









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 <i>(limited to \$1,500 for a family in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to \$1,500 for a family a plan year)</i>
Cardiac rehab programs	\$20 copay	Non-PLUS deductible and 20% coinsurance
Chemotherapy	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Chiropractic care	\$20 copay <i>(limited to 20 visits in a plan year)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to 20 visits in a plan year)</i>
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 <i>(limited to one exam every 24 months)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to one exam every 24 months)</i>
Eyeglasses and contact lenses	PLUS deductible <i>(limited to the first lenses within six months after eye injury or cataract surgery)</i>	PLUS deductible <i>(limited to the first lenses within six months after eye injury or cataract surgery)</i>
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 <i>(limited to \$2,000 for each impaired ear every 24 months)</i>	No member costs <i>(limited to \$2,000 for each impaired ear every 24 months)</i>
▪ Age 22 and over	No member costs <i>(limited to \$1,700 for each impaired ear every 24 months)</i>	No member costs <i>(limited to \$1,700 for each impaired ear every 24 months)</i>
Hearing exams	No member costs <i>(but you may owe a copay for the office visit)</i>	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 <i>(but you may owe a copay for the office visit)</i>	No member costs <i>(but you may owe a copay for the office visit)</i>
 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)	<ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ 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.) <ul style="list-style-type: none"> Neonatal ICU 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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 <i>(limited to 30 visits in a plan year except with autism diagnosis)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to 30 visits in a plan year except with autism diagnosis)</i>
Office visits	<i>See "Doctor visits" on page 1.</i>	
Oxygen	PLUS deductible	Non-PLUS deductible and 20% coinsurance
Personal Emergency Response Systems (PERS)		
<ul style="list-style-type: none"> Installation 	PLUS deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>	PLUS deductible and 20% coinsurance <i>(limited to \$50 in a plan year)</i>
<ul style="list-style-type: none"> Rental 	PLUS deductible and 20% coinsurance <i>(limited to \$40 a month)</i>	PLUS deductible and 20% coinsurance <i>(limited to \$40 a month)</i>
 Physical therapy	\$20 copay <i>(limited to 30 visits in a plan year except with autism diagnosis)</i>	Non-PLUS deductible and 20% coinsurance <i>(limited to 30 visits in a plan year except with autism diagnosis)</i>
Prescription drugs	<ul style="list-style-type: none"> From a network pharmacy (30-day supply): \$10/30/65 copay By mail order (90-day supply): \$25/75/165 <i>Benefits administered by CVS Caremark. Call 877-876-7214 for information.</i>	
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)		
<ul style="list-style-type: none"> Inpatient hospital 	PLUS deductible	Non-PLUS deductible and 20% coinsurance
<ul style="list-style-type: none"> 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 <i>(limited to 100 days in a plan year)</i>	PLUS deductible and 20% coinsurance <i>(limited to 100 days in a plan year)</i>
 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 (<i>you also have an inpatient copay; see “Inpatient services”</i>)	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 (<i>you may also owe a copay for the office visit</i>)	Non-PLUS deductible and 20% coinsurance
Tobacco cessation counseling	No member costs (<i>limited to 300 minutes in a plan year</i>)	No member costs (<i>some limitations apply</i>)
 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 <i>You don't owe a copay for the first 3 visits.</i>	Non-PLUS deductible and 20% coinsurance