	ABC+ Choice	ABC+ Share	ABC+ Advantage 3	ABC+ Advantage 6	ABC+ Advantage 9
DEDUCTIBLE & OUT OF POCKET FOR IN NETWORK SERVICES					
Deductible	$0	$0	$0	$0	$0
Out of Pocket Maximum	$0	$0	$0	$0	$0
PREVENTIVE & WELLNESS SERVICES Some services are subject to age and other limitations. Not covered if services are provided at a hospital. Participating Providers (In Network)	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)	$0 Copay (Plan pays 100% of covered preventive and wellness services)
PRIMARY CARE OFFICE VISIT Not covered if services are provided at a hospital. Participating Providers (In Network)	Not Covered	$25 Copay	$25 Copay Combined limit of 3 visits per plan year with Specialist Office Visits.	$25 Copay Combined limit of 6 visits per plan year with Specialist Office Visits.	$25 Copay Combined limit of 9 visits per plan year with Specialist Office Visits.
SPECIALIST OFFICE VISIT Not covered if services are provided at a hospital. Participating Providers (In Network)	Not Covered	Not Covered	$50 Copay Combined limit of 3 visits per plan year with Primary Care Office Visit.	$50 Copay Combined limit of 6 visits per plan year with Primary Care Office Visit.	$50 Copay Combined limit of 9 visits per plan year with Primary Care Office Visit.
OUTPATIENT SERVICES (Limited to Mental & Behavioral Health or Substance Abuse) Not covered if services are provided at a hospital. Considered a Specialist Visit. Partial hospitalization is not covered. Participating Providers (In Network)	Not Covered	Not Covered	$50 Copay	$50 Copay	$50 Copay
SUPPLEMENTAL HOSPITAL BENEFIT	Not Covered	$5,000 Limited to $1,000 per day; maximum of 5 days of hospitalization per calendar year.	$5,000 Limited to $1,000 per day; maximum of 5 days of hospitalization per calendar year.	$10,000 Limited to $1,000 per day; maximum of 10 days of hospitalization per calendar year.	$15,000 Limited to $1,000 per day; maximum of 15 days of hospitalization per calendar year.
PHARMACY BENEFITS (Subject to Formulary) Limited to the preventive drugs outlined by the Patient Protection & Affordable Care Act	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)	Generic - $0 Copay (Limited to Preventive Generic)

PLEASE NOTE:

Out of Network services, and services provided at a hospital, will not be covered, unless otherwise specified.

Refer to the schedule of benefits for a more in-depth list of Benefits Coverage, Limitations and Exclusions. If this differs from the Schedule of Benefits, the Schedule of Benefits will govern.