aetna®

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

**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 a per person per calendar year $50 Home Health Care and $100 DME deductible) |
| **Hospital Deductible** | $50 per confinement per person Up to a calendar year maximum of $240 per family. | Combined with medical deductible |
| **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** |
| **Preventive 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 routine newborn nursery care) | No copayment | Allowance Schedule |
| **Surgery, Surgical Assistant, Anesthesia, Oxygen** | No copayment | Allowance Schedule |
| **Pre-Admission Testing** | $15 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 | No copayment |
| **MENTAL HEALTH AND ALCOHOL/SUBSTANCE ABUSE SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** (Semi-private room and board) | $50 per confinement per person up to a calendar year maximum of $240 per family | Allowance Schedule |
| **Outpatient** | $15 copayment | Allowance Schedule |
| **DURABLE MEDICAL EQUIPTMENT (DME)** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Deductible, Copayment/Coinsurance** (**e.g.** hospital beds, oxygen, oxygen equipment, wheelchairs, PAP devices and supplies, diabetic pumps and supplies, catheters, artificial arms, legs, eyes, ears) | No copayment. Subject to allowed amount **AFTER** $100 deductible* per person per calendar year | 50% of allowed amount **AFTER** $100 deductible* per person per calendar year plus any amount billed above the allowed amount |
| **HOME HEALTHCARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Home Health Care Deductible** | No copayment | $50 deductible |
| **Home Health Care Visits**<br>One visit equals up to 4 hours of care | No copayment<br>200 visits per calendar year | 25% coinsurance<br>40 visits per calendar year |
| **Home Infusion Therapy** | No copayment | 25% coinsurance |

***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 | OUT-OF-NETWORK |
|---|---|---|
| **Hospice Care** | No copayment | Allowance Schedule |
| **Diagnostic Procedures**<br>**X-rays, Radium and Radionuclide**<br>**MRI/MRA, PET/CAT scans**<br>**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 |
| **Cardiac Rehabilitation** | $15 copayment | Allowance Schedule |
| **Chemotherapy/Radiation Therapy** | No copayment | Allowance Schedule |
| **Kidney Dialysis** | No copayment | Allowance Schedule |
| **Ear Coverage**<br>Treatment for disease and injury of the ears | $15 copayment | Allowance Schedule |
| **Chiropractic Care**<br>Unlimited visits. Pre-certification required after 20th visit | $15 copayment | Allowance Schedule |
| **Podiatric Services**<br>Routine Services, such as removal of corns are not covered | $15 copayment | Allowance Schedule |
| **Family Planning Services**<br>Tubal Ligation and Vasectomy | $15 copayment | Allowance Schedule |
| **Infertility Care** | No copayment | Allowance Schedule |
| **Advanced Reproductive Technologies**<br>in-Vitro fertilization<br>ZIFT/GIFT/ICIS ( 3 cycle per lifetime) | No copayment | Allowance Schedule |