aetna®

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	30% of eligible expenses after deductible
Emergency Room **Waived if admitted**	$35 copayment	$35 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	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 **A visit equals up to 4 hours of care**	No Copayment 200 visits per calendar year	
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