MTA New York City Transit Authority
SIRTOA ATDA

Effective Date: 05-01-2023
Aetna Choice® POS II Plus Option

PLAN DESIGN & BENEFIT OVERVIEW
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Services	$35 copayment	$35 copayment
Emergency Room **Waived if admitted**	$100 copayment	$100 copayment Waived if admitted
Emergency Use of Land Ambulance	No copayment	No copayment
Emergency Use of Air Ambulance	No copayment	No copayment
MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage (Semi-private room and board)	No copayment	30% of eligible expenses after deductible
Outpatient	$5 copayment	30% of eligible expenses after deductible
DURABLE MEDICAL EQUIPMENT (DME)	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible, Copayment/Coinsurance (**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 **AFTER** $100 deductible* per person per calendar year	50% of allowed amount **AFTER** $100 deductible* per person per calendar year plus any amount billed above the allowed amount
HOME HEALTHCARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Home Health Care Visits 200 visits per calendar year One visit equals up to 4 hours of care	No Copayment	25% of eligible expenses after deductible
Home Infusion Therapy	No copayment	25% of eligible expenses after deductible

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

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