MTA New York City Transit Authority
Effective Date: 01-01-2017
Aetna Choice® POS II – High

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 Home Health Care which is $50 per person per calendar year)
Hospital Deductible	$50 per confinement per person Up to a calendar year maximum of $240 per family.	
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
Preventative Care Physical exams, eye exams, well woman, Immunizations, diagnostic screenings	$15 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 Newborn Nursery Care)	No copayment	Allowance Schedule
Infertility Care	No copayment	Allowance Schedule
Advanced Reproductive Technologies in-Vitro fertilization ZIFT/GIFT/ICIS (3 cycle per lifetime)	No 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	No copayment	No copayment
Emergency Use of Land Ambulance	No copayment	No copayment
Emergency Use of Air Ambulance	No copayment	Same as in-network
MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Unlimited number of medically necessary visits up to 365 days	$50 per confinement per person up to a calendar year maximum of $240 per family	Allowance Schedule
Outpatient Unlimited number of medically necessary visits	$15 copayment	Allowance Schedule
ADDITIONAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Durable Medical Equipment (DME) Prosthetics and Medical Supplies	No copayment **AFTER** $100 deductible per person per calendar year	50% of allowed amount plus any amount billed above the allowed amount
Home Health Care Deductible	No copayment	$50 deductible
Home Health Care Visits **A visit equals up to 4 hours of care**	No Copayment 200 visits per calendar year	25% coinsurance 40 visits per calendar year

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Hospice Care	No copayment	Allowance Schedule
Home Infusion Therapy	No copayment	$100 deductible per person per calendar year- 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
Chemotherapy/Radiation Therapy	No copayment	Allowance Schedule
Kidney Dialysis	No copayment	Allowance Schedule
Ear Coverage Treatment for disease and injury of the ears	No 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