MTA-NYC Transit: Aetna Open Access® Aetna Select

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs

Coverage for: Employee + Family | **Plan Type:** EPO

⚠ This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.mtabsc.info** or by calling 1-646-376-0123.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, there is a $100 annual deductible on durable medical equipment.	You will pay the first $100 of covered durable medical equipment per year before benefits are payable.
Is there an out-of-pocket limit on my expenses?	No, there is no out-of-pocket limit on your expenses.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	The plan has no out-of-pocket limit.	Not applicable because there is no out-of-pocket limit on your plan..
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan uses network providers. If you use a non-network provider your cost may be more. For a list of network providers, see www.aetnaNYCT.com or call 1-855-824-5349.	If you use a network provider, this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non-network provider for some services. Plans may use the term network, preferred, or participating for providers within their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No, You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5 See your policy or plan document for additional information about excluded services.

Questions: Call toll free 1-855-824-5349 or visit us at **www.aetnaNYCT.com**. If you aren't clear about any of the terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-855-824-5349 to request a copy.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use a Out-of-Network Provider	Limitations & Exceptions
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	No Charge	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Not Covered	None
	Mental/Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you become pregnant	Prenatal and postnatal care	No Charge	Not Covered	None
	Delivery and all inpatient services	No Charge	Not Covered	None
If you have a recovery or other special health need	Home health care	No Charge	Not Covered	200 Visits Benefits limited to per calendar year.
	Rehabilitation services	No Charge	Not Covered	There is a limit of 90 visits per calendar year for Physical, Occupational and Speech Therapy
	Habilitation services	No Charge	Not Covered	Habilitation services subject to/combined with rehabilitation limits
	Skilled nursing care	No Charge	Not Covered	Limited to 100 days per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Out-of-Network Provider	Limitations & Exceptions
	Durable Medical Equipment	$100 Annual Deductible	Not Covered	No dollar limits apply to this benefit.
If your child needs dental or eye care	Hospice service	No Charge	Not Covered	Limited to 210 days per lifetime
	Eye exam	No Charge	Not Covered	1 exam per calendar. year
	Glasses	Covered up to $45	Not Covered	Every 24 months, for a select group of frames at a participating Provider
	Dental Check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for others)

• Cosmetic Surgery	• Hearing Aids • Long-term care	• Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy for other covered services and your costs for these services

Infertility treatment	Routine eye care (adult), may be covered with limitations	Bariatric Surgery

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