

PPO K-Split

PPO C

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General Information

Cost Sharing Expenses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Deductible - Single	\$0	\$1,000		\$500	\$500		\$2,000	\$2,000	
Deductible - Family	\$0	\$3,000		\$1,500	\$1,500		\$6,000	\$6,000	
Coinsurance	0%	30%		20%	30%		20%	40%	
Annual Out of Pocket Maximum - Single	\$4,600	\$4,600		\$4,600	\$4,600		\$4,600	\$4,600	
Annual Out of Pocket Maximum - Family	\$9,200	\$9,200		\$9,200	\$9,200		\$9,200	\$9,200	
Annual Out of Pocket Maximum - Per Person Cap	N/A	N/A		N/A	N/A		N/A	N/A	

Office Visit Cost Shares

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cost Share - Primary Care	\$25 Copayment	30% Coinsurance Subject to Deductible		\$15 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Specialist	\$40 Copayment	30% Coinsurance Subject to Deductible		\$15 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	\$25 Copayment	30% Coinsurance Subject to Deductible		\$15 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	

Plan Limits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Plan/Calendar Year			Plan Year Benefits			Plan Year Benefits			Plan Year Benefits
Diabetic Preauthorization and Step Therapy			No			No			No

Who is Covered

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Domestic Partner Coverage			Not Covered			Not Covered			Not Covered

Inpatient Services

Inpatient Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Services	\$250 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	\$250 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Substance Use Detoxification	\$250 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Skilled Nursing Facility	\$250 Copayment	30% Coinsurance Subject to Deductible	120 Days per year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	120 Days per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	120 Days per year
Physical Rehabilitation	\$250 Copayment	30% Coinsurance Subject to Deductible	60	Covered in Full	30% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	40% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	\$250 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Inpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Inpatient Hospital Surgery	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Outpatient Facility Services

Outpatient Facility Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
SurgiCenters and Freestanding Ambulatory Centers Surgical Care	\$100 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Diagnostic X-ray	\$40 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive or Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	\$40 Copayment	30% Coinsurance Subject to Deductible		\$15 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	
Substance Use Care	\$40 Copayment	30% Coinsurance Subject to Deductible		\$15 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	

Home and Hospice Care

Home Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Home Care	Covered in Full	25% Coinsurance Subject to \$50 Deductible		20% Coinsurance Subject to \$50 Deductible	25% Coinsurance Subject to \$50 Deductible		20% Coinsurance Subject to \$50 Deductible	25% Coinsurance Subject to \$50 Deductible	

Hospice Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Hospice Care Inpatient	Covered in Full	30% Coinsurance Subject to Deductible		20% Coinsurance	30% Coinsurance		20% Coinsurance	40% Coinsurance	

Outpatient and Office Professional Services

Professional Services

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Office Surgery	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - \$40 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Infusion Therapy	PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service		PCP / Specialist - Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - \$40 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Chiropractic Care	Specialist - \$40 Copayment PCP - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - \$40 Copayment PCP - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Rehab and Habilitation

Outpatient Facility

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	\$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	\$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	\$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year

Outpatient Professional Services

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Physical Rehabilitation	PCP / Specialist - \$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Occupational Rehabilitation	PCP / Specialist - \$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year
Speech Rehabilitation	PCP / Specialist - \$40 Copayment	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible	45 Visits per year	PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	45 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible	1 Exam per year	PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	1 Exam per year
Adult Immunizations	PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered		PCP / Specialist - Covered in Full	Not Covered	
Well Child Visits and Immunizations	PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full		PCP / Specialist - Covered in Full	Covered in Full	
Routine GYN Visit	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	

Preventive Facility Services Meeting Federal Guidelines*

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Cervical Cytology Preventative	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Professional

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prostate Cancer Screening	Specialist - \$40 Copayment PCP - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	40% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Bone Density Screening Professional	Specialist - \$40 Copayment PCP - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Preventive services in addition to those required under Federal Guidelines - Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Mammography Screening Facility	Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	30% Coinsurance Subject to Deductible		Covered in Full	40% Coinsurance Subject to Deductible	

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Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Colonoscopy Screening Facility	\$100 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Bone Density Screening Facility	\$40 Copayment	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	

Other Benefits

Additional Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Treatment of Diabetes Insulin and Supplies	PCP / Specialist - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - \$25 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$15 Copayment	30% Coinsurance Subject to Deductible		PCP / Specialist - \$30 Copayment	40% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Medical Supplies	PCP / Specialist - 20% Coinsurance	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	30% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance Subject to Deductible	40% Coinsurance Subject to Deductible	
Acupuncture	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Private Duty Nursing	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered

Emergency Services

ER Facility

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Facility Emergency Room Visit	\$250 Copayment	\$250 Copayment		\$150 Copayment	\$150 Copayment		\$150 Copayment	\$150 Copayment	

Transportation

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Prehospital Emergency and Transportation - Ground or Water	\$40 Copayment	\$40 Copayment		\$50 Copayment	\$50 Copayment		\$50 Copayment	\$50 Copayment	

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Urgent Care

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Urgent Care Center Facility Visit	\$25 Copayment	30% Coinsurance Subject to Deductible		\$25 Copayment	30% Coinsurance Subject to Deductible		\$30 Copayment	40% Coinsurance Subject to Deductible	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Adult Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Adult Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Eye Exams - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Eyewear - Routine	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Rx Benefits

Rx Plan

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Rx Plan			DRUG COVERAGE EXCLUDED			DRUG COVERAGE EXCLUDED			DRUG COVERAGE EXCLUDED

Rx Benefits

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Days Supply Per Retail Order	30			30			30		
Days Supply Per Mail Order	90			90			90		
Copays Per Mail Order Supply	N/A			N/A			N/A		

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This document is not a contract. It is only intended to highlight the coverage of this program. Benefits are determined by the terms of the contract. Any inconsistencies between this document and the contract shall be resolved in favor of the contract in effect at the time services are rendered. All benefits are subject to medical necessity. All day and visit limits are combined limits for both in and out of network benefits. * For non-grandfathered groups, Preventive Services coverage required by the Patient Protection and Affordable Care Act are not quoted herein. Please refer to the United States Preventive Services Task Force list of items and services rated "A" or "B" that are covered pursuant to the Patient Protection and Affordable Care Act requirements.