Roanoke College Medical Plan Designs

Plan Year Effective January 1, 2026

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***

Basic Vision Coverage Provided by ***BlueView Vision***

Disclaimer: The benefit booklet will govern the final claim payment process for the above benefits.

	PPO PLAN 7 (High Deductible Plan)	HMO PLAN 9 (Open Access)	PPO PLAN 4 (Traditional PPO)
Deductible	$3,400/$6,800 (Embedded)	None	$750/$1,500
Out-of-Pocket Limit	$3,400/$6,800 (Includes Deductible & Rx)	$2,500/$5,000	$3,250/$6,500 (Deductible Is Included)
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Inpatient Hospital	0% after deductible	$350/day to $1,750	20% after deductible
Hospice	0% after deductible	No Charge	No Charge
Outpatient Surgery	0% after deductible	$300	20% after deductible
Diagnostic Lab/X-Ray	0% after deductible	$25/$50	20% after deductible
Complex Diagnostic	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	No Charge	No Charge	No Charge
LiveHealth Online Visit	$50 or 0% after deductible	$5	$5 not subject to deductible
Immunizations	Covered at 100%	Covered at 100%	Covered at 100%
Well Baby Care	Covered at 100%	Covered at 100%	Covered at 100%
Allergy Shots/Serum	0% after deductible	$25/$50	No Charge (If services are billed with an office visit charge, the office visit copay will apply)
Shots & Injections	0% after deductible	$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	0% after deductible	No Charge	20% after deductible
Spinal Manipulation (30 visits per CY)	0% after deductible	$25	$40 not subject to deductible
Occupational Therapy (30 office visit limit per CY combined W/ OT &PT)	0% after deductible	$25	$30 not subject to deductible
Physical Therapy (30 office visit limit per CY combined W/ OT &PT)	0% after deductible	$25	$30 not subject to deductible
Speech Therapy (30 visits per CY)	0% after deductible	$25	$30 not subject to deductible

	PPO PLAN 7 (High Deductible Plan)	HMO PLAN 9 (Open Access)	PPO PLAN 4 (Traditional PPO)
MENTAL & NERVOUS DISORDERS			
Inpatient	0% after deductible	$350/day to $1,750	20% after deductible
Outpatient	0% after deductible	$25	Office Visit: $20 Outpatient Facility: 100% after deductible
SUBSTANCE ABUSE			
Inpatient	0% after deductible	$350/day to $1,750	20% after deductible
Outpatient	0% after deductible	$25	Office Visit: $20 Outpatient Facility: 100% after deductible

MATERNITY		
PPO PLAN 7 (High Deductible Plan)	**HMO PLAN 9 (Open Access)**	**PPO PLAN 4 (Traditional PPO)**
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

BASIC VISION (Once Per Calendar Year)
$15 Not Subject To Deductible For All Plans

PRESCRIPTION DRUG COVERAGE			
	PPO PLAN 7 (High Deductible Plan)	**HMO PLAN 9 (Open Access)**	**PPO PLAN 4 (Traditional PPO)**
Prescription Drug Deductible	Medical deductible applies	$150/$300 deductible (excludes generics)	$150/$300 deductible (excludes generics)
Out-of-Pocket Maximum	See above	$4,100/$8,200	$3,350/$6,700
RETAIL			
Tier 1 - Typically Generic	0% after deductible	$10	$10
Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	0% after deductible	Greater of $40 or 30% coinsurance up to $80	Greater of $40 or 30% coinsurance up to $80
Tier 3 - Typically Non-Preferred	0% after deductible	Greater of $60 or 40% coinsurance up to $120	Greater of $60 or 40% coinsurance up to $120
Tier 4 - Typically Preferred Specialty	0% after deductible	50% coinsurance up to a $200 maximum	50% coinsurance up to a $200 maximum
MAIL ORDER			
Tier 1 - Typically Generic	0% after deductible	$10	$10
Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	0% after deductible	Greater of $80 or 30% coinsurance up to $160	Greater of $80 or 30% coinsurance up to $160
Tier 3 - Typically Non-Preferred	0% after deductible	Greater of $120 or 40% coinsurance up to $240	Greater of $120 or 40% coinsurance up to $240
Tier 4 - Typically Preferred 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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