	ABC Advantage 3
DEDUCTIBLE & OUT OF POCKET FOR IN NETWORK SERVICES	
Deductible (Individual | Family)	$0
Out of Pocket Maximum (Individual | Family)	$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)
PRIMARY CARE OFFICE VISIT Not covered if services are provided at a hospital. Combined limit of 3 visits per plan year with Specialist Office Visits.	
Participating Providers (In Network)	$25 Copay
SPECIALIST OFFICE VISIT Not covered if services are provided at a hospital. Combined limit of 3 visits per plan year with Primary Care Office Visit.	
Participating Providers (In Network)	$50 Copay
OUTPATIENT SERVICES (Limited to Mental & Behavioral Health or Substance Abuse) Not covered if services are provided at a hospital. Considered a Specialist Visit. Combined limit of 3 visits per plan year with Primary Care Office Visit. Partial hospitalization is not covered.	
Participating Providers (In Network)	$50 Copay
PHARMACY BENEFITS (Subject to Formulary) Limited to the preventive drugs outlined by the Patient Protection & Affordable Care Act	
Preventive Prescription Services	Generic - $0 Copay (Limited to Preventive Generic)
SUPPLEMENTAL HOSPITAL BENEFIT Limited to $1,000 per day; maximum of 5 days per calendar year. Neonatal Intensive Care (NICU) not covered. Pre-existing conditions within past twelve months excluded.	
Hospitalization (Room and Board) Including MHSA (Mental Health and Substance Abuse)	$5,000 Supplemental Hospital Benefit

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 document differs from the Schedule of Benefits, the Schedule of Benefits will govern.