MEDICAL

<table>
<tr><td rowspan="2">Summary of Benefits III-A Trust Standard Plan FRP 500
Effective Date: October 1, 2022</td><td colspan="2">Preferred Blue Large</td></tr>
<tr><td>In-Network</td><td>Out-of-Network</td></tr>
<tr><td>Benefit Period* Deductible (Individual/Family)</td><td colspan="2">$500 / $1,000</td></tr>
<tr><td>Cost Sharing</td><td>You pay 20% of the allowed amount</td><td>You pay 40% of the allowed amount</td></tr>
<tr><td>Individual Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)</td><td>$2,500</td><td>$4,000</td></tr>
<tr><td>Family Out-of-Pocket Limit (See Plan for services that do not apply to the limit.) (Includes applicable Deductible, Cost Sharing and Copayments)</td><td>$5,000</td><td>$8,000</td></tr>
<tr><td>Copayment (Applies to In-Network only. Other services rendered during an Office Visit will be subject to Deductible and Cost Sharing.)</td><td>You pay a $20 Copayment</td><td>Not applicable</td></tr>
<tr><td rowspan="2">COVERED SERVICES
By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization.</td><td>In-Network</td><td>Out-of-Network</td></tr>
<tr><td colspan="2">What you pay</td></tr>
<tr><td>Acupuncture (Only for a licensed acupuncturist) (Limited to 52 visits combined In- and Out-of-Network per member, per Benefit Period)</td><td>No charge up to $80 of the allowed amount per day</td><td>No charge up to $80 of the billed charge per day</td></tr>
<tr><td>Advanced Imaging Services (Outpatient services only)
(Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography Scan (CT Scan), Positron Emission Tomography (PET), Nuclear Cardiology)</td><td>Deductible and Cost Sharing</td><td rowspan="3">Deductible and Cost Sharing</td></tr>
<tr><td>Allergy Injections
• Administration Only

• Allergy Serum</td><td>$5 Copayment (if this is the only service provided during the visit)

$20 Copayment</td></tr>
<tr><td>Ambulance Transportation Services
• Ground Ambulance Services</td><td rowspan="3">Deductible and Cost Sharing</td></tr>
<tr><td>• Air Ambulance Services
(Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.)</td><td>Deductible and In-Network Cost Sharing</td></tr>
<tr><td>Bariatric Surgery for Morbid Obesity (Lifetime maximum benefit of $20,000 combined per Participant.)</td><td rowspan="3">Deductible and Cost Sharing</td></tr>
<tr><td>Breastfeeding Support and Supply Services (Limited to one (1) breast pump purchase per Benefit Period, per Participant)</td><td>No charge</td></tr>
<tr><td>Cardiac Rehabilitation Therapy Services – Outpatient (Limited to 36 visits combined per Participant, per Benefit Period)</td><td>Deductible and Cost Sharing</td></tr>
</table>

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding Plan, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding Plan, the Plan will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding Plan.

Preferred Blue®PPO

COVERED SERVICES *By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization*	**In-Network**	**Out-of-Network**
	What you pay	
Chiropractic Care Additional services, such as laboratory, x-ray, and other Diagnostic Services are not included in the Office Visit. *(Limited to 24 visits combined per Participant, per Benefit Period)*	Copayment	Deductible and Cost Sharing
Colonoscopies and Sigmoidoscopies (Preventive and Diagnostic)	No charge	
Dental Services Related to Accidental Injury	Deductible and Cost Sharing	Deductible and Cost Sharing
Diabetes Self-Management Education Services (Only for accredited Providers approved by BCI.)	Copayment	
Diagnostic Services	Deductible and Cost Sharing	
Durable Medical Equipment, Orthotic Devices and Prosthetic Appliances		
Emergency Services – Facility Services (Copayment waived if admitted) (Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount. Additional services, such as laboratory, x-ray, and other Diagnostic Services are subject to applicable Deductible, Cost Sharing and/or Copayment.)	$100 Copayment for hospital Outpatient emergency room visit, then Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Emergency Services – Professional Services (Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.)	Deductible and In-Network Cost Sharing. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Hearing and Hearing Aid Exams	Copayment	Deductible and Cost Sharing
Home Health Skilled Nursing	Deductible and Cost Sharing	
Home Intravenous Therapy		80% Cost Sharing after Deductible
Hospice Services	No charge	Deductible and Cost Sharing
Hospital Services (Inpatient and Outpatient services at a licensed general hospital or ambulatory surgical facility.)	Deductible and Cost Sharing	
Mammograms (Preventive and Diagnostic)	No charge	
Maternity Services and/or Involuntary Complications of Pregnancy	Deductible and Cost Sharing	
Mental Health and Substance Use Disorder – Inpatient (Facility and Professional Services)	Deductible and Cost Sharing	
Mental Health and Substance Use Disorder – Outpatient: **Psychotherapy Services**	Copayment	
Pediatric Outpatient Psychotherapy Services (For Participants under the age of eighteen (18).)	No charge	
Facility and other Professional Services	Deductible and Cost Sharing	
Outpatient Applied Behavioral Analysis	Copayment	
• **Pediatric Outpatient Applied Behavioral Analysis** (For Participants under the age of eighteen (18).)	No charge	

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding Plan, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding Plan, the Plan will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding Plan.

Preferred Blue® PPO

<table>
<tr><th rowspan="2">COVERED SERVICES
By choosing a Noncontracting Provider you may be responsible for the difference between what Blue Cross allows and what the Noncontracting Provider charges. This is called balance-billing. Some services may require Prior Authorization</th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><th colspan="2">What you pay</th></tr>
<tr><td>Treatment for Autism Spectrum Disorder</td><td colspan="2">Covered the same as any other illness, depending on the services rendered, see appropriate Covered Services section of the Benefits Outline. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.</td></tr>
<tr><td>Outpatient Habilitation Physical Therapy Services (Limited to 40 visits combined per Participant, per Benefit Period.)</td><td>Copayment</td><td rowspan="14">Deductible and Cost Sharing</td></tr>
<tr><td>Outpatient Habilitation Therapy Services (Includes speech and occupational therapies. Limited to 40 visits combined per Participant, per Benefit Period.)</td><td>Deductible and Cost Sharing</td></tr>
<tr><td>Outpatient Rehabilitation Physical Therapy Services (Limited to 40 visits combined per Participant, per Benefit Period.)</td><td>Copayment</td></tr>
<tr><td>Outpatient Rehabilitation Therapy Services (Includes speech and occupational therapies. Limited to 40 visits combined per Participant, per Benefit Period.)</td><td>Deductible and Cost Sharing</td></tr>
<tr><td>Palliative Care Services</td><td>No charge</td></tr>
<tr><td>Physician Office Visit (Other services rendered during a Physician Office Visit will be subject to Deductible and Cost Sharing.)</td><td>Copayment</td></tr>
<tr><td>Post-Mastectomy/Lumpectomy Reconstructive Surgery</td><td>Deductible and Cost Sharing</td></tr>
<tr><td>Pediatric Physician Office Visit (For Participants under the age of eighteen (18).)</td><td rowspan="3">No charge</td></tr>
<tr><td>Prescribed Contraceptive Services (Includes diaphragms, intrauterine devices (IUDs), implantables, injections, tubal ligation and vasectomy.)</td></tr>
<tr><td>PSA Tests and Pap Smears</td></tr>
<tr><td>Rehabilitation or Habilitation Services</td><td rowspan="4">Deductible and Cost Sharing</td></tr>
<tr><td>Skilled Nursing Facility (Limited to 30 days combined per Participant, per Benefit Period.)</td></tr>
<tr><td>Sleep Study Services</td></tr>
<tr><td>Surgical/Medical (Professional Services)</td></tr>
<tr><td>Telehealth Virtual Care Services</td><td colspan="2">Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services – see appropriate Covered Services section.</td></tr>
<tr><td>Therapy Services (Including chemotherapy, growth hormone therapy, radiation and renal dialysis.)</td><td rowspan="2">Deductible and Cost Sharing</td><td rowspan="3">Deductible and Cost Sharing</td></tr>
<tr><td>Transplant Services</td></tr>
<tr><td>Preventive Care Benefits (See Plan for specifically listed preventive care services.)</td><td>No charge for services specifically listed

For services not specifically listed Deductible and Cost Sharing</td></tr>
<tr><td>Immunizations (See Plan for specifically listed immunizations.)</td><td colspan="2">No charge for listed immunizations</td></tr>
</table>

*The specified period of time during which charges for Covered Services must be incurred in order to accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits.

This information is for comparison purposes only and not a complete description of benefits. All descriptions of coverage are subject to the provisions of the corresponding Plan, which contains all the terms and conditions of coverage. Certain services not specifically noted may be excluded. Please refer to the Plan issued for a complete description of benefits, exclusions limitations and conditions of coverage. If there is a difference between this comparison and its corresponding Plan, the Plan will control. This comparison is subject to annual update and may not reflect the information contained in the corresponding Plan.