Excellus

RASHP II

Benefit Comparison
Benefit Time Period 01/01/2024 - 12/31/2024

General Information

Cost Sharing Expenses

Benefit Name	Extended In Network	Extended Out of Network	Extended Limits	Select In Network	Select Out of Network	Select Limits	Value In Network	Value Out of Network	Value Limits
Deductible - Single	$0	$250		$0	$500		$0	$750	
Deductible - Family	$0	$750		$0	$1,500		$0	$2,250	
Coinsurance	0%	20%		0%	20%		0%	20%	
Annual Out of Pocket Maximum - Single	$4,200	$4,200		$4,200	$4,200		$4,200	$4,200	
Annual Out of Pocket Maximum - Family	$12,600	$12,600		$12,600	$12,600		$12,600	$12,600	
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	Extended In Network	Extended Out of Network	Extended Limits	Select In Network	Select Out of Network	Select Limits	Value In Network	Value Out of Network	Value Limits
Cost Share - Primary Care	$5 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Specialist	$10 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Cost Share - Sick Kids	N/A	N/A		$5 Copayment	20% Coinsurance Subject to Deductible		N/A	N/A Subject to Deductible	

Plan Limits

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

Who is Covered

	Extended			Select			Value		
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	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$100 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$100 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Detoxification	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$100 Copayment	20% Coinsurance Subject to Deductible	
Skilled Nursing Facility	Covered in Full	20% Coinsurance Subject to Deductible	120 Days per year	Covered in Full	20% Coinsurance Subject to Deductible	120 Days per year	$100 Copayment	20% Coinsurance Subject to Deductible	120 Days per year
Physical Rehabilitation	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year	Covered in Full	20% Coinsurance Subject to Deductible	60 Days per year	$100 Copayment	20% Coinsurance Subject to Deductible	60 Days per year
Maternity Care	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$100 Copayment	20% 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	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Anesthesia	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% 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	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$50 Copayment	20% Coinsurance Subject to Deductible	

	Extended			Select			Value		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Diagnostic X-ray	$10 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	Covered in Full	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Infusion Therapy	Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service		Inclusive of Primary Service	Inclusive of Primary Service	
Dialysis	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	$5 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% Coinsurance Subject to Deductible	
Substance Use Care	$5 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% 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	20% Coinsurance Subject to $50 Deductible		Covered in Full	20% Coinsurance Subject to $50 Deductible		Covered in Full	20% Coinsurance Subject to $50 Deductible	
Home Infusion Therapy	Covered in Full	20% Coinsurance Subject to $50 Deductible		Covered in Full	20% Coinsurance Subject to $50 Deductible		Covered in Full	20% 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	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	

Outpatient and Office Professional Services

Professional Services

	Extended			Select			Value		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Office Surgery	Specialist - $10 Copayment PCP - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic X-ray	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diagnostic Laboratory and Pathology	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Radiation Therapy	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Chemotherapy	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% 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	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Mental Health Care	PCP / Specialist - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Maternity Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - 20% Coinsurance	20% Coinsurance Subject to Deductible	
Telehealth	Specialist - $10 Copayment PCP - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
TeleMedicine Program	PCP / Specialist - $5 Copayment	Not Covered		PCP / Specialist - $10 Copayment	Not Covered		PCP / Specialist - $10 Copayment	Not Covered	
Chiropractic Care	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Allergy Testing	Specialist - $10 Copayment PCP - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Allergy Treatment Including Serum	Specialist - $10 Copayment PCP - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Hearing Evaluations Routine	PCP / Specialist - $10 Copayment	Not Covered	1 Exam per calendar year	PCP / Specialist - $15 Copayment	Not Covered	1 Exam per calendar year	PCP / Specialist - $20 Copayment	Not Covered	1 Exam per calendar year

Rehab and Habilitation

Outpatient Facility

Benefit Name	Extended In Network	Extended Out of Network	Extended Limits	Select In Network	Select Out of Network	Select Limits	Value In Network	Value Out of Network	Value Limits
Physical Rehabilitation	$10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Occupational Rehabilitation	$10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	$10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	$20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year

Outpatient Professional Services

Benefit Name	Extended In Network	Extended Out of Network	Extended Limits	Select In Network	Select Out of Network	Select Limits	Value In Network	Value Out of Network	Value Limits
Physical Rehabilitation	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Occupational Rehabilitation	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year
Speech Rehabilitation	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year	PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	30 Visits per year

Preventive Services

Preventive Professional Services Meeting Federal Guidelines*

Benefit Name	Extended In Network	Extended Out of Network	Extended Limits	Select In Network	Select Out of Network	Select Limits	Value In Network	Value Out of Network	Value Limits
Adult Physical Examination	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	1 Exam per year	PCP / Specialist - Covered in Full	Not Covered	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	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Routine GYN Visit	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year
Pre/Post-Natal Care	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	

	Extended			Select			Value		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% 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	20% Coinsurance Subject to Deductible	2 Exams per year	Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year	Covered in Full	20% Coinsurance Subject to Deductible	2 Exams per year
Mammography Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% 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 - $10 Copayment PCP - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Mammography Screening Professional	PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible		PCP / Specialist - Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Professional	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Professional	PCP / Specialist - $10 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	

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

	Extended			Select			Value		
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	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible	
Colonoscopy Screening Facility	Covered in Full	20% Coinsurance Subject to Deductible		Covered in Full	20% Coinsurance Subject to Deductible		$50 Copayment	20% Coinsurance Subject to Deductible	
Bone Density Screening Facility	$10 Copayment	20% Coinsurance Subject to Deductible		$15 Copayment	20% Coinsurance Subject to Deductible		$20 Copayment	20% 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 - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Diabetic Equipment	PCP / Specialist - $5 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $15 Copayment	20% Coinsurance Subject to Deductible		PCP / Specialist - $20 Copayment	20% Coinsurance Subject to Deductible	
Durable Medical Equipment (DME)	PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 20% Coinsurance	Not Covered		PCP / Specialist - 20% Coinsurance	Not Covered	
Medical Supplies	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered	PCP / Specialist - Not Covered	Not Covered	Not Covered
Acupuncture	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year	PCP / Specialist - 50% Coinsurance	50% Coinsurance Subject to Deductible	10 Visits per year
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

Diagnoses

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Reimbursement for Travel and Lodging Expenses	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

	Extended			Select			Value		
Benefit Name	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**	**In Network**	**Out of Network**	**Limits**
Facility Emergency Room Visit	$50 Copayment	$50 Copayment		$50 Copayment	$50 Copayment		$50 Copayment	$50 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	$25 Copayment	$25 Copayment		$25 Copayment	$25 Copayment		$50 Copayment	$50 Copayment	

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	$25 Copayment		$25 Copayment	$25 Copayment		$25 Copayment	$25 Copayment	

Ancillary Benefits

Vision

Benefit Name	In Network	Out of Network	Limits	In Network	Out of Network	Limits	In Network	Out of Network	Limits
Pediatric Eye Exams - Routine	$10 Copayment	Not Covered	1 Exam per calendar year	$15 Copayment	Not Covered	1 Exam per calendar year	$20 Copayment	Not Covered	1 Exam per calendar year
Pediatric Eyewear - Routine	20% Coinsurance	Not Covered	1 Pair per calendar year	20% Coinsurance	Not Covered	1 Pair per calendar year	20% Coinsurance	Not Covered	1 Pair per calendar year
Adult Eye Exams - Routine	$10 Copayment	Not Covered	1 Exam every 2 calendar years	$15 Copayment	Not Covered	1 Exam every 2 calendar years	$20 Copayment	Not Covered	1 Exam every 2 calendar years
Adult Eyewear - Routine	Covered	Not Covered	$60 Reimbursement every 2 calendar years	Covered	Not Covered	$60 Reimbursement every 2 calendar years	Covered	Not Covered	$60 Reimbursement every 2 calendar years

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			$5/$15/$30			$5/$20/$35			$10/$25/$40

Rx Benefits

	Extended			Select			Value		
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	3			3			3		
	2092079 - 1			2092080 - 1			2092081 - 1		

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 (USPSTF) list of items and services rated "A" or "B", the guidelines supported by the Health Resources and Services Administration (HRSA) and the list of immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) for a complete list of services that are covered pursuant to the Patient Protection and Affordable Care Act requirements.