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.

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HRA Benefits Effective: 09/01/2023 – 6/30/2024 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays
In-Network Annual Deductible per Individual (Ind)	First \$750	Remaining \$5,250	100% After Deductible
In-Network Annual Deductible per Family (Fam)	First \$1,500	Remaining \$10,500	100% After Deductible
In-Network Coinsurance	0%	0%	0%
In-Network Inpatient Services			
Facility Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
In Patient Hospital & Physician Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Maternity-Pre & Post Natal Care	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Inpatient Mental Health & Substance Abuse	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
In-Network Outpatient Services			
Facility Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Physician/Surgeon Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Skilled Nursing, Home Health Care, Including Hospice Care	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Infertility Services & Infertility Oral & Injectable Drugs	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	\$750 Ind/\$1,500 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 Fam of Deductible	80% After Deductible
Durable Medical Equipment	\$750 Ind/\$1,500 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 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.

This benefit description is not a contract or a complete listing of benefits. For more detailed information, please refer to your subscriber agreement and summary of benefit coverage on your secure member home page on BCBSRI.com or call BCBSRI Customer Service.

Preventative Office Visits, Routine GYN, Well Baby Visits 100% Coverage \$0 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage \$0 100% Goverage \$0 100% Coverage \$0 100% Goverage \$0 100% Goverage \$0 100% after \$50 Copay \$0 Urgent Care (i.e., Walk-in treatment centers) \$50 Copay \$50 Copay \$50 Copay \$0 100% after \$50 Copay \$50 Copay \$0 100% after \$50 Copay	Timil Temas Temas Timil Sement (Titel) Elice of				
In Network Coinsurance 10% 10% 10% 10% 10% 10% 10% 10	HRA Benefits Effective: 09/01/2023 – 6/30/2024 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays	
In Network Coinsurance 10%	In-Network Annual Deductible per Individual (Ind)	First \$750	Remaining \$5,250	100% After Deductible	
Pacility Services S750 Ind/\$1,500 Fam of Deductible S5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible 100%	In-Network Annual Deductible per Family (Fam)	First \$1,500	Remaining \$10,500	100% After Deductible	
Facility Services	In-Network Coinsurance	0%	0%	0%	
n Patient Hospital & Physician Services \$750 Ind/\$1,500 Fam of Deductible Maternity-Pre & Post Natal Care \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible nnetwork Outpatient Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible Network Outpatient Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible Physician/Surgeon Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$5,250 Ind/\$1,500 Fam of Deductible \$5,250 I	In-Network Inpatient Services				
Maternity-Pre & Post Natal Care \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible Insaltent Mental Health & Substance Abuse \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible Insaltent Mental Health & Substance Abuse \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fa	Facility Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Maternity-Pre & Post Natal Care Inpatient Mental Health & Substance Abuse Inpatient Mental Health & Substance Abuse Institute Mental Health & Substance Abuse treatment Institute Mental Health & Substance Abuse tr	In Patient Hospital & Physician Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
## Network Outpatient Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$6,250 Ind/\$10,500 Fam of D		\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Facility Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible Physician/Surgeon Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible Stall Physician/Surgeon Services (Specially Services & Index	Inpatient Mental Health & Substance Abuse	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Physician/Surgeon Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$100% After Deductible 100% After Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After So Copay 100% After	In-Network Outpatient Services				
Skilled Nursing, Home Health Care, Including Hospice Care Infertility Services & Infertility Oral & Injectable Drugs Injectable Drugs Infertility Oral & Injectable Drug And Injectable Drugs Infertility Oral & Injecta	Facility Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Infertility Services & Infertility Oral & Injectable Drugs \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$100% After S0 Deduction \$100% After S0 Deductio	Physician/Surgeon Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Short-term Rehabilitation Therapy (Physical, Occupational, & Speech) Durable Medical Equipment S750 Ind/\$1,500 Fam of Ded + 20% after Ded. S5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible 8	Skilled Nursing, Home Health Care, Including Hospice Care	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
Durable Medical Equipment In-Network Outpatient Preventive and Diagnostic Services Primary Care Office Visits So PCMH / \$30 nonPCMH Copay Preventative Office Visits, Routine GYN, Well Baby Visits 100% Coverage Preventative Diagnostic X-Rays, Lab Tests, & Imaging Adult & Pediatric Preventive Care & Immunizations 100% Coverage So 100% Coverage Adult & Pediatric Preventive Care & Immunizations 100% Coverage So 100% Coverage Preventative Diagnostic X-Rays, Lab Tests, & Imaging Adult & Pediatric Preventive Care & Immunizations 100% Coverage So 100% Coverage Preventive Care & Immunizations 100% Coverage So 100% Coverage So 100% Coverage So 100% Coverage Preventive Care & Immunizations So Copay So 100% Coverage So 100% Goverage So 10	Infertility Services & Infertility Oral & Injectable Drugs	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible	
In-Network Outpatient Preventive and Diagnostic Services Primary Care Office Visits \$0 PCMH / \$30 nonPCMH Copay \$0 \$100% after \$0 PCMH / \$30 nonPCMH 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 \$0 \$100% Coverage \$100% Coverag	Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	\$750 Ind/\$1,500 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 Fam of Deductible	80% After Deductible	
Primary Care Office Visits, Routine GYN, Well Baby Visits 100% Coverage Preventative Office Visits, Routine GYN, Well Baby Visits 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage Socialty Coverage Socialty Coverage Socialty Care Office Visits Socialty Care Office Visits Socialty Care Office Visits Socialty Care Office Visits (Max 12 visits per year) Socialty Care Office Visits (Max 12 visits per year) Socialty Coverage Socialty Coverage Socialty Care Office Visits (Max 12 visits per year) Socialty Coverage Socialty Care Office Visits (Max 12 visits per year) Socialty Coverage Socialty Care Office Visits (Max 12 visits per year) Socialty Coverage Socialty Care Office Visits (Max 12 visits per year) Socialty Coverage Socialty Cover		\$750 Ind/\$1,500 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 Fam of Deductible	80% After Deductible	
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High-end Radiology Services, Major Diagnostics, and Nuclear Medicine Specialty Care Office Visits Spo Copay Spo Copa	Preventive Diagnostic X-Rays, Lab Tests, & Imaging	100% Coverage		100% Coverage	
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Emergency Room (Waived if admitted) Secondary Sec	Urgent Care (i.e Walk-in treatment centers)	\$50 Copay	\$0	100% after \$50 Copay	
In-Network Prescription Drug Retail Prescription Drugs \$7/\$25/\$40/\$65 Copay \$0 100% after \$7/\$25/\$40/\$6 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	Ambulance Services	\$50 Copay	\$0	100% after \$50 Copay	
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Coinsurance 20% Remaining Coinsurance Amounts 80% Out-of-pocket maximum per Individual \$1,200 N/A N/A	•		_	80% After Deductible	
Out-of-pocket maximum per Individual \$1,200 N/A N/A	·				
	Out-of-pocket maximum per Individual	\$1,200		N/A	
	Out-of-pocket maximum per Family			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.