

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: 07/01/2021 (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 \$1,000 | Remaining \$11,000 | 100% After Deductible |
| In-Network Coinsurance | 0% | 0% | 0% |
| In-Network Inpatient Services | | | |
| Facility Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| In Patient Hospital & Physician Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Maternity-Pre & Post Natal Care | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Inpatient Mental Health & Substance Abuse | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| In-Network Outpatient Services | | | |
| Facility Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Physician/Surgeon Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Skilled Nursing, Home Health Care, Including Hospice Care | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Infertility Services & Infertility Oral & Injectable Drugs | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| Short-term Rehabilitation Therapy (Physical, Occupational, & Speech) | \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. | \$5,500 Ind/\$11,000 Fam of Deductible | 80% After Deductible |
| Durable Medical Equipment | \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. | \$5,500 Ind/\$11,000 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.

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| In-Network Coinsurance | 0% | 0% | 0% |
| In-Network Inpatient Services | | | |
| Facility Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
| In Patient Hospital & Physician Services | \$500 Ind/\$1,000 Fam of Deductible | \$5,500 Ind/\$11,000 Fam of Deductible | 100% After Deductible |
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| 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 |
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** Out-of-network diabetic foot & eye exams are \$20 per visit