

Schedule of Benefits

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 ASC: 813929
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For: Aetna Choice POS II- State Law Enforcement Labor Alliance (SLEOLA)

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Plan Year Deductible*		
Individual Deductible*	None	\$250
Family Deductible*	None	\$500

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out- of -Pocket Limit includes plan deductible.

Plan Maximum Out -of -Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit	None	\$3,000
Family Maximum Out of Pocket Limit	None	\$6,000
<i>Lifetime Maximum Benefit per person</i>	Unlimited	Unlimited

Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, copayments, 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
Wellness Benefit		
Routine Physical Exams Adults only.	100% per exam	Not Covered
Includes coverage for immunizations.	100% per visit	80% per visit after Plan Year deductible
Maximum Exams per 12 consecutive month period		
Adults age 22 to 65	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% per exam	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 consecutive month period		
For age 3 to 21	1 exam	Not Covered
Routine Gynecological Exam	100% per exam	80% per exam after Plan Year deductible
Maximum exams per Plan Year	1 exam	1 exam
Hearing Exam	\$15 exam copay then the plan pays 100%	Not Covered

Maximum tests per Plan Year	1 test	Not Covered
Hearing Supply Maximum of \$5,000 per 36 month period <i>(basic model hearing aid)</i>	1 hearing aid per ear	1 hearing aid per ear
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
Routine Mammography	100% per test	80% per test after Plan Year deductible
Mammography (diagnostic benefit)	100% per test	80% per test after Plan Year deductible
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 40 1 test per Plan Year for females age 40 and over	1 baseline mammogram for females age 35 through 39 1 test per Plan Year for females age 40 and over
Prostate Specific Antigen Test For covered males age 40 and over.	100% per test	80% per test after Plan Year deductible
Maximum tests per Plan Year	1 test	1 test
Routine Digital Rectal Exam For covered males age 40 and over.	100% per test	80% per test after Plan Year deductible
Maximum tests per Plan Year	1 test	1 test
Routine Pap Smears	100% per test	80% per test after Plan Year deductible
Maximum tests per Plan Year	1 test	1 test
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Maximum tests per Plan Year	1 test	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 5 consecutive year period	1 test	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum Tests per 10 consecutive year period	1 test	1 test
Family Planning Services <i>*Voluntary Sterilizations and Abortions</i>		
Physician	\$15 per visit copay then the plan pays 100%	80% per visit after Plan Year deductible
Specialist	\$25 per visit copay then the plan pays 100%	80% per visit after Plan Year deductible
	100% for Outpatient Surgery	
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction (Up to a maximum of \$45)	100% per exam	100% per exam No Plan Year deductible applies.
Maximum Benefit per 12 consecutive month period	1 exam	1 exam

Vision Eyewear	100%	100%
		No deductible applies.

Combined Maximum Benefit for 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
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Physician Services		
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Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	\$15 visit copay then the plan pays 100%	80% per visit after Plan Year deductible
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Specialist Office Visits	\$25 visit copay then the plan pays 100%	80% per visit after Plan Year deductible
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Physician Office Visits-Surgery		
Physician	\$15 visit copay then the plan pays 100%	80% per visit after Plan Year deductible
Specialist	\$25 visit copay then the plan pays 100%	80% per visit after Plan Year deductible

Walk-in Clinics Non-Emergency Visit	Payable in accordance with the type of expense incurred and the place where service is provided.	80% per visit after Plan Year deductible
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Physician Services for Inpatient Facility and Hospital Visits	100% per visit	80% per visit after Plan Year deductible
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Administration of Anesthesia	100% per procedure	80% per procedure after Plan Year deductible
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Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Allergy Injections	100% per visit	80% per visit after Plan Year deductible
Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	\$50 copay per visit then the plan pays 100%	\$50 copay per visit then the plan pays 100%
	\$50 copay per visit then the plan pays 100% for emergency physician services	\$50 copay per visit then the plan pays 100% for emergency physician services
		No Plan Year deductible applies.
		See Important Note Below
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 (your deductible and payment percentage), 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 us the bill at the address listed on the back of your member ID card and we 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%	\$50 copay per visit then the plan pays 50%
	\$50 copay per visit then the plan pays 50% for emergency physician services	\$50 copay per visit then the plan pays 50% for emergency physician services
		No Plan Year deductible applies

Important Notice:
A separate **hospital** emergency room **deductible** or **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.

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$20 copay per visit then the plan pays 100%	80% per visit after Plan Year deductible

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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Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	100% per procedure	80% per procedure after Plan Year deductible

Complex Imaging Services		
Complex Imaging	100% per test	80% per test after Plan Year deductible

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per procedure	80% per procedure after Plan Year deductible

Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	100% per procedure	80% per procedure after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per visit/surgical procedure	80% per visit/surgical procedure after Plan Year deductible

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.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Hospital Facility Expenses</i>		
Room and Board (including maternity)	100% per admission	80% per admission after Plan Year deductible
Other than Room and Board	100% per admission	80% per admission after Plan Year deductible
<i>Skilled Nursing Inpatient Facility</i>	100% per admission	80% per admission after Plan Year deductible
Maximum Visits per Plan Year	180 visits	180 visits
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	100% per visit	80% per visit after the Plan Year deductible
Maximum Visits per Plan Year	120 visits	120 visits
<i>Private Duty Nursing (Outpatient)</i>	100% per visit	80% per visit after the Plan Year deductible
<i>Hospice Benefits</i>		
<i>Hospice Care - Facility Expenses (Room & Board)</i>	100% per admission	80% per admission after Plan Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	100% per admission	80% per admission after Plan Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days
<i>Hospice Outpatient Visits</i>	100% per visit	80% per visit after Plan Year deductible

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.	Payable in accordance with the type of expense incurred and the place where service is provided.
Advanced Reproductive Technology (ART) Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit*	3 attempts per live birth*	3 attempts per live birth*
Ovulation Induction Maximum Benefit*	3 attempts per live birth*	3 attempts per live birth*
Maximum per lifetime*	\$100,000*	\$100,000*
<i>(Combined Maximum for all Infertility)</i>		
*Does not apply toward the plan payment limit.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	100% per visit	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per admission	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
<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>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>	100%	100%
<i>Ground, Air or Water Ambulance (non-emergent)</i>	100%	80%
<i>Diabetic Equipment, Supplies and Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Durable Medical and Surgical Equipment</i> (including coverage for foot orthotics based on medical necessity)	100% per item	80% per item after the Plan Year deductible
<i>Jaw Joint Disorder Treatment</i>	100% per visit	80% per visit after Plan Year deductible
<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.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Prosthetic Devices</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Nutritional Support	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		

Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		

Outpatient Physical, Occupational and Speech Therapy combined and Spinal Manipulation	\$25 per visit copay then the plan pays 100%	80% per visit after Plan Year deductible
Services rendered by Chiropractor	100% per visit	80% per visit after Plan Year deductible

Combined Physical, Occupational and Speech Therapy Maximum visits per Plan Year	50 visits	50 visits
Services rendered by Chiropractor	Unlimited	Unlimited

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.

Deductible Provisions

Out-of-Network Plan Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Plan Year for which no benefits will be paid. The **out-of-network Plan Year deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network Plan Year deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Plan Year.

Out-of-Network Family Deductible Limit

When you incur **out-of-network covered expenses** that apply toward the **out-of-network Plan Year deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network Plan Year family deductible limit**. Your **out-of-network family deductible limit** will be considered to be met for the rest of the Plan Year once the combined **covered expenses** reach the **out-of-network family deductible limit** in a Plan Year.

Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Plan Year that apply toward that year's **out-of-network Plan Year deductible** will also count toward the following year's **out-of-network Plan Year deductible**.

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 Out-of-Pocket

The **Maximum Out-of-Pocket** is the maximum amount you are responsible to pay for **covered expenses** during the Plan Year. Once you satisfy the **Maximum Out-of-Pocket**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Plan Year. The limit applies to both **network** and **out-of-network** benefits.

This plan has an Individual and Family **Maximum Out-of-Pocket**. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

Once the amount of eligible expenses you have paid during the Plan Year meet the Individual **Maximum Out-of-Pocket** the plan will pay 100% of **covered expenses** for that person for the remainder of the Plan Year.

The Family **Maximum Out-of-Pocket** can be met with a combination of family members or by any single individual within the family. When this limit is reached, your plan will pay 100% of the family's **covered expenses** for the rest of the Plan Year.

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.

The Plan Year maximum benefit applies to **network care** and **out-of-network care** expenses combined.

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.