

Schedule of Benefits

Employer: State of Maryland

ASA: 813929

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Schedule: 3A

Booklet Base: 3

For: Open Access Exclusive Provider Organization (EPO) Aetna Select Medical Plan- State Law Enforcement Labor Alliance (SLEOLA)

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
Routine Physical Exams 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
Well Child Exams Includes coverage for immunizations	100%	Not Covered

Maximum exams		
Under age 3		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	3 exams	Not Covered
25th-36th months of life	3 exams	Not Covered
Maximum exams per 12 months		
For age 3 to 21	1 exam	Not Covered

Routine Gynecological Exam	100%	Not Covered
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Maximum exams per Plan Year	1 exam	Not Covered
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Hearing Exam	\$15 exam copay then the plan pays 100%	Not Covered
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Maximum exams per 36 month period	1 exam	Not Covered
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Hearing Supply Maximum of \$5,000 per 36 month period <i>(basic model hearing aid)</i>	1 hearing aid per ear	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Routine Cancer Screening		
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Routine Mammography	100%	Not Covered
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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
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Prostate Specific Antigen Test For covered males age 40 and over	100% per test	Not Covered
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Maximum tests per Plan Year	1 test	Not Covered
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Routine Digital Rectal Exam For covered males age 40 and over	100% per test	Not Covered
Maximum tests per Plan Year	1 test	Not Covered
Routine Pap Smears	100% per test	Not Covered
Maximum tests per Plan Year	1 test	Not Covered
Fecal Occult Blood Test	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
Sigmoidoscopy 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
Double Contrast Barium Enema (DCBE) 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
Colonoscopy 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

Family Planning Services**Voluntary Sterilizations and Abortions*

Physician	\$15 per visit copay then the plan pays 100%	Not Covered
Specialist	\$25 per visit copay then the plan pays 100%	Not Covered
	100% for Outpatient Surgery	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Vision Care

Eye Examinations (including refraction)	100%	Not Covered
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(Up to a maximum of \$45)

Maximum Benefit per 12 consecutive month period	1 exam	Not Covered
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Vision Eyewear	100%	Not Covered
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Combined Maximum Benefit per 12 consecutive month period for All Vision Supplies includes frames, lenses, and contacts. (Does not apply toward the plan's lifetime maximum) \$200

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Physician Services

Office Visits to Primary Care Physician	\$15 visit copay then the plan pays 100%	Not Covered
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Office visits (non-surgical) to non-specialist

Specialist Office Visits	\$25 visit copay then the plan pays 100%	Not Covered
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Walk-In Clinics Non-Emergency Visit	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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Physician Office Visits - Surgery		
Physician	\$15 per visit copay then the plan pays Plan Year	Not Covered
Specialist	\$25 per visit copay then the plan pays 100%	Not Covered
Physician Services for Inpatient Facility and Hospital Visits		
	100% per visit	Not Covered
Administration of Anesthesia		
	100%	Not Covered
Allergy Testing and Treatment		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Allergy Injections		
	100% per visit	Not Covered
Immunizations when not part of the physical exam		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prenatal Visits		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	\$50 copay per visit then the plan pays 100%	Paid same as Network benefits
	\$50 copay per visit then the plan pays 100% for emergency physician services	<i>*See Important note below</i>

***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.

Non-Emergency Care in a Hospital Emergency Room	\$50 copay per visit then the plan pays 50%	Not Covered
	\$50 copay per visit then the plan pays 50% for emergency physician services	

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$20 copay per visit then the plan pays 100%	Paid same as Network benefits

Urgent Medical Care <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.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		

Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	100% per procedure	Not Covered
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Complex Imaging Services		
Complex Imaging	100% per test	Not Covered

Diagnostic Laboratory Testing		
	100% per procedure	Not Covered

Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	100% per procedure	Not Covered

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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Hospital Facility Expenses</i>		
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% per admission	Not Covered
Maximum Days per Plan Year	180 days	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<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
<i>Hospice Benefits</i>		
<i>Hospice Care –Facility Expenses (Room & 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

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses 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
Advanced Reproductive Technology (ART) Expenses	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
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
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
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
Inpatient Residential Treatment Facility Expenses	100% per admission	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit	Not Covered

Outpatient Treatment Of Mental Disorders

Outpatient Services

Office Visits	\$15 per visit copay then the plan pays 100%	Not Covered
Other Than Office Visits	100%	Not Covered

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Inpatient Treatment of Substance Abuse

Hospital Facility Expenses

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

Inpatient Residential Treatment Facility Expenses	100% per admission	Not Covered
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Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit	Not Covered
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Outpatient Treatment of Substance Abuse

Outpatient Services	\$15 per visit copay then the plan pays 100%	Not Covered
Office Visits		
Other Than Office Visits	100%	Not Covered

PLAN FEATURES

NETWORK

OUT-OF-NETWORK

Obesity Treatment Non Surgical

Outpatient Obesity Treatment (non surgical)	100% per visit	Not Covered
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Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per admission	Not Covered
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Outpatient Morbid Obesity Surgery	100% per service	Not Covered
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered
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PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i>			
<i>Transplant Facility Expenses</i>	100% per admission	Not Covered	Not Covered
<i>Transplant Physician Services</i> (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
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</i>	100% per visit	Not Covered
<i>Ground, Air or Water Ambulance</i>	100%	Not Covered
<i>Diabetic Equipment, Supplies and Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Durable Medical and Surgical Equipment</i> <i>(including coverage for foot orthotics based on medical necessity)</i>	100% per item	Not Covered
<i>Jaw Joint Disorder Treatment</i>	100% per visit	Not Covered

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

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

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

<i>Outpatient Physical, Occupational, and Speech Therapy and Spinal Manipulation</i>	\$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

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.