



MTA New York City Transit Authority

Effective Date: 01-01-2017

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 \$3000 Family Per calendar year
Hospital Deductible	\$0	\$1000 Individual \$3000 Per calendar year
Member Coinsurance	Covered 100%	30% of eligible expenses after deductible
Coinsurance Limit	Not applicable	Not applicable
Lifetime Maximum	Unlimited	Unlimited
Maximum Out of Pocket (copayment/coinsurance)	\$1,500 Individual \$3,000 Family Per Calendar year	\$10,000 Individual \$30,000 Family Per Calendar year
PCP/ Referral Requirement	None	None
MEDICAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Preventative Care Physical exams, eye exams, well woman, Immunizations, diagnostic screenings	\$5 copayment	30% of eligible expenses after deductible
Routine Well Child Exams/Immunizations	\$5 Copayment	30% of eligible expenses after 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 room and board)	No Copayment	30% of eligible expenses after deductible
Surgery, Surgical Assistant, Anesthesia, Oxygen	No cost for eligible expenses	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	\$35 copayment	\$35 copayment
Waived if admitted		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	No Copayment	30% of eligible expenses after deductible
Outpatient	\$5 copayment	30% of eligible expenses after deductible
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 eligible expenses after \$100 deductible per year not subject to the plan deductible
Home Health Care Deductible	No cost for eligible expenses	25% of eligible expenses after \$1000 Individual/\$3000 family deductible per calendar year
Home Health Care Visits	No Copayment 200 visits per calendar year	
A visit equals up to 4 hours of care		



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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	\$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
Chiropractic Care	\$5 copayment	30% of eligible expenses after deductible