

# Schedule of Benefits

Employer: State of Maryland

ASA: 813929

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Schedule: 1A

Booklet Base: 1

For: Open Access Exclusive Provider Organization (EPO) Aetna Select Medical Plan

## Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Lifetime Maximum Benefit per person</i>	Unlimited	Not applicable

*The coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible to pay any remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.*

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Preventive Care</i>		
<i>Routine Physical Exams</i>		
<i>Office Visits -</i>	100% per visit. No copay applies.	Not Covered
<i>Covered Persons through age 22: Maximum Age &amp; Visit Limits per Plan Year</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b> log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	Not Covered
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Plan Year</i>	1 visit	Not Covered
<i>Covered Persons age 65 and over: Maximum Visits per Plan Year</i>	1 visit	Not Covered.

<b>Preventive Care Immunizations</b> <i>Performed in a facility or <b>physician's</b> office</i>	100% per visit.  No <b>copay</b> applies.	Not Covered
<b>Screening &amp; Counseling Services-Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>	100% per visit.  No <b>copay</b> applies.	Not Covered
<i>Obesity</i> Maximum Visits per Plan Year <i>(This maximum applies only to Covered Persons ages 22 &amp; older.)</i>	26 visits <i>(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*</i>	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Misuse of Alcohol and/or Drugs</i> Maximum Visits per Plan Year	5 visits*	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Use of Tobacco Products</i> Maximum Visits per Plan Year	8 visits*	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<b>Well Woman Preventive Visits</b> <b>Office Visits</b>	100%	Not Covered
Maximum Visits per Plan Year	1 visit	Not Covered
<b>Hearing Exam</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum exams per 36 month period	1 exam	Not Covered
Hearing Supply Maximum per 36 month period (basic model only)	\$5,000	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Routine Cancer Screenings</i></b>		
<b><i>Outpatient</i></b>	100% per visit	Not Covered
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b>, log onto the <b>Actna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i>	Not Covered
<b><i>Prenatal Care Office Visits</i></b>	100% per visit  No <b>copay</b> applies.	Not Covered
<b>Important Note:</b> Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
<b><i>Comprehensive Lactation Support and Counseling Services</i></b>		
<b>Lactation Counseling Services Facility or Office Visits</b>	100% per visit  No <b>copay</b> applies.	Not Covered.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per Plan Year	Not Covered
<b>*Important Note:</b> Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
<b>Breast Pumps &amp; Supplies</b>	100% per item.  No <b>copay</b> applies.	Not Covered
<b><i>Family Planning - Other</i></b>		
Voluntary Termination of Pregnancy Outpatient	100% per visit	Not Covered.
Voluntary Sterilization for Males Outpatient	100% per visit	Not Covered.

<b>Family Planning Services</b>		
Female Contraceptive Counseling Services -Office Visits.	100% per visit	Not Covered.

Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per Plan Year	Not Covered.
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\*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

<b>Family Planning - Female Voluntary Sterilization</b>		
<b>Inpatient</b>	100% per visit	Not Covered
	No copay applies.	
<b>Outpatient</b>	100% per visit	Not Covered
	No copay applies.	

<b>Family Planning Services - Female Contraceptives</b>		
<b>Female Contraceptive Devices</b> (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% except Brand name covered at plan rate or same as office visit when provided in an office.	Not Covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Vision Care</b>		
<b>Eye Examinations</b> (including refraction)  (Up to a maximum of \$45)	100%	Not Covered
Maximum Benefit per Plan Year	1 exam	Not Covered
<b>Vision Supplies</b>	100%	Not Covered
Maximum Benefit per Plan Year consecutive month period for All Vision Supplies		\$200

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Physician Services</i></b>		
<b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non-specialist	\$15 visit <b>copay</b> then the plan pays 100%	Not Covered
<b><i>Specialist Office Visits</i></b>	\$30 visit <b>copay</b> then the plan pays 100%	Not Covered
<b><i>Walk-In Clinics Non-Emergency Visit</i></b>	\$15 visit <b>copay</b> then the plan pays 100%	Not Covered
<b><i>Physician Office Visits - Surgery</i></b>		
<b><i>Physician</i></b>	100% per visit	Not Covered
<b><i>Specialist</i></b>	100% per visit	Not Covered
<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	100% per visit	Not Covered
<b><i>Administration of Anesthesia</i></b>	100%	Not Covered
<b><i>Allergy Injections</i></b>	100% per visit	Not Covered
<b><i>Immunizations (when not part of the physical exam)</i></b> <i>immunizations for travel are excluded</i>	100% per visit	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Emergency Medical Services</b>		
<b>Hospital Emergency Facility and Physician</b>	\$75 <b>copay</b> per visit then the plan pays 100%  \$75 <b>copay</b> per visit then the plan pays 100% for emergency physician services	Paid same as Network benefits  *See Important note below
<p><b>*Important Note:</b> Please note that as these providers are not Network Providers and do not have a contract with <b>Aetna</b>, the provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or <b>physician</b> bills you for an amount above your cost share, you are not responsible for paying that amount. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		

<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$75 <b>copay</b> per visit then the plan pays 50%  \$75 <b>copay</b> per visit then the plan pays 50% for emergency physician services	Not Covered
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**Important Notice:**  
A separate **hospital** emergency room **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

<b>Urgent Care Services</b>		
<b>Urgent Medical Care</b> (at a non-hospital free standing facility)	\$30 <b>copay</b> per visit then the plan pays 100%	Not Applicable
<b>Urgent Medical Care</b> (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Outpatient Diagnostic and Preoperative Testing</b>		
<b>Complex Imaging Services</b>		
<b>Complex Imaging</b> Precert required	100% per test	Not Covered
<b>Diagnostic Laboratory Testing</b>		
	100% per procedure	Not Covered

<b>Diagnostic X-Rays</b>		
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<i>Diagnostic X-Rays (except Complex Imaging Services)</i>	100% per procedure	Not Covered
<b>Outpatient Surgery</b>		
<i>Outpatient Surgery</i>	100% per visit/surgical procedure	Not Covered
<b>Inpatient Facility Expenses</b>		
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<i>Birth Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Hospital Facility Expenses</b>		
Room and Board (including maternity)	100% per admission	Not Covered
Other than Room and Board	100% per admission	Not Covered
<i>Skilled Nursing Inpatient Facility</i>	100%	Not Covered
Maximum Days per Plan Year	180 days	Not Covered
<b>Specialty Benefits</b>		
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<i>Home Health Care(Outpatient)</i>	100% per visit	Not Covered
Maximum Visits per Plan Year	120 visits	Not Covered
<i>Private Duty Nursing (Outpatient)</i>	100% per visit	Not Covered
<b>Hospice Benefits</b>		
<i>Hospice Care –Facility Expenses (Room &amp; Board)</i>	100% per admission	Not Covered
<i>Hospice Care – Other Expenses during a stay</i>	100% per admission	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered

<i>Hospice Outpatient Visits</i>	100% per visit	Not Covered
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Infertility Treatment</i></b>		
<b><i>Basic Infertility Expenses</i></b> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Comprehensive Infertility Expenses</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Artificial Insemination Maximum Benefit	3 attempts per live birth	Not Covered
Invitro Fertilization (IVF) Maximum Benefit	3 attempts per live birth	Not Covered
Maximum per lifetime	\$100,000	Not Covered
<i>Combined Maximum for all Infertility</i>		
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Inpatient Treatment of Mental Disorders</i></b>		
<b><i>Hospital Facility Expenses</i></b>		
Room and Board	100% per admission	Not Covered
Other than Room and Board	100% per admission	Not Covered
Physician Services	100% per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	100% per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	100% per visit	Not Covered
<b><i>Outpatient Treatment Of Mental Disorders</i></b>		
<b><i>Outpatient Services</i></b>	\$15 per visit copay then the plan pays 100%	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Substance Abuse</i></b>		
<b><i>Hospital Facility Expenses</i></b>		
Room and Board	100% per admission	Not Covered
Other than Room and Board	100% per admission	Not Covered
Physician Services	100% per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	100% per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	100% per visit	Not Covered
<b><i>Outpatient Treatment of Substance Abuse</i></b>		
<b><i>Outpatient Services</i></b>	\$15 per visit copay then the plan pays 100%	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Obesity Treatment Non Surgical</i></b>		
<b><i>Outpatient Obesity Treatment (non surgical)</i></b>	100% per visit	Not Covered
<b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b>	100% per admission	Not Covered
<b><i>Outpatient Morbid Obesity Surgery</i></b>	100% per service	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>			
<b><i>Transplant Facility Expenses</i></b>	100% per admission	Not Covered	Not Covered
<b><i>Transplant Physician Services</i></b> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Other Covered Health Expenses</i></b>		
<b><i>Acupuncture</i></b>	100% per visit	Not Covered
<b><i>Ground, Air or Water Ambulance</i></b>	100%	Not Covered
<b><i>Diabetic Equipment, Supplies and Education</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Durable Medical and Surgical Equipment</i></b>	100% per item	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Prosthetic Devices</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Nutritional Support</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Therapies</i></b>		
<b><i>Chemotherapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Infusion Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Radiation Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>		
<b><i>Outpatient Physical, Occupational, and Speech Therapy combined</i></b>	\$30 per visit copay then the plan pays 100%	Not Covered
<b><i>Services Rendered by Chiropractor</i></b>	100%	

<b>Combined Physical, Occupational and Speech Therapy Maximum visits per Plan Year</b>	50 visits	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Spinal Manipulation</i></b>		
	100%	Not Covered

## Expense Provisions

**The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## Copayments and Payment Provisions

### Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

### Payment Provisions

#### Coinsurance

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Coinsurance”. The coinsurance may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

## General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.