MTA New York City Transit Authority
TWU Local 100 and MTA Bus

Effective Date: 01-01-2024
Aetna Choice® POS II – High Option

PLAN DESIGN & BENEFIT OVERVIEW
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Medical Deductible	$0	$100 per person per calendar year Medical and Hospital combined (except for a per person per calendar year $50 Home Health Care and $100 DME deductible)
Hospital Deductible	$50 per confinement per person Up to a calendar year maximum of $240 per family.	Combined with medical deductible
Member Coinsurance	Covered 100%	Allowance Schedule
Coinsurance Limit	Not applicable	Not applicable
Lifetime Maximum	Unlimited	Unlimited
Maximum Out of Pocket (copayment/coinsurance)	Not applicable	Not applicable
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	Allowance Schedule
Routine Well Child Exams/Immunizations	No copayment	Allowance Schedule
PCP Office Visits	$15 copayment	Allowance Schedule
Specialist Office Visit	$15 copayment	Allowance Schedule
Second Surgical Opinion	$15 copayment	Allowance Schedule
INPATIENT HOSPITAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage (Semi-private room and board)	$50 per confinement per person up to a calendar year maximum of $240 per family	Allowance Schedule
Inpatient Obstetrical Care (includes delivery, postpartum care and routine newborn nursery care)	No copayment	Allowance Schedule
Surgery, Surgical Assistant, Anesthesia, Oxygen	No copayment	Allowance Schedule
Pre-Admission Testing	$15 copayment	Allowance Schedule
OUTPATIENT HOSPITAL SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Ambulatory/Outpatient Surgery	No copayment	Allowance Schedule

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EMERGENCY MEDICAL CARE	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Services	$15 copayment	$15 copayment
Emergency Room	$100 copayment	$100 copayment
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 (Semi-private room and board)	$50 per confinement per person up to a calendar year maximum of $240 per family	Allowance Schedule
Outpatient	$15 copayment	Allowance Schedule
Applied Behavioral Analysis* (ABA for Autism) ***Precertification Required***	No copayment	Allowance Schedule
DURABLE MEDICAL EQUIPTMENT (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 Deductible	No copayment	$50 deductible
Home Health Care Visits One visit equals up to 4 hours of care	No copayment 200 visits per calendar year	25% coinsurance 40 visits per calendar year
Home Infusion Therapy	No copayment	25% coinsurance

***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	Allowance Schedule
Diagnostic Procedures **X-rays, Radium and Radionuclide** **MRI/MRA, PET/CAT scans** **Laboratory tests**	$15 copayment	Allowance Schedule
Allergy Office Visit	$15 copayment	Allowance Schedule
Allergy Testing/Treatment	No copayment	Allowance Schedule
Physical/Occupational Therapy	$15 copayment	Allowance Schedule
Speech/Language Therapy	$15 copayment	Allowance Schedule
Cardiac Rehabilitation	$15 copayment	Allowance Schedule
Chemotherapy/Radiation Therapy	No copayment	Allowance Schedule
Kidney Dialysis	No copayment	Allowance Schedule
Ear Coverage Treatment for disease and injury of the ears	$15 copayment	Allowance Schedule
Chiropractic Care Unlimited visits. Pre-certification required after 20th visit	$15 copayment	Allowance Schedule
Podiatric Services Routine Services, such as removal of corns are not covered	$15 copayment	Allowance Schedule
Family Planning Services Vasectomy Tubal Ligation	$15 copayment $15 copayment No copayment	Allowance Schedule Allowance Schedule Allowance Schedule
Infertility Care	No copayment	Allowance Schedule
Advanced Reproductive Technologies in-Vitro fertilization ZIFT/GIFT/ICIS (3 cycles per lifetime)	No copayment	Allowance Schedule