

Schedule of Benefits

Employer: State of Maryland
 ASA: 813929
 Issue Date: June 14, 2013
 Effective Date: July 1, 2013
 Schedule: 4A
 Booklet Base: 4

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	\$125
Family Deductible*	None	\$250

*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:

- For out-of-network expenses: 1,500.

Family Maximum Out of Pocket Limit:

- For out-of-network expenses: \$3,000.

<i>Lifetime Maximum Benefit per person</i>	Unlimited	Unlimited
--------------------------------------------	-----------	-----------

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining coinsurance. 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
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% per visit No copay or deductible applies.	Not Covered
<i>Covered Persons through age 22: Maximum Age & Visit Limits</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 physician log onto the Aetna website www.aetna.com, 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.
Preventive Care Immunizations <i>Performed in a facility or physician's office</i>	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% per visit No copay or deductible applies.	No Coverage
<i>Obesity Maximum Visits per plan year (This maximum applies only to Covered Persons ages 22 & 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>)*]	No coverage
<i>Misuse of Alcohol and/or Drugs Maximum Visits per plan year</i>	5 visits*	No Coverage
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
<i>Use of Tobacco Products Maximum Visits per plan year</i>	8 visits*	No Coverage

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Well Woman Preventive Visits Office Visits	100% per visit No copay or deductible applies.	80% per visit No Plan Year deductible applies.
Well Woman Preventive Visits Maximum Visits per Plan Year	1 visit	1 visit
Hearing Exam	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum exams per 24 month period	1 exam	Not Covered
Hearing Supply Maximum per 36 month period (Basic model hearing aids only)	\$5,000	\$5,000 1 hearing aid per ear up to the dollar maximum for dependent children under age 19.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings		
All Other Routine Exams and Screenings	100% per visit No copay or deductible applies.	80% per visit No Plan Year deductible applies.
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 physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>	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 physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.</i>

***Prenatal Care
Office Visits***

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible.

Important Note: 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.

Comprehensive Lactation Support and Counseling Services

**Lactation Counseling Services
Facility or Office Visits**

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

Lactation Counseling Services
Maximum Visits either in a group or
individual setting

6* visits per **plan year**

Covered same as office visit

***Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

Breast Pumps & Supplies

100% per item.
No **copay** or **deductible** applies.

80% per item after Plan Year
deductible

Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.

Family Planning Services

Female Contraceptive Counseling
Services -Office Visits.

100% per visit.
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

**Contraceptive Counseling
Services - Maximum Visits either
in a group or individual setting**

2* visits per **plan year**

covered same as office visit

***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*.

Family Planning - Other

Voluntary Termination of Pregnancy

Outpatient

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

Voluntary Sterilization for Males

Outpatient

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

Family Planning - Female Voluntary Sterilization

Inpatient

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

Outpatient

100% per visit
No **copay** or **deductible** applies.

80% per visit after Plan Year
deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Family Planning Services - Female Contraceptives		
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% No copay or deductible applies except Brand name covered at plan rate or same as office visit when provided in an office.	80% after Plan Year deductible .

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction (Up to a maximum of \$45)	100% per exam No copay or deductible applies.	100% per exam No Plan Year deductible applies
Maximum Benefit per Plan Year	1 exam	1 exam

Vision Supplies	100% No copay or deductible applies.	100% No Plan Year deductible applies.
------------------------	-------------------------------------------------------	-------------------------------------------------

Maximum Benefit for All Vision Supplies per plan year. \$200

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	\$15 visit copay then the plan pays 100% No deductible applies.	80% per visit after Plan Year deductible

Specialist Office Visits	\$25 visit copay then the plan pays 100% No deductible applies.	80% per visit after Plan Year deductible
---------------------------------	--------------------------------------------------------------------------------------	-------------------------------------------------

Physician Office Visits-Surgery		
Physician	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible
Specialist	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible

Walk-In Clinics Non-Emergency Visit	\$15 visit copay then the plan pays 100%	80% per visit after Plan Year deductible
	No deductible applies.	Routine services are excluded
Physician Services for Inpatient Facility and Hospital Visits	100% per visit	80% per visit after Plan Year deductible
	No copay or deductible applies.	
Administration of Anesthesia	100% per procedure	80% per procedure after Plan Year deductible
	No copay or deductible applies.	
Immunizations (when not part of the physical exam) <i>immunizations for travel are excluded</i>	100% per visit	80% per visit after Plan Year deductible
	No copay or deductible applies.	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	\$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 deductible applies.	No deductible applies.
		<i>See Important Note Below</i>
<p>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 coinsurance), 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 physician 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.</p>		

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 deductible applies.	No 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.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

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
	No deductible applies.	

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.
----------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------	---------------------------------------------------------------------------------

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****Complex Imaging Services**

Complex Imaging Precert is required	100% per test No copay or deductible applies.	80% per test after Plan Year deductible
-----------------------------------------------	----------------------------------------------------------------	------------------------------------------------

Diagnostic Laboratory Testing

Diagnostic Laboratory Testing	100% per procedure No copay or deductible applies.	80% per procedure after Plan Year deductible
When performed in the physician's office	100% per procedure No copay or deductible applies.	80% per procedure after Plan Year deductible

Diagnostic X-Rays (except Complex Imaging Services)

Diagnostic X-Rays	100% per procedure No copay or deductible applies.	80% per procedure after Plan Year deductible
When performed in the physician's office	100% per procedure No copay or deductible applies.	80% per procedure after Plan Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Outpatient Surgery</i>	100% per visit/surgical procedure No copay or deductible applies.	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 No copay or deductible applies.	80% per admission after Plan Year deductible
Other than Room and Board	100% per admission No copay or deductible applies.	80% per admission after Plan Year deductible

<i>Skilled Nursing Inpatient Facility</i>	100% per admission No copay or deductible applies.	80% per admission after Plan Year deductible
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------

Maximum Days per Plan Year	180 days	180 days
----------------------------	----------	----------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	100% per visit No copay or deductible applies.	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 No copay or deductible applies.	80% per visit after the Plan Year deductible
-------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------------------

<i>Hospice Benefits</i>		
<i>Hospice Care - Facility Expenses (Room & Board)</i>	100% per admission No copay or deductible applies.	80% per admission after Plan Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	100% per admission No copay or deductible applies.	80% per admission after Plan Year deductible

Maximum Benefit per lifetime	Unlimited days	Unlimited days
------------------------------	----------------	----------------

<i>Hospice Outpatient Visits</i>	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible
----------------------------------	-----------------------------------------------------------------	-------------------------------------------------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
---------------	---------	----------------

<i>Infertility Treatment</i>		
------------------------------	--	--

<i>Basic Infertility Expenses</i> 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.
----------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

<i>Comprehensive Infertility Expenses</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.
-------------------------------------------	--------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------

Artificial Insemination Maximum Benefit	3 attempts per live birth	3 attempts per live birth	3 attempts per live birth
In vitro Fertilization (IVF) Maximum Benefit	3 attempts per live birth	3 attempts per live birth	3 attempts per live birth
Maximum per lifetime	\$100,000	\$100,000	

The Comprehensive Infertility services maximum per lifetime amounts shown above will not be used to satisfy the plan **Maximum Out of Pocket Limit**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
---------------	---------	----------------

<i>Obesity Treatment Non Surgical</i>		
---------------------------------------	--	--

<i>Outpatient Obesity Treatment (non surgical)</i>	100% per visit No copay or deductible applies.	Not Covered
----------------------------------------------------	-----------------------------------------------------------------	-------------

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
---------------	---------	----------------

<i>Obesity Treatment Surgical</i>		
-----------------------------------	--	--

<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	100% per admission No copay or deductible applies.	Not Covered
---------------------------------------------------------------------------------------------------	---------------------------------------------------------------------	-------------

<i>Outpatient Morbid Obesity Surgery</i>	100% per service No copay or deductible applies.	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 No copay or deductible applies.	80% per admission after Plan Year deductible	80% per admission No Plan Year deductible applies
<i>Transplant Physician Services</i> (including office 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	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture</i>	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible
<i>Ground, Air or Water Ambulance</i>	100% No copay or deductible applies.	100%
<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>	100% per item No copay or deductible applies.	80% per item after the 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.
<i>Nutritional Support</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.

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.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</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>Radiation Therapy</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.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	\$25 per visit copay then the plan pays 100% No deductible applies.	80% per visit after Plan Year deductible
Combined Physical, Occupational and Speech Therapy Maximum visits per Plan Year	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Spinal Manipulation</i>		
	100% per visit No copay or deductible applies.	80% per visit after Plan Year deductible

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

Covered expenses applied to the **out-of-network provider deductibles** will not be applied to satisfy the **network provider deductibles**. Covered expenses applied to the **network provider deductibles** will not be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Plan Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Plan Year **deductibles**.

Out-of-Network Provider Plan Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Plan Year from an **out-of-network provider** for which no benefits will be paid. This individual Plan Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Plan Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Plan Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Plan Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Plan Year **deductibles** must reach this family **deductible** limit in a Plan Year.

When this occurs in a Plan Year, the individual Plan Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the 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 Plan Year **deductibles** for **network providers** or **out-of-network** providers will also count toward the following year's **network providers** or **out-of-network** providers **deductibles**.

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

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". 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 coinsurance may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Maximum Out of Pocket Limit

The **Maximum Out of Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Plan Year. This Plan has an individual **Maximum Out of Pocket Limit**. As to the individual **Maximum Out of Pocket Limit**, each of you must meet your **Maximum Out of Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out of Pocket Limit**. See list below.

Out-of-Network Provider Maximum Out of Pocket Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Plan Year meets the individual **Maximum Out of Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Plan Year for that person.

Family Maximum Out of Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **out-of-network provider Maximum Out of Pocket Limit**, these expenses will also count toward a family **out-of-network provider Maximum Out of Pocket Limit**.

To satisfy this family **out-of-network provider Maximum Out of Pocket Limit** for the rest of the Plan Year, the following must happen:

Two family members have individually satisfied their individual **out-of-network provider Maximum Out of Pocket Limit** in a Plan Year. Once these family members have each satisfied their individual **out-of-network provider Maximum Out of Pocket Limit**, the individual **out-of-network provider Maximum Out of Pocket Limit** is considered met for the remaining family members for the rest of the Plan Year.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.