

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

Effective Date: 01-01-2023 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	\$1,500 Individual	\$10,000 Individual
(copayment/coinsurance)	\$3,000 Family	\$30,000 Family
	Per Calendar year	per Calendar year
PCP/ Referral Requirement	None	None
MEDICAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	No copayment	30% of eligible expenses after
Physical exams, eye exams, well		deductible
woman, immunizations,		
diagnostic screenings		
Routine Well Child	No copayment	30% of eligible expenses after
Exams/Immunizations		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	No copayment	30% of eligible expenses after
room and board)		deductible
Inpatient Obstetrical Care	No copayment	30% of eligible expenses after
(includes delivery, postpartum		deductible
care and routine newborn		
nursery care)		
Surgery, Surgical Assistant,	No copayment	30% of eligible expenses after
Anesthesia, Oxygen		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 20 th 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