

# Schedule of Benefits

**Employer:** State of Maryland

**ASA:** 813929

**Issue Date:** February 17, 2012

**Effective Date:** July 1, 2011

**Schedule:** 1A

**Booklet Base:** 1

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

## Aetna Select Medical Plan

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

*Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, co payments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.*

*All covered expenses are subject to the plan year deductible unless otherwise noted in the schedule below.*

*Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.*

PLAN FEATURES	NETWORK	OUT OF NETWORK
<b>Routine Physical Exams</b> Adults only. Includes coverage for immunizations	100%	Not Covered

Maximum exams per 12 consecutive month period

Adult age 22 to 65	1 exam	Not Covered
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<b>Well Child Exams</b> Includes coverage for immunizations	100%	Not Covered
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Maximum exams

Under age 3

first 12 months of life	7 exams	Not Covered
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13th-24th months of life	3 exams	Not Covered
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25th-36th months of life	3 exams	Not Covered
Maximum exams per 12 months		
For age 3 to 21	1 exam	Not Covered
<b><i>Routine Gynecological Exam</i></b>	100%	Not Covered
Maximum exams per Plan Year	1 exam	Not Covered
<b><i>Hearing Exam</i></b>	\$15 exam <b>copay</b> then the plan pays 100%	Not Covered
Maximum exams per 36 month period	1 exam	Not Covered
Hearing Supply Maximum of \$5,000 per 36 month period <i>(basic model hearing aid)</i>	1 hearing aid per ear	Not Covered
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Routine Cancer Screening</i></b>		
<b><i>Routine Mammography</i></b>	100%	Not Covered
Maximum tests per Plan Year Mammograms may be covered at any age and/or more frequently if recommended by the attending Physician.	1 baseline mammogram for females age 35 through 39  1 test per Plan Year for females age 40 and over	Not Covered
<b><i>Prostate Specific Antigen Test</i></b> For covered males age 40 and over	100% per test	Not Covered
Maximum tests per Plan Year	1 test	Not Covered
<b><i>Routine Digital Rectal Exam</i></b> For covered males age 40 and over	100% per test	Not Covered
Maximum tests per Plan Year	1 test	Not Covered

<b>Routine Pap Smears</b>	100% per test	Not Covered
Maximum tests per Plan Year	1 test	Not Covered
<b>Fecal Occult Blood Test</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Plan Year	1 test	Not Covered
<b>Sigmoidoscopy</b> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
<b>Double Contrast Barium Enema (DCBE)</b> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
<b>Colonoscopy</b> age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 10 consecutive year period	1 test	Not Covered
<b>Family Planning Services</b> <i>*Voluntary Sterilizations and Abortions</i>		
<b>Physician</b>	\$15 per visit <b>copay</b> then the plan pays 100%	Not Covered
<b>Specialist</b>	\$25 per visit <b>copay</b> then the plan pays 100%	Not Covered
	100% for Outpatient Surgery	

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 12 consecutive month period	1 exam	Not Covered
<b>Vision Eyewear</b>	100%	Not Covered
Combined Maximum Benefit per 12 consecutive month period for All Vision Supplies includes frames, lenses, and contacts. \$200 (Does not apply toward the plan's lifetime maximum)		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Physician Services</b>		
<b>Office Visits to Primary Care Physician</b> Office visits (non-surgical) to non-specialist	\$15 visit <b>copay</b> then the plan pays 100%	Not Covered
<b>Specialist Office Visits</b>	\$25 visit <b>copay</b> then the plan pays 100%	Not Covered
<b>Walk-In Clinics Non-Emergency Visit</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Physician Office Visits - Surgery</b>		
<b>Physician</b>	\$15 per visit <b>copay</b> then the plan pays Plan Year	Not Covered
<b>Specialist</b>	\$25 per visit <b>copay</b> then the plan pays 100%	Not Covered
<b>Physician Services for Inpatient Facility and Hospital Visits</b>	100% per visit	Not Covered

<b>Administration of Anesthesia</b>	100%	Not Covered
<b>Allergy Testing and Treatment</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Allergy Injections</b>	100% per visit	Not Covered
<b>Immunizations when not part of the physical exam</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Prenatal Visits</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
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<b>Emergency Medical Services</b>		
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<b>Hospital Emergency Facility</b>	<p>\$50 <b>copay</b> per visit then the plan pays 100%</p> <p>\$50 <b>copay</b> per visit then the plan pays 100% for emergency physician services</p>	<p>Paid same as Network benefits</p> <p><i>*See Important note below</i></p>
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**\*Important Note:** Please note that as these providers are not Network Providers and do not have a contract with **Aetna**, 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 provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

<b>Non-Emergency Care in a Hospital Emergency Room</b>	<p>\$50 copay per visit then the plan pays 50%</p> <p>\$50 <b>copay</b> per visit then the plan pays 50% for emergency physician services</p>	Not Covered
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<b>Urgent Care Services</b>		
<b>Urgent Medical Care</b> <i>(at a non-hospital free standing facility)</i>	\$20 copay per visit then the plan pays 100%	Paid same as Network benefits
<b>Urgent Medical Care</b> <i>(from other than a non-hospital free standing facility)</i>	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.

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Outpatient Diagnostic and Preoperative Testing</b>		
<b>Diagnostic and Preoperative Testing</b> <i>(except complex imaging services)</i>	100% per procedure	Not Covered
<b>Complex Imaging Services</b>		
<b>Complex Imaging</b>	100% per test	Not Covered
<b>Diagnostic Laboratory Testing</b>		
	100% per procedure	Not Covered
<b>Diagnostic X-Rays</b>		
<b>Diagnostic X-Rays (except Complex Imaging Services)</b>	100% per procedure	Not Covered

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Outpatient Surgery</b>		
<b>Outpatient Surgery</b>	100% per visit/surgical procedure	Not Covered

<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Facility Expenses</b>		
<b>Birthing Center</b>	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

<b>Skilled Nursing Inpatient Facility</b>	100% per admission	Not Covered
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Maximum Days per Plan Year	180 days	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b>Specialty Benefits</b>		
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<b>Home Health Care(Outpatient)</b>	100% per visit	Not Covered
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Maximum Visits per Plan Year	120 visits	Not Covered
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<b>Private Duty Nursing (Outpatient)</b>	100% per visit	Not Covered
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<b>Hospice Benefits</b>		
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<b>Hospice Care –Facility Expenses</b> (Room & Board)	100% per admission	Not Covered
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<b>Hospice Care – Other Expenses during a stay</b>	100% per admission	Not Covered
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Maximum Benefit per lifetime	Unlimited days	Not Covered
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<b>Hospice Outpatient Visits</b>	100% per visit	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<b>Infertility Treatment</b>		
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<b>Basic Infertility Expenses</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
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<b>Advanced Reproductive Technology (ART) Expenses</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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Artificial Insemination Maximum Benefit*	3 attempts per live birth*	Not Covered
Ovulation Induction Maximum Benefit*	3 attempts per live birth*	Not Covered
Maximum per lifetime*	\$100,000*	Not Covered
<i>(Combined Maximum for all Infertility)</i>		
*Does not apply toward the plan payment limit.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Mental Disorders</i></b>		
<b><i>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>		
<b><i>Office Visits</i></b>	\$15 per visit <b>copay</b> then the plan pays 100%	Not Covered
<b><i>Other Than Office Visits</i></b>	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
<b><i>Office Visits</i></b>		
<b><i>Other Than Office Visits</i></b>	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 in lieu of anesthesia</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> <i>(including coverage for foot orthotics based on medical necessity)</i>	100% per item	Not Covered
<b><i>Jaw Joint Disorder Treatment</i></b>	100% per visit	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>Outpatient Therapies</b>		
<b>Chemotherapy</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Infusion Therapy</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b>Radiation Therapy</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>Short Term Outpatient Rehabilitation Therapies</b>		
<b>Outpatient Physical, Occupational, and Speech Therapy and Spinal Manipulation</b>	\$25 per visit copay then the plan pays 100%	Not Covered
Services rendered by Chiropractor	100% per visit	Not Covered
Combined Physical, Occupational, and Speech Therapy Maximum visits per Plan Year	50 visits	Not Covered
Services rendered by Chiropractor	Unlimited	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 Benefit Deductible 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

### Payment Percentage

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 Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

### Maximum Benefit Provisions

#### Plan Year **Maximum Benefit**

The most the plan will pay for covered expenses incurred by any one covered person in a Plan Year is called the Plan Year maximum 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.