



MTA New York City Transit Authority

Effective Date: 01-01-2017

Aetna Choice<sup>®</sup> POS II Plus Option

**PLAN DESIGN & BENEFIT OVERVIEW**  
**ADMINISTERED BY AETNA LIFE INSURANCE COMPANY**

<b>BENEFIT</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Medical Deductible</b>	\$0	\$1000 Individual per calendar year \$3000 Family per calendar year \$100 DME deductible per person per calendar year
<b>Hospital Deductible</b>	\$0	Combined with medical deductible
<b>Member Coinsurance</b>	Covered 100%	30% of eligible expenses after deductible
<b>Coinsurance Limit</b>	Not applicable	Not applicable
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Maximum Out of Pocket</b> (copayment/coinsurance)	\$1,500 Individual \$3,000 Family Per Calendar year	\$10,000 Individual \$30,000 Family per Calendar year
<b>PCP/ Referral Requirement</b>	None	None
<b>MEDICAL SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Preventive Care</b> Physical exams, eye exams, well woman, immunizations, diagnostic screenings	\$5 copayment	30% of eligible expenses after deductible
<b>Routine Well Child Exams/Immunizations</b>	\$5 copayment	30% of eligible expenses after deductible
<b>PCP Office Visits</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Specialist Office Visit</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Second Surgical Opinion</b>	\$5 copayment	30% of eligible expenses after deductible
<b>INPATIENT HOSPITAL SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> (Semi-private room and board)	No copayment	30% of eligible expenses after deductible
<b>Inpatient Obstetrical Care</b> (includes delivery, postpartum care and routine newborn nursery care)	No copayment	30% of eligible expenses after deductible
<b>Surgery, Surgical Assistant, Anesthesia, Oxygen</b>	No copayment	30% of eligible expenses after deductible
<b>Pre- Admission Testing</b>	\$5 copayment	30% of eligible expenses after deductible
<b>OUTPATIENT HOSPITAL SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Ambulatory/Outpatient Surgery</b>	No copayment	30% of eligible expenses after deductible



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<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Services</b>	\$35 copayment	\$35 copayment
<b>Emergency Room</b>	\$35 copayment	\$35 copayment
<b>Waived if admitted</b>		Waived if admitted
<b>Emergency Use of Land Ambulance</b>	No copayment	No copayment
<b>Emergency Use of Air Ambulance</b>	No copayment	No copayment
<b>MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> (Semi-private room and board)	No copayment	30% of eligible expenses after deductible
<b>Outpatient</b>	\$5 copayment	30% of eligible expenses after deductible
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Deductible, Copayment/Coinsurance</b> (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears)	No copayment. Subject to allowed amount <b>AFTER</b> \$100 deductible* per person per calendar year	50% of allowed amount <b>AFTER</b> \$100 deductible* per person per calendar year plus any amount billed above the allowed amount
<b>HOME HEALTHCARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Home Health Care Visits</b> 200 visits per calendar year One visit equals up to 4 hours of care	No Copayment	25% of eligible expenses after deductible
<b>Home Infusion Therapy</b>	No copayment	25% of eligible expenses after deductible

\*DME \$100 deductible not applicable to Positive Airway Pressure (PAP) devices, PAP supplies or insulin pump supplies.



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<b>ADDITIONAL BENEFITS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Hospice Care</b>	No copayment	30% of eligible expenses after deductible
<b>Diagnostic Procedures X-rays, Radium and Radionuclide MRI/MRA, PET/CAT scans Laboratory tests</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Allergy Office Visit Office, testing and treatment</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Physical/Occupational Therapy Up to 90 visits per calendar year</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Speech/Language Therapy Up to 90 visits per calendar year</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Cardiac Rehabilitation</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Chemotherapy/ Radiation Therapy</b>	\$5 copayment in office No copayment in outpatient facility	30% of eligible expenses after deductible
<b>Kidney Dialysis</b>	\$5 copayment in office No copayment in outpatient facility	30% of eligible expenses after deductible
<b>Ear Coverage Treatment for disease and injury of the ears</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Chiropractic Care Unlimited visits. Pre-certification required after 20<sup>th</sup> visit</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Podiatric Services Routine services, such as removal of corns are not covered</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Family Planning Services Tubal Ligation and Vasectomy</b>	\$5 copayment	30% of eligible expenses after deductible
<b>Infertility Care</b>	No copayment	30% of eligible expenses after deductible
<b>Advanced Reproductive Technologies in-Vitro fertilization ZIFT/GIFT/ICIS ( 3 cycle per lifetime)</b>	No copayment	30% of eligible expenses after deductible