

\*\*We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.

This amount is based on the out-of-network plan you or your employer picks.

- For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

- For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to [www.aetna.com](http://www.aetna.com) and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.

This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

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](http://www.aetna.com).

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both 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.**