Roanoke College Medical Plan Designs Effective January 1, 2022

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

All Plans are Non-Grandfathered	Plan 4 - PPO	Plan 9 - HMO (Open Access)	Plan 7 - PPO High Deductible
Maternity	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	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	Member pays 0% after deductible is met; applies to all maternity services.
Spinal Manipulation (30 visits per CY)	$40 not subject to deductible	$25	0% after 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)	$30 not subject to deductible	$25	0% after deductible
Mental & Nervous Disorders			
Inpatient (no limit)	20% after deductible	$350/day to $1,750	0% after deductible
Outpatient (no limit)	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after ded)	$25	0% after deductible
Substance Disorders			
Inpatient (no limit)	20% after deductible	$350/day to $1,750	0% after deductible
Outpatient (no limit)	Office Visit: $20 (from $40); Outpatient Facility: 100% after deductible (was 20% after ded)	$25	0% after deductible
Blue View Vision By Anthem			
Vision Exam (Blue View Vision)	$15 not subject to deductible	$15 not subject to deductible	$15 not subject to deductible
Prescription By IngenioRx			
Certain Preventive Medications Will Be Covered at No Cost To The Member			
Prescription Drug Deductible	$150/$300 ded (excludes generics)	$150/$300 ded (excludes generics)	Medical deductible applies prior to coinsurance being applicable
Generic	Retail: $10 Mail Order: $10	Retail: $10 Mail Order: $10	0% after deductible
Brand	Retail: 30% coinsurance with a minimum of $40 (unless cost of drug is < $40) and a maximum of $80 Mail Order: 30% coinsurance with a minimum of $80 (unless cost of drug is < $80) and a maximum of $160	Retail: 30% coinsurance with a minimum of $40 (unless cost of drug is < $40) and a maximum of $80 Mail Order: 30% coinsurance with a minimum of $80 (unless cost of drug is < $80) and a maximum of $160	0% after deductible
Non Preferred Brand	Retail: 40% coinsurance with a minimum of $60 (unless cost of drug is < $60) and a maximum of $120 Mail Order: 40% coinsurance with a minimum of $120 (unless cost of drug is < $120) and a maximum of $240	Retail: 40% coinsurance with a minimum of $60 (unless cost of drug is < $60) and a maximum of $120 Mail Order: 40% coinsurance with a minimum of $120 (unless cost of drug is < $120) and a maximum of $240	0% after deductible
Specialty	50% coinsurance up to a $200 maximum	50% coinsurance up to a $200 maximum	0% after deductible
Out-of-Pocket Maximum: Rx (includes copays and coinsurance)	$3,600/$7,200	$4,100/$8,200	See above
Out of Network			
Deductible	$500/$1,000 (not combined with in-network deductible)	$1,000/$2,000	$3,000/$6,000 (embedded)
Coinsurance	30%	30%	40%
OOP Maximum	$4,500/$9,000 (not combined with in-network)	$3,500/$7,000	$6,000/$12,000 (not combined with in-network)

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.

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