EXHIBIT A HEALTHCARE

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay per visit	$10 copay plus 20% coinsurance per visit	None
	Specialist visit	$10 copay per visit	$10 copay plus 20% coinsurance per visit	Chiropractic Services are limited to 12 visit(s) per year; $15 copay for allergy and dermatology office visits
	Preventive care/screening/immunization	No Charge	$10 copay plus 20% coinsurance	Member liability for Out-of-Network is based on services received; You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	Preauthorization is recommended for certain services
	Imaging (CT/PET scans, MRIs)	No Charge	20% coinsurance	
If you need drugs to treat your illness or condition	Tier 1 generic drugs	20% Coinsurance (Retail & Mail Order)	Not Covered	All specialty and some non-specialty medications require a Prior Authorization before being dispensed. Frequency of fills are as follows: 30 days for retail; 90 days for mail; 30 days for Specialty. Infertility drugs: 20% coinsurance. This information may change with the PBM (Pharmacy Benefits Manager)
	Tier 2 preferred brand name drugs	20% Coinsurance (Retail & Mail Order)	Not Covered	
	Tier 3 non-preferred brand name drugs	20% Coinsurance (Retail & Mail Order)	Not Covered	
	Tier 4 specialty prescription drugs	20% Coinsurance (CVS Specialty Pharmacy only)	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	Preauthorization is recommended; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Physician/surgeon fees	No Charge	20% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
If you need immediate medical attention	Emergency room care	$25 copay per visit	$25 copay; deductible does not apply per visit	Emergency room: Copay waived if admitted. Urgent care: Applies to the visit only. If additional services are provided additional out of pocket costs would apply based on services received.
	Emergency medical transportation	$50 copay per trip	$50 copay; deductible does not apply per trip	
	Urgent care	$10 copay per urgent care center visit	$10 copay plus 20% coinsurance per urgent care center visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	Preauthorization is recommended; 45 day limit at an inpatient rehabilitation facility; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Physician/surgeon fee	No Charge	20% coinsurance	Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit No Charge for outpatient services	$10 copay plus 20% coinsurance/office visit 20% coinsurance for outpatient services	Preauthorization is recommended for certain services
	Inpatient services	No Charge	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$10 copay per visit	$10 copay plus 20% coinsurance per visit	Cost sharing does not apply for preventive services; Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization is recommended.
	Childbirth/delivery professional services	No Charge	20% coinsurance	
	Childbirth/delivery facility services	No Charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	20% coinsurance	Private duty nursing: 20% coinsurance; Preauthorization is recommended
	Rehabilitation services	20% coinsurance	20% coinsurance	Services include Physical, Occupational and Speech Therapy; Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	No Charge	20% coinsurance	Preauthorization is recommended; Custodial care is not covered
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is recommended for certain services. Some In-Network services related to RI Mastectomy Treatment Mandate are covered at No Charge.
	Hospice service	No Charge	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$10 copay per visit	$10 copay plus 20% coinsurance per visit	Limited to one routine eye exam per year.
	Children's glasses	100% of provider charge	100% of provider charge; deductible does not apply	Limited to $100 per member age 0 - 18 per occurrence/$100 per member age 19 and over per year for prescription glasses (frames and/or lenses) or contact lenses.
	Children's dental check-up	Not Covered	Not Covered	None