Plan: Health Reimbursement Arrangement (HRA) - BlueChip

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: 07/01/2024 (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.

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In-Network Annual Deductible per Individual (Ind) In-Network Annual Deductible per Family (Fam) In-Network Coinsurance In-Network Coinsurance In-Network Coinsurance In-Network Inpatient Services In-Network Inpatient Services In Patient Hospital & Physician Services In Patient Mental Health & Substance Abuse In Physician Services Infertitity Services & Infertitity Graf & Injectable Drugs Infertitity Services & Infertitity Graf & Injectable Drugs Infertitity Services &	Administrator, London Freath Administrators		ian, Health Kennbursement Arra	ingement (11101) - bidecii
In-Network Coinsurance NK OK OK OK OK OK OK OK	HRA Benefits Effective: 07/01/2024 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays
InNetwork Inpatient Services 5750 Ind/\$1,500 Fam of Deductible 55,250 Ind/\$10,500 Fam of Deductible 100% After Deducti	In-Network Annual Deductible per Individual (Ind)	First \$750	Remaining \$5,250	100% After Deductible
Facility 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 \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible 107 After Deduct	In-Network Coinsurance	0%	0%	0%
Patient Hospital & Physician Services	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 planter Mental Health & Substance Abuse \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible 100% After Deductible Innetwork Outpatient Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$1,500 Fam of Deductible 100% After Deductible Physician/Surgeon Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$1,500 Fam of Deductible 100% After Deductible Skilled Nursing, Home Health Care, Including Hospice Care Infertifity Services & Infe	Facility Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Impatient Mental Health & Substance Abuse Impatient Services S750 Ind/\$1,500 Fam of Deductible S750 Ind/\$1,500 Fam of	In Patient Hospital & Physician Services	\$750 Ind/\$1,500 Fam of Deductible	\$5,250 Ind/\$10,500 Fam of Deductible	100% After Deductible
Facility Services Facility Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$5,250 Ind/\$1	Maternity-Pre & Post Natal Care	\$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 \$6,5250 Ind/\$10,500 Fam of Deduct	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 Spo Copay \$10	In-Network Outpatient Services			
Skilled Nursing, Home Health Care, Including Hospice Care \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible \$6,250 Ind/\$10,500 Fam of Ded	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	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 \$5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible 80	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 5750 Ind/\$1,500 Fam of Ded + 20% after Ded . \$5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible In-Network Outpatient Preventive and Diagnostic Services \$0 PCMH / \$30 nonPCMH Copay \$0 \$100% after \$0 PCMH / \$30 nonPCMH Copay \$0 \$100% after \$0 PCMH / \$30 nonPCMH Copay \$0 \$100% Coverage \$0 \$100% after \$50 Copay	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 \$100% Coverage \$0 \$100% Coverage \$100% after \$50 Copay \$100% after	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		\$750 Ind/\$1,500 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 Fam of Deductible	80% After Deductible
Preventative Office Visits, Routine GYN, Well Baby Visits 100% Coverage \$0 100% Coverage 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% after \$50 Copay \$0 100% after	In-Network Outpatient Preventive and Diagnostic Services			
Preventive Diagnostic X-Rays, Lab Tests, & Imaging Adult & Pediatric Preventive Care & Immunizations 100% Coverage \$100% after \$50 Copay \$100%	Primary Care Office Visits	\$0 PCMH / \$30 nonPCMH Copay	\$0	
Adult & Pediatric Preventive Care & Immunizations 100% Coverage \$0 100% Coverage High-end Radiology Services, Major Diagnostics, and Nuclear Medicine Specialty Care Office Visits \$50 Copay \$0 100% after \$50 Copay Chiropractic Office Visits (Max 12 visits per year) \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay Cutpatient Mental Health & Substance Abuse treatment \$50 Copay \$50 Copay \$50 100% after \$50 Copay Urgent Care (i.e Walk-in treatment centers) \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$60 100% after \$7 / \$25 / \$40 / \$65 Copay \$60 100% after \$7 / \$25 / \$40 / \$65 Copay \$60 Copay \$60 100% after \$7 / \$25 / \$40 / \$65 Copay \$60 Copay	Preventative Office Visits, Routine GYN, Well Baby Visits	100% Coverage	\$0	100% Coverage
High-end Radiology Services, Major Diagnostics, and Nuclear Medicine Specialty Care Office Visits Specialty Care Office Visits Specialty Care Office Visits (Max 12 visits per year) Specialty Care Office Visits (Max 12 visits per year) Specialty Care Office Visits (Max 12 visits per year) Specialty Care (Iimit 1 visit per year) Specialty Special	Preventive Diagnostic X-Rays, Lab Tests, & Imaging	100% Coverage		100% Coverage
Specialty Care Office Visits \$50 Copay \$0 100% after \$50 Copay \$0 \$0 100% after \$50 Copay \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Adult & Pediatric Preventive Care & Immunizations			100% Coverage
Chiropractic Office Visits (Max 12 visits per year) S50 Copay S50 Copay S50 Cop				
Eye Exams (limit 1 visit per year) S50 Copay Outpatient Mental Health & Substance Abuse treatment \$50 Copay Outpatient Mental Health & Substance Abuse treatment \$50 Copay S50 Copay \$0 \$0 \$100% after \$50 Copay Ambulance Services \$50 Copay \$50 Copay \$50 \$50 Copay	· · · ·	\$50 Copay		· '
Outpatient Mental Health & Substance Abuse treatment \$50 Copay \$0 100% after \$50 Copay Urgent Care (i.e Walk-in treatment centers) \$50 Copay \$50 Copay \$50 100% after \$50 Copay Ambulance Services \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$200 Copay \$50 100% after \$200 Copay \$50 100% after \$7 / \$25 / \$40 / \$65 Copay \$50 Copay Out-of-Network Prescription Drugs \$57 / \$25 / \$40 / \$65 Copay \$50 Remaining Deductible Amounts \$50 Copay Out-of-Network Services Annual Deductible per Individual Annual Deductible per Family First \$400 Remaining Deductible Amounts \$50 Copay Remaining Deductible Amounts \$50 Copay \$50 After \$50 Copay \$50 Copay Out-of-Network Services Annual Deductible per Individual \$50 Copay	Chiropractic Office Visits (Max 12 visits per year)	\$50 Copay		100% after \$50 Copay
Urgent Care (i.e., Walk-in treatment centers) Ambulance Services Emergency Room (Waived if admitted) Emergency Room (Waived if admitted) Services Retail Prescription Drugs Copay Solut-of-Network Services Annual Deductible per Individual Annual Deductible per Family Coinsurance Count-of-pocket maximum per Individual Solution Solutio	Eye Exams (limit 1 visit per year)	\$50 Copay	\$0	100% after \$50 Copay
Ambulance Services \$50 Copay \$0 100% after \$50 Copay \$0 100% after \$50 Copay \$0 100% after \$200 Copay \$0 100% after \$200 Copay \$0 100% after \$200 Copay \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Outpatient Mental Health & Substance Abuse treatment	\$50 Copay	\$0	100% after \$50 Copay
Emergency Room (Waived if admitted) Sample	Urgent Care (i.e Walk-in treatment centers)	\$50 Copay	\$0	100% after \$50 Copay
In-Network Prescription Drugs Retail Prescription Drugs \$7/\$25/\$40/\$65 Copay \$0 100% after \$7/\$25/\$40/\$65 Copay Out-of-Network Services Annual Deductible per Individual Annual Deductible per Family First \$400 Remaining Deductible Amounts 80% After Deductible Annual Deductible per Family Coinsurance 20% Remaining Coinsurance Amounts 80% N/A N/A	Ambulance Services	\$50 Copay	\$0	100% after \$50 Copay
Retail Prescription Drugs \$7 / \$25 / \$40 / \$65 Copay \$0 \frac{100% after \$7 / \$25 / \$40 / \$65 Copay}{Copay} Out-of-Network Services Annual Deductible per Individual First \$200 Remaining Deductible Amounts 80% After Deductible Annual Deductible per Family Remaining Deductible Amounts 80% After Deductible Annual Deductible Per Family Remaining Coinsurance Amounts 80% After Deductible Coinsurance 20% Remaining Coinsurance Amounts 80% Out-of-pocket maximum per Individual \$1,200 N/A N/A	Emergency Room (Waived if admitted)	\$200 Copay	\$0	100% after \$200 Copay
Copay Out-of-Network Services Annual Deductible per Individual Annual Deductible per Family Coinsurance Coinsurance 20% Remaining Deductible Amounts 80% After Deductible	In-Network Prescription Drug			
Out-of-Network Services Remaining Deductible Amounts 80% After Deductible 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	Retail Prescription Drugs	\$7 / \$25 / \$40 / \$65 Copay	\$0	100% after \$7 / \$25 / \$40 / \$65 Copay
Annual Deductible per Family First \$400 Remaining Deductible Amounts 80% After Deductible Coinsurance 20% Remaining Coinsurance Amounts 80% N/A N/A	Out-of-Network Services			<u></u>
Annual Deductible per Family First \$400 Remaining Deductible Amounts 80% After Deductible Coinsurance 20% Remaining Coinsurance Amounts 80% N/A N/A	Annual Deductible per Individual	First \$200	Remaining Deductible Amounts	80% After Deductible
Coinsurance 20% Remaining Coinsurance Amounts 80% Out-of-pocket maximum per Individual \$1,200 N/A N/A	Annual Deductible per Family		_	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	\$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.