

MTA New York City Transit Authority Spring Creek Local 1181 and SIRTOA TCU

Effective Date: 01-01-23 Aetna Choice[®] POS II – Basic Option

PLAN DESIGN & BENEFIT OVERVIEW ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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 per calendar year \$50 Home Health Care and \$100 DME deductible) Hospital Deductible \$50 per confinement per person per calendar year \$50 Home Health Care and \$100 DME deductible Member Coinsurance Covered 100% Allowance Schedule Coinsurance Limit Not applicable Not applicable Idetime Maximum Unlimited Unlimited Maximum Out of Pocket Not applicable Not applicable (copayment/coinsurance) None None PCP/ Referral Requirement None None Mumunizations, diagnostic screenings No copayment Allowance Schedule Preventive Care No copayment Allowance Schedule PCP Office Visit \$15 copayment Allowance Schedule Specialist Office Visit \$15 copayment Allowance Schedule INPATIENT HOSPITAL SERVICES IN-NETWORK OUT-OF-NETWORK INPATIENT HOSPITAL SERVICES IN-NETWORK OUT-OF-NETWORK Inpatient Coverage (Semi-private roo anal board) \$50 per confinement per pers	BENEFIT	IN-NETWORK	OUT-OF-NETWORK
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of \$240 per family	Inpatient Coverage (Semi-private	\$50 per confinement per person	Allowance Schedule
	room and board)		
Inpatient Obstetrical Care No copayment Allowance Schedule		of \$240 per family	
	Inpatient Obstetrical Care	No copayment	Allowance Schedule
(Includes delivery, postpartum	(Includes delivery, postpartum		
care and routine newborn	care and routine newborn		
nursery care)	nursery care)		
Surgery, Surgical Assistant, No copayment Allowance Schedule		No copayment	Allowance Schedule
Anesthesia, Oxygen			
Pre-Admission Testing\$15 copaymentAllowance Schedule	Pre-Admission Testing	\$15 copayment	Allowance Schedule
OUTPATIENT HOSPITAL SERVICES IN-NETWORK OUT-OF-NETWORK		IN-NETWORK	OUT-OF-NETWORK
Ambulatory/Outpatient Surgery No copayment Allowance Schedule	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	No copayment	No copayment
Ambulance		
Emergency Use of Air Ambulance	No copayment	No copayment
MENTAL HEALTH AND	IN-NETWORK	OUT-OF-NETWORK
ALCOHOL/SUBSTANCE ABUSE SERVICES		
Inpatient (Semi-private room and	\$50 per confinement per person	Allowance Schedule
board)	up to a calendar year maximum	
	of \$240 per family	
Outpatient	\$15 copayment	Allowance Schedule
DURABLE MEDICAL EQUIPTMENT (DME)	IN-NETWORK	OUT-OF-NETWORK
Deductible,	No copayment. Subject to	50% of allowed amount AFTER
Copayment/Coinsurance	allowed amount AFTER \$100	\$100 deductible* per person per
(e.g. hospital beds, oxygen,	deductible* per person per	calendar year plus any amount
oxygen equipment, wheelchairs,	calendar year	billed above the allowed amount
PAP devices and supplies, diabetic		
pumps and supplies, catheters,		
artificial arms, legs, eyes, ears)		
HOME HEALTHCARE	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Deductible	No copayment	\$50 deductible
Home Health Care Visits	No Copayment	25% coinsurance
One visit equals up to 4 hours of	200 visits per calendar year	40 visits per calendar year
care		
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	\$15 copayment	Allowance Schedule
Laboratory tests Allergy Office Visit	\$15 copayment	Allowance Schedule
Allergy Testing/Treatment	No copayment	Allowance Schedule
Physical/Occupational Therapy		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 20 th visit	\$15 copayment	Allowance Schedule
Podiatric Services Routine services, such as removal of corns are not covered	\$15 copayment	Allowance Schedule
Family Planning Services	\$15 copayment	Allowance Schedule
Vasectomy	\$15 copayment	Allowance Schedule
Tubal Ligation	No copayment	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