Wellpoint

Plan Benefits – PLUS

Effective July 1, 2025

Summary of PLUS plan benefits

This summary shows the PLUS plan benefits for many medical and behavioral health services. For a complete and detailed description of benefits and Plan provisions, see your member handbook.

- **Deductibles** – The **PLUS deductible,** which applies to services from contracted providers, is $500 for one person or $1,000 for a family each plan year. The separate **non-PLUS deductible** of $500 for one person – or $1,000 for a family – applies to services from non-contracted providers.
- **Out-of-pocket cost limits** – The **PLUS out-of-pocket maximum** ($5,000 for one person and $10,000 for a family) limits your costs for services with contracted providers. The separate **non-PLUS out-of-pocket maximum** ($5,000 and $10,000) limits your costs with non- contracted providers.
- **Allowed amounts** – All benefits shown in this summary are limited to Wellpoint's allowed amounts. The allowed amount is the most that Wellpoint pays for a covered service.
- **Preapprovals** – Services marked with a ☎ phone symbol need to be preapproved.

Benefits for medical care under PLUS

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ Ambulances	PLUS deductible	PLUS deductible
Anesthesia	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Bereavement counseling	PLUS deductible and 20% coinsurance *(limited to $1,500 for a family in a plan year)*	Non-PLUS deductible and 20% coinsurance *(limited to $1,500 for a family a plan year)*
Cardiac rehab programs	$20 copay	Non-PLUS deductible and 20% coinsurance
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chiropractic care	$20 copay *(limited to 20 visits in a plan year)*	Non-PLUS deductible and 20% coinsurance (*limited to 20 visits in a plan year)*
Diabetic supplies	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Dialysis	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Doctor visits		
▪ PCP visits	$10/20/40 copay	Non-PLUS deductible and 20% coinsurance
▪ Specialist visits	$30/60/75 copay	Non-PLUS deductible and 20% coinsurance
▪ Virtual care (telehealth)	$10 copay	Non-PLUS deductible and 20% coinsurance
Doctors – other services		
▪ At an emergency room	PLUS deductible	PLUS deductible
▪ Inpatient hospital care	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital care	$30/60/75 copay	Non-PLUS deductible and 20% coinsurance
Drug screening (lab tests)	PLUS deductible	Non-PLUS deductible and 20% coinsurance

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ **Durable medical equipment (DME)**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Early intervention programs	No member costs	No member costs
Emergency room visits	$100 copay and PLUS deductible	$100 copay and PLUS deductible
☎ **Enteral therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Eye exams (routine)	$30/60/75 copay *(limited to one exam every 24 months)*	Non-PLUS deductible and 20% coinsurance *(limited to one exam every 24 months)*
Eyeglasses and contact lenses	PLUS deductible *(limited to the first lenses within six months after eye injury or cataract surgery)*	PLUS deductible *(limited to the first lenses within six months after eye injury or cataract surgery)*
Family planning services	No member costs	No member costs
Fitness club reimbursement	Reimbursed up to $100 for one person and $200 for a family in a plan year	Reimbursed up to $100 for one person and $200 for a family in a plan year
Hearing aids		
▪ Age 21 and under	No member costs *(limited to $2,000 for each impaired ear every 24 months)*	No member costs *(limited to $2,000 for each impaired ear every 24 months)*
▪ Age 22 and over	No member costs *(limited to $1,700 for each impaired ear every 24 months)*	No member costs *(limited to $1,700 for each impaired ear every 24 months)*
Hearing exams	No member costs *(but you may owe a copay for the office visit)*	Non-PLUS deductible and 20% coinsurance
☎ **High-tech imaging (e.g., MRIs, CT and PET scans)**		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	$100 daily copay and PLUS deductible	$100 daily copay, non-PLUS deductible, and 20% coinsurance
☎ **Home health care**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Home infusion therapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Hospice care**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Immunizations (vaccines)	No member costs *(but you may owe a copay for the office visit)*	No member costs *(but you may owe a copay for the office visit)*
☎ **Inpatient medical care**		
▪ At a hospital or rehab facility (semi-private room)	$275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	Non-PLUS deductible and 20% coinsurance
▪ At a hospital or rehab facility (medically necessary private room)	▪ **First 90 days:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA) ▪ **After 90 days:** Dollar difference between the semi-private room rate and the private room rate	▪ **First 90 days:** Non-PLUS deductible and 20% coinsurance ▪ **After 90 days:** 20% coinsurance, and the dollar difference between the semi-private room rate and the private room rate

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ **Inpatient medical care *(cont.)***		
▪ Neonatal ICU	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** $275/500/1,500 quarterly copay and PLUS deductible ($500 copay outside of MA)	▪ **At a designated hospital:** $275 quarterly copay and PLUS deductible ▪ **At other hospitals:** Non-PLUS deductible and 20% coinsurance
Lab services	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Nutrition counseling	No member costs	No member costs
☎ **Occupational therapy**	$20 copay *(limited to 30 visits in a plan year except with autism diagnosis)*	Non-PLUS deductible and 20% coinsurance *(limited to 30 visits in a plan year except with autism diagnosis)*
Office visits	*See "Doctor visits" on page 1.*	
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)		
▪ Installation	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*	PLUS deductible and 20% coinsurance *(limited to $50 in a plan year)*
▪ Rental	PLUS deductible and 20% coinsurance *(limited to $40 a month)*	PLUS deductible and 20% coinsurance *(limited to $40 a month)*
☎ **Physical therapy**	$20 copay *(limited to 30 visits in a plan year except with autism diagnosis)*	Non-PLUS deductible and 20% coinsurance *(limited to 30 visits in a plan year except with autism diagnosis)*
Prescription drugs	▪ From a network pharmacy (30-day supply): $10/30/65 copay ▪ By mail order (90-day supply): $25/75/165 *Benefits administered by CVS Caremark. Call 877-876-7214 for information.*	
Preventive care	No member costs	No member costs
☎ **Prosthetics and orthotics**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Radiation therapy**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Radiology (e.g., X-rays)		
▪ Inpatient hospital	PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Outpatient hospital and non-hospital-owned locations	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Retail health clinic visits	$20 copay	$20 copay
☎ **Skilled nursing and long-term care facilities**	PLUS deductible and 20% coinsurance *(limited to 100 days in a plan year)*	PLUS deductible and 20% coinsurance *(limited to 100 days in a plan year)*
☎ **Sleep studies**	PLUS deductible	Non-PLUS deductible and 20% coinsurance
☎ **Speech therapy**	$20 copay	Non-PLUS deductible and 20% coinsurance

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ **Surgery – inpatient hospital**	PLUS deductible *(you also have an inpatient copay; see "Inpatient services")*	Non-PLUS deductible and 20% coinsurance
☎ **Surgery – outpatient**		
▪ At a hospital	$250 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Eye and GI surgery at a non-hospital-owned facility	$150 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ All other outpatient surgery at a non-hospital-owned facility	$250 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ At a doctor's office	Deductible *(you may also owe a copay for the office visit)*	Non-PLUS deductible and 20% coinsurance
Tobacco cessation counseling	No member costs *(limited to 300 minutes in a plan year)*	No member costs *(refer to GIC for limit)*
☎ **Transplants**		
▪ At a Quality Center or Designated Hospital for transplants	$275/500/1,500 quarterly copay and PLUS deductible	$275/500/1,500 quarterly copay and PLUS deductible
▪ At other hospitals	$275/500/1,500 quarterly copay, PLUS deductible, and 20% coinsurance	Non-PLUS deductible and 20% coinsurance
Urgent care center visits	$20 copay	$20 copay
Virtual care (telehealth)	$10 copay	Non-PLUS deductible and 20% coinsurance
Wigs (after cancer treatment)	20% coinsurance	20% coinsurance

Benefits for behavioral health care under PLUS

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
☎ **Applied Behavior Analysis (ABA)**	$10 copay	Non-PLUS deductible and 20% coinsurance
Emergency service programs	No member costs	No member costs
☎ **Inpatient behavioral health care**		
▪ Facility charges	$275 quarterly copay and PLUS deductible	Non-PLUS deductible and 20% coinsurance
▪ Professional services	No member costs	Non-PLUS deductible and 20% coinsurance
Medication-assisted treatment	No member costs	No member costs
☎ **Outpatient services**		
▪ Acupuncture withdrawal management (detox)	$20 copay	Non-PLUS deductible and 20% coinsurance
▪ All other outpatient services	$10 copay	Non-PLUS deductible and 20% coinsurance
Substance use disorder assessment / referral	No member costs	No member costs
Therapy	$10 copay	Non-PLUS deductible and 20% coinsurance

Service	Your member costs with contracted providers	Your member costs with non-contracted providers
Virtual care (telehealth)	$10 copay *You don't owe a copay for the first 3 visits.*	Non-PLUS deductible and 20% coinsurance