Roanoke College Medical Plan Designs

Plan Year Effective January 1, 2023

Benefit plan provisions are subject to change from time to time at direction of the Virginia Private Colleges Benefits Consortium (VPCBC) Board of Directors. For maximum benefits, use in-network providers.

Health Coverage Provided by ***Anthem***
Prescription Drug Coverage Provided by ***CarelonRx***
Disclaimer: The benefit booklet will govern the final claim payment process for the above benefits.

All Plans are Non-Grandfathered	PPO Plan 7 (High Deductible Plan)	HMO Plan 9 (Open Access)	PPO Plan 4
Deductible	$3,000/$6,000 (embedded)	None	$750/$1,500
Out-of-Pocket Maximum: Medical (includes copays and coinsurance)	$3,000/$6,000 (includes deductible and Rx)	$2,500/$5,000	$3,250/$6,500 (deductible is included)
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital (per admission)	0% after deductible	$350/day to $1,750	20% after deductible
Skilled Nursing (limited to 100 day maximum per confinement)	0% after deductible	No Charge	20% after deductible
Home Health Care	0% after deductible	No Charge	No Charge
Hospice	0% after deductible	No Charge	No Charge
Outpatient Surgery	0% after deductible	$300	20% after deductible
Professional Services (surgeon, radiologist, pathologist, anesthesiologist, etc.)	0% after deductible	$50 - applies to office visit; no charge if inpatient hospital, outpatient surgery or ER	Providers Office: Covered under office visit copay if performed same day. Facility and all other: 20% after deductible.
Second Surgical Opinion	0% after deductible	$25/$50	$20/$40 not subject to deductible
Diagnostic Lab/X-Ray (non-complex)	0% after deductible	$25/$50 - applies if billed separately from office visit or if no office visit applies	Providers Office: Covered under office visit copay if performed same day Facility: 20% after deductible
Complex Diagnostic - MRIs, MRA, CAT, PET CT, MRS and other complex scans	0% after deductible	$300	20% after deductible
PCP Office Visit	0% after deductible	$25	$20 not subject to deductible
Specialist Office Visit	0% after deductible	$50	$40 not subject to deductible
Preventive Care	0% not subject to deductible	0%	0% not subject to deductible
LiveHealth Online Visit	$50 or 0% after deductible	$5	$5 not subject to deductible
Immunizations/Well Baby Care	0% not subject to deductible	0%	0% not subject to deductible
Allergy Testing	0% after deductible	$25/$50	$20/$40 not subject to deductible
Allergy Shots/Serum	0% after deductible	Serum Only: No Charge Serum plus administration of shot: $25/$50	No Charge (If services are billed with an office visit charge, the office visit copay will apply)

All Plans are Non-Grandfathered	PPO Plan 7 (High Deductible Plan)	HMO Plan 9 (Open Access)	PPO Plan 4
Shots and Therapeutic Injections	0% after deductible	Serum Only: No Charge Serum plus administration of shot: $25/$50	20% after deductible
Emergency Room	0% after deductible	$250	20% after deductible
Urgent Care	0% after deductible	$25/$50	$20/$40 not subject to deductible
Durable Medical Equipment (Prosthetics covered with no limit)	0% after deductible	No Charge	20% after deductible
Maternity	Member pays 0% after deductible is met; applies to all maternity services.	Initial visit to confirm pregnancy: $50 copayment to the OB or $25 copayment to the PCP A PCP/Specialist copay will be assessed for each visit to a provider that is not the OB Diagnostic testing and ultrasounds: $50 copayment per visit Global payment to the OB: $300 copayment per pregnancy Inpatient: $350/day up to $1,750 copayment	Initial visit to confirm pregnancy: $40 copayment to OB or $20 copayment to PCP A PCP/Specialist copay will be assessed for each visit to a provider that is not the OB Diagnostic testing and ultrasounds: $40 per visit for diagnostic testing; Inpatient: 20% of the allowable charge after deductible; if OB bills globally IP services will be covered at 20% after deductible
Spinal Manipulation (30 visits per CY)	0% after deductible	$25	$40 not subject to deductible
Occupational, Physical and Speech Therapy (30 office visit limit per CY combined for OT and PT; separate 30 visit limit per CY for speech)	0% after deductible	$25	$30 not subject to deductible
Mental & Nervous Disorders			
Inpatient (no limit)	0% after deductible	$350/day to $1,750	20% after deductible
Outpatient (no limit)	0% after deductible	$25	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after deductible)
Substance Abuse			
Inpatient (no limit)	0% after deductible	$350/day to $1,750	20% after deductible
Outpatient (no limit)	0% after deductible	$25	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after deductible)

Blue View Vision By Anthem			
Vision Exam (limited to 1 every 12 months) Blue View Vision	$15 not subject to deductible	$15 not subject to deductible	$15 not subject to deductible
All Plans are Non-Grandfathered	**PPO Plan 7 (High Deductible Plan)**	**HMO Plan 9 (Open Access)**	**PPO Plan 4**
Out of Network Coverage			
Deductible	$3,000/$6,000 (embedded)	$1,000/$2,000	$500/$1,000 (not combined with in-network deductible)
Coinsurance	40%	30%	30%
OOP Maximum	$6,000/$12,000 (not combined with in-network)	$3,500/$7,000	$4,500/$9,000 (not combined with in-network)
All Plans are Non-Grandfathered	**PPO Plan 7 (High Deductible Plan)**	**HMO Plan 9 (Open Access)**	**PPO Plan 4**
Prescription By CarelonRx			
Prescription Drug Deductible (certain preventive medications will be covered at no cost to the member)	Medical deductible applies prior to coinsurance being applicable	$150/$300 deductible (excludes generics)	$150/$300 deductible (excludes generics)
Out-of-Pocket Maximum: Rx (includes copays and coinsurance)	See above	$4,100/$8,200	$3,600/$7,200
Retail			
Generic	0% after deductible	$10	$10
Brand	0% after deductible	Retail: 30% coinsurance with a minimum of $40 (unless cost of drug is < $40) and a maximum of $80	30% coinsurance with a minimum of $40 (unless cost of drug is < $40) and a maximum of $80
Non-Preferred Brand	0% after deductible	40% coinsurance with a minimum of $60 (unless cost of drug is < $60) and a maximum of $120	40% coinsurance with a minimum of $60 (unless cost of drug is < $60) and a maximum of $120
Specialty	0% after deductible	50% coinsurance up to a $200 maximum	50% coinsurance up to a $200 maximum
Mail Order			
Generic	0% after deductible	$10	$10
Brand	0% after deductible	30% coinsurance with a minimum of $80 (unless cost of drug is < $80) and a maximum of $160	30% coinsurance with a minimum of $80 (unless cost of drug is < $80) and a maximum of $160
Non-Preferred Brand	0% after deductible	40% coinsurance with a minimum of $120 (unless cost of drug is < $120) and a maximum of $240	40% coinsurance with a minimum of $120 (unless cost of drug is < $120) and a maximum of $240
Specialty	0% after deductible	50% coinsurance up to a $200 maximum	50% coinsurance up to a $200 maximum
Not Embedded means the first listed limit applies if employee-only coverage is elected; the second listed limit applies if a spouse or any dependents are also covered. There is no lesser limit per covered life.			
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