

MTA New York City Transit Authority ATU 726/1056/1179 and Spring Creek Local 1181

Effective Date: 01-01-2024 Aetna Select Option National Network

PLAN DESIGN & BENEFIT OVERVIEW ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

BENEFIT	IN-NETWORK
Medical Deductible	None
Hospital Deductible	None
Member Coinsurance	None
Coinsurance Limit	None
Maximum Out of Pocket	Not Applicable
Lifetime Maximum	Unlimited
PCP/ Referral Requirement	None
MEDICAL SERVICES	IN-NETWORK
Preventive Care	No copayment
Physical Exams, eye exams well	
woman, immunizations,	
diagnostic screenings	
Routine Well Child	No copayment
Exams/Immunizations	
PCP Office Visits	No copayment
Specialist Office Visit	No copayment
Second Surgical Opinion	No copayment
INPATIENT HOSPITAL SERVICES	IN-NETWORK
Inpatient Hospital	No copayment
(Semi- private room and board)	
Inpatient Obstetrical Care	No copayment
(Includes delivery, postpartum	
care and routine newborn	
nursery care)	
Surgery, Surgical Assistant,	No copayment
Anesthesia and Oxygen	
Pre-Admission Testing	No copayment
OUTPATIENT HOSPITAL SERVICES	IN-NETWORK
Ambulatory/Outpatient Surgery	No copayment



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EMERGENCY MEDICAL CARE	IN-NETWORK
Urgent Care Services	No copayment
Emergency Room	\$100 copayment
Emergency Use of Land	No copayment
Ambulance	no sopu, mem
Emergency Use of Air Ambulance	No copayment
MENTAL HEALTH AND	IN-NETWORK
ALCOHOL/SUBSTANCE ABUSE	
SERVICES	
Inpatient Coverage	No copayment
(Semi-private room and board)	
Outpatient	No copayment
DURABLE MEDICAL EQUIPMENT	IN-NETWORK
(DME)	
<u> </u>	
Deductible/Copayment	No copayment. Subject to
Deductible/Copayment (e.g. hospital beds, oxygen,	No copayment. Subject to allowed amount AFTER \$100
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs,	• •
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic	allowed amount AFTER \$100 deductible* per person per
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters,	allowed amount AFTER \$100
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears)	allowed amount AFTER \$100 deductible* per person per calendar year
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) HOME HEALTHCARE	allowed amount AFTER \$100 deductible* per person per
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) HOME HEALTHCARE Home Healthcare Visits	allowed amount AFTER \$100 deductible* per person per calendar year
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) HOME HEALTHCARE Home Healthcare Visits 200 visits per calendar year	allowed amount AFTER \$100 deductible* per person per calendar year IN-NETWORK No copayment
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) HOME HEALTHCARE Home Healthcare Visits	allowed amount AFTER \$100 deductible* per person per calendar year IN-NETWORK No copayment
Deductible/Copayment (e.g. hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) HOME HEALTHCARE Home Healthcare Visits 200 visits per calendar year	allowed amount AFTER \$100 deductible* per person per calendar year IN-NETWORK No copayment

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