Roger Williams University has implemented a health provision that works in conjunction with Blue Cross & Blue Shield of Rhode Island. This provision is a "plan" within your medical insurance plan that pays a portion of your in & out of network deductible medical claim. The plan is called a "deductible health reimbursement arrangement" (HRA).

Your primary insurance plan with BCBSRI includes an in & out of network deductible of $6,000 for individual plans and $12,000 for family plans. Your employer's HRA is put in place to pay a majority of your deductible expenses after you pay a small first portion of the deductible amount. Below describes the services applied toward your deductible, the amounts you owe, the amounts your HRA pays, and the amount BCBSRI pays after your deductible is satisfied.

HRA Benefits Effective: 07/01/2023 – 8/31/2023 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays
In-Network Annual Deductible per Individual (Ind)	**First $500**	**Remaining $5,500**	**100% After Deductible**
In-Network Annual Deductible per Family (Fam)	**First $750**	**Remaining $11,250**	**100% After Deductible**
In-Network Coinsurance	**0%**	**0%**	**0%**
In-Network Inpatient Services			
Facility Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
In Patient Hospital & Physician Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Maternity-Pre & Post Natal Care	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Inpatient Mental Health & Substance Abuse	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
In-Network Outpatient Services			
Facility Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Physician/Surgeon Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Skilled Nursing, Home Health Care, Including Hospice Care	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Infertility Services & Infertility Oral & Injectable Drugs	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	$500 Ind/$750 Fam of Ded + 20% after Ded.	$5,500 Ind/$11,250 Fam of Deductible	80% After Deductible
Durable Medical Equipment	$500 Ind/$750 Fam of Ded + 20% after Ded.	$5,500 Ind/$11,250 Fam of Deductible	80% After Deductible
Out-of-Network Services			
Annual Deductible per Individual	First $200	Remaining Deductible Amounts	80% After Deductible
Annual Deductible per Family	First $400	Remaining Deductible Amounts	80% After Deductible
Coinsurance	20%	Remaining Coinsurance Amounts	80%
Out-of-pocket maximum per Individual	$1,200	N/A	N/A
Out-of-pocket maximum per Family	$2,400	N/A	N/A

IMPORTANT:

* For out-of-network services, members will have to pay the first $200 of the out-of-network deductible and then 20% coinsurance for the remaining medical expense. Your employer's HRA will pay the additional amounts applied toward your out-of-network and coinsurance benefit.

** For questions regarding your health plan and HRA please call BCBSRI at 401-459-5000.

HRA Benefits Effective: 07/01/2023 – 8/31/2023 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays
In-Network Annual Deductible per Individual (Ind)	**First $500**	**Remaining $5,500**	**100% After Deductible**
In-Network Annual Deductible per Family (Fam)	**First $750**	**Remaining $11,250**	**100% After Deductible**
In-Network Coinsurance	**0%**	**0%**	**0%**
In-Network Inpatient Services			
Facility Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
In Patient Hospital & Physician Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
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Inpatient Mental Health & Substance Abuse	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
In-Network Outpatient Services			
Facility Services	$500 Ind/$750 Fam of Deductible	$5,500 Ind/$11,250 Fam of Deductible	100% After Deductible
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Durable Medical Equipment	$500 Ind/$750 Fam of Ded + 20% after Ded.	$5,500 Ind/$11,250 Fam of Deductible	80% After Deductible
In-Network Outpatient Preventive and Diagnostic Services			
Primary Care Office Visits	$30 Copay	$0	100% after $30 Copay
Preventative Office Visits, Routine GYN, Well Baby Visits	100% Coverage	$0	100% Coverage
Preventive Diagnostic X-Rays, Lab Tests, & Imaging	100% Coverage	$0	100% Coverage
Adult & Pediatric Preventive Care & Immunizations	100% Coverage	$0	100% Coverage
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine	100% Coverage	$0	100% Coverage
Diabetic Foot & Eye Exams	100% Coverage**	$0	100% Coverage
Specialty Care Office Visits	$50 Copay	$0	100% after $50 Copay
Chiropractic Office Visits (Max 20 visits per year)	$50 Copay	$0	100% after $50 Copay
Eye Exams (limit 1 visit per year)	100% Coverage	$0	100% Coverage
Outpatient Mental Health & Substance Abuse treatment	$50 Copay	$0	100% after $50 Copay
Urgent Care (i.e.. Walk-in treatment centers)	$50 Copay	$0	100% after $50 Copay
Ambulance Services	$50 Copay	$0	100% after $50 Copay
Emergency Room (Waived if admitted)	$200 Copay	$0	100% after $200 Copay
In-Network Prescription Drug			
Retail Prescription Drugs	$7/$25/$40/$65 Copay	$0	100% after $7/$25/$40/$65 Copay
Out-of-Network Services			
Annual Deductible per Individual	First $200	Remaining Deductible Amounts	80% After Deductible
Annual Deductible per Family	First $400	Remaining Deductible Amounts	80% After Deductible
Coinsurance	20%	Remaining Coinsurance Amounts	80%
Out-of-pocket maximum per Individual	$1,200	N/A	N/A
Out-of-pocket maximum per Family	$2,400	N/A	N/A

* For out-of-network services, members will have to pay the first $200 of the out-of-network deductible and then 20% coinsurance for the remaining medical expense. Your employer's HRA will pay the additional amounts applied toward your out-of-network and coinsurance benefit.
** Out-of-network diabetic foot & eye exams are $20 per visit