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: 07/01/2024 (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.

Plan: Health Reimbursement Arrangement (HRA) – HMC2C

In-Network Annual Deductible per Individual (Ind)				
In Network Annual Deductible per Family (Fam) 10% After Deductible 10% After Deductib	HRA Benefits Effective: 07/01/2024 (plan year ded)	You Pay	HRA Pays For You	BCBSRI Pays
## Network Coinsurance 0% 0% 0% 0% 0% 0% 0% 0	In-Network Annual Deductible per Individual (Ind)	First \$750	Remaining \$5,250	100% After Deductible
Pacitity Services \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$10,500 Fam of Deductible	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 \$750 Ind/\$1,500 Fam of Deductible \$5,250 Ind/\$1,500 Fam o	In-Network Coinsurance	0%	0%	0%
Patient Hospital & Physician Services \$750 Ind/\$1,500 Fam of Deductible \$52,50 Ind/\$10,500 Fam of Deductible \$5750 Ind/\$1,500 Fam of Deductible \$5750	In-Network Inpatient Services			
Maternity-Pre & Post Natal Care Inpatient Mental Health & Substance Abuse Investwork Outpatient Services Primary Care Office Visits Preventive Diagnostic K-arey, Lab Tests. & Imminizations Inight Redistric Preventive Care & Immunizations Inight Redistric	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 Mental Health & Substance Abuse treatment Impatient 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
Another Network Outpatient Services Sacility Services \$750 Ind/\$1,500 Fam of Deductible \$55,250 Ind/\$10,500 Fam of Deductible \$55,250 Ind/\$10,50	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 100% After Deductible 5750 Ind/\$1,500 Fam of Deductible 55,250 Ind/\$10,500 Fam of Deductible 100% After Deductible 55,250 Ind/\$10,500 Fam of Deductible 100% After	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 \$6,250 Ind/\$10,500 Fam of Deduc	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	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 Deductible Short-term Rehabilitation Therapy (Physical, Occupational, & Speech) \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. \$5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible Durable Medical Equipment \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. \$5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible In-Network Outpatient Preventive and Diagnostic Services \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. \$5,250 Ind/\$10,500 Fam of Deductible 80% After Deductible Primary Care Office Visits \$500 Ind/\$1,000 Fam of Ded + 20% after Ded. \$5,550 Ind/\$10,500 Fam of Deductible 80% After Deductible Preventative Office Visits \$25 Copay \$0 100% after \$25 Copay Preventive Diagnostic X-Rays, Lab Tests, & Imaging 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 Specialty Care Office Visits \$40 Copay \$0 100% after \$40 Copay Chiropractic Office Visits (Max 12 visits per year) \$40 Copay \$0 100% after \$40 Copay Eye Exams (limit 1 visit per year) \$40 Copay \$0 100% after	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 Spool Ind/\$1,000 Fam of Ded + 20% after Ded. Spool Ind/\$1,000 Fam of Ded. Spool Ind/\$1	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 In Network Outpatient Preventive and Diagnostic Services Preventative Office Visits Preventative Office Visits, Routine GYN, Well Baby Visits Preventative Office Visits, Routine GYN, Well Baby Visits Preventative Office Visits, Routine GYN, Well Baby Visits 100% Coverage Preventive Diagnostic X-Rays, Lab Tests, & Imaging 100% Coverage 100% Coverage \$0 100% After \$40 Copay \$0 100% after \$50 Copay \$0 100% after \$50 Copay \$0 In Network Prescription Drug Retail Prescription Drugs \$77 \\$25 \\$40 \\$65 Copay \$0 Remaining Deductible Amounts \$0 Remaining Deductible Amounts \$0 Remaining Deductible Amounts \$0 80% 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
Primary Care Office Visits 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 Retail Preventive Care & Immunizations 100% Coverage 100% after \$40 Copay 100% after \$50	Short-term Rehabilitation Therapy (Physical, Occupational, & Speech)	\$500 Ind/\$1,000 Fam of Ded + 20% after Ded.	\$5,250 Ind/\$10,500 Fam of Deductible	80% After Deductible
Primary Care Office Visits \$25 Copay \$0 100% after \$25 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 High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% Coverage High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine 100% Coverage \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$40 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$40 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$40 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$40 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$50 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$50 Copay \$0 100% after \$40 Copay High-end Radiology Services, Major Diagnostics, and Nuclear Medicine \$50 Copay \$0 100% after \$40 Copay High-end Radiology	Durable Medical Equipment	\$500 Ind/\$1,000 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% after \$40 Copay \$0 100% after \$50 C	In-Network Outpatient Preventive and Diagnostic Services			
Preventive Diagnostic X-Rays, Lab Tests, & Imaging Adult & Pediatric Preventive Care & Immunizations 100% Coverage 100% After \$40 Copay 100% After \$50 Copay	Primary Care Office Visits	\$25 Copay	\$0	100% after \$25 Copay
Adult & Pediatric Preventive Care & Immunizations 100% Coverage \$0 100% Coverage High-end Radiology Services, Major Diagnostics, and Nuclear Medicine Specialty Care Office Visits \$40 Copay \$0 100% after \$40 Copay Specialty Care Office Visits (Max 12 visits per year) \$40 Copay \$0 100% after \$40 Copay Specialty Care Office Visits (Max 12 visits per year) \$40 Copay \$0 100% after \$40 Copay Specialty Care Office Visits (Max 12 visits per year) \$40 Copay \$0 100% after \$40 Copay Specialty Care (i.e., Walk-in treatment centers) \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 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 Opay Specialty Care Office Visits (Max 12 visits per page of 100% after \$40 Copay Specialty Care Opay Specialty Care Op	Preventive Diagnostic X-Rays, Lab Tests, & Imaging	100% Coverage		100% Coverage
Specialty Care Office Visits \$40 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			-
Chiropractic Office Visits (Max 12 visits per year) Eye Exams (limit 1 visit per year) Syo Copay \$0 100% after \$40 Copay Outpatient Mental Health & Substance Abuse treatment \$40 Copay Urgent Care (i.e., Walk-in treatment centers) Ambulance Services Eregency Room (Waived if admitted) Retail Prescription Drug Retail Prescription Drugs Annual Deductible per Individual Annual Deductible per Family Coinsurance Out-of-pocket maximum per Individual \$40 Copay \$40 Copay \$40 Copay \$40 Copay \$40 Copay \$50 100% after \$40 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 Copay \$50 Copay \$50 Copay \$50 Copay \$50 100% after \$50 Copay		100% Coverage	·	100% Coverage
Eye Exams (limit 1 visit per year) S40 Copay Outpatient Mental Health & Substance Abuse treatment Y40 Copay Urgent Care (i.e., Walk-in treatment centers) Ambulance Services Exercises S50 Copay S0 100% after \$40 Copay Mental Health & Substance Abuse treatment \$40 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 100% after \$50 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 1	Specialty Care Office Visits	\$40 Copay	•	100% after \$40 Copay
Outpatient Mental Health & Substance Abuse treatment \$40 Copay Urgent Care (i.e Walk-in treatment centers) Ambulance Services Emergency Room (Waived if admitted) In-Network Prescription Drug Retail Prescription Drugs S7 / \$25 / \$40 / \$65 Copay Annual Deductible per Individual Annual Deductible per Family Coinsurance Out-of-pocket maximum per Individual \$40 Copay \$50 Copay \$50	Chiropractic Office Visits (Max 12 visits per year)	\$40 Copay	\$0	100% after \$40 Copay
Urgent Care (i.e., Walk-in treatment centers) \$50 Copay \$50 Copay Ambulance Services \$50 Copay \$50 Copay \$50 100% after \$50 Copay Emergency Room (Waived if admitted) \$150 Copay \$50 100% after \$50 Copay \$50 Copay \$50 100% after \$50 Copay \$50 100% after \$150 Copay In-Network Prescription Drug Retail Prescription Drugs \$7 / \$25 / \$40 / \$65 Copay \$50 \$100% after \$7 / \$25 / \$40 / \$65 Copay \$50 \$100% after \$7 / \$25 / \$40 / \$65 Copay \$50 Copay Copay Copay Copay Copay Remaining Deductible Amounts \$50 Copay \$50 Copay \$50 Copay Remaining Deductible Amounts \$50 Copay \$50 Copay N/A N/A N/A	Eye Exams (limit 1 visit per year)	\$40 Copay	\$0	100% after \$40 Copay
Ambulance Services \$50 Copay \$0 100% after \$50 Copay \$0 100% after \$150 Copay \$0 \$0 100% after \$150 Copay \$0 \$0 \$0 \$0 after \$150 Copay \$0 \$0 \$0 \$0 after \$7 / \$25 / \$40 / \$60 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	Outpatient Mental Health & Substance Abuse treatment	\$40 Copay	\$0	100% after \$40 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 First \$200 Remaining Deductible Amounts 80% After Deductible Annual Deductible per Family Coinsurance 100% after \$7/\$25/\$40/\$65 Copay Remaining Deductible Amounts 80% After Deductible 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 First \$400 Remaining Deductible Amounts 80\% After Deductible Coinsurance 20\% Remaining Coinsurance Amounts 80\% After Deductible Note of Pocket maximum per Individual \$1,200 N/A N/A	Emergency Room (Waived if admitted)	\$150 Copay	\$0	100% after \$150 Copay
Retail Prescription Drugs\$77\$257\$407\$55 Copay\$0CopayOut-of-Network ServicesSome of the prescription DrugsCopayAnnual Deductible per IndividualFirst \$200Remaining Deductible Amounts80% After DeductibleAnnual Deductible per FamilyFirst \$400Remaining Deductible Amounts80% After DeductibleCoinsurance20%Remaining Coinsurance Amounts80%Out-of-pocket maximum per Individual\$1,200N/AN/A	In-Network Prescription Drug			
Annual Deductible per Individual Annual Deductible per Family Annual Deductible per Family First \$400 Remaining Deductible Amounts 80% After Deductible Remaining Coinsurance Amounts 80% 80% N/A 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% Out-of-pocket maximum per Individual \$1,200 N/A N/A	Out-of-Network Services			
Coinsurance 20% Remaining Coinsurance Amounts 80% Out-of-pocket maximum per Individual \$1,200 N/A N/A	Annual Deductible per Individual	First \$200	Remaining Deductible Amounts	80% After Deductible
Out-of-pocket maximum per Individual \$1,200 N/A N/A	Annual Deductible per Family	First \$400	Remaining Deductible Amounts	80% After Deductible
	Coinsurance	20%	Remaining Coinsurance Amounts	80%
Out-of-pocket maximum per Family \$2,400 N/A N/A	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.