Pressmen Welfare Fund

Group Medical/Rx
Renewal Options Report

August 9, 2022

Prepared by
Lakeshore Benefit Group Insurance Brokerage, LLC

P: 860.738.9512
F: 860.738.9736

Pressmen Welfare Fund

Table of Contents

Pressmen Welfare Fund

Section One

Pressmen Welfare Fund

Plan Comparison Summary

Plan Design	Kaiser HMO (Signature)	Kaiser DHMO (Signature)	Kaiser DHMO (Select)	Kaiser DHMO Minimum Value (Signature)
Carrier	KAISER PERMANENTE	KAISER PERMANENTE	KAISER PERMANENTE	KAISER PERMANENTE
Plan Type	HMO	HMO	HMO	HMO
In Network Deductible	None	$750/$1,500	$750/$1,500	$5,000/$10,000
Out of Network Deductible	N/A	N/A	N/A	N/A
In Network Coinsurance	0%	10%	20%	40%
Out of Network Coinsurance	N/A	N/A	N/A	N/A
In Network Out of Pocket Maximum	$3,500/$9,400 (plan year)	$3,000/$6,000 (plan year)	$3,000/$6,000 (plan year)	$8,500/$17,000 (plan year)
Out of Network Out of Pocket Maximum	N/A	N/A	N/A	N/A
PCP Office Co-Pay	$15 copay	$15 copay	$20 copay	$70 copay after deductible
Specialist Office Co-Pay	$20 copay	$25 copay	$30 copay	$90 copay
Chiropractic Services	$20 copay (20 visits per plan year)	$15 copay (20 visits per plan year)	$15 copay (20 visits per plan year)	Not Covered
Acupuncture Services	$20 copay (20 visits per plan year)	$15 copay (20 visits per plan year)	$15 copay (20 visits per plan year)	Not Covered
Out Patient Diagnostic (lab and x-ray)	Covered in Full	$15 copay	$20 copay	$70/$150 copay
Out Patient Diagnostic (CT,PET, MRI, MRA and nuclear medicine)	$100 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Out Patient Surgical	$50 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
In Patient Hospital	$100 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Room Co-Pay	$100 copay	$100 copay	$100 copay	40% coinsurance after deductible
Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Rx Deductible	None	None	None	None
Rx Generic	$5/$15	$5/$15	$5/$15	$25/$35
Rx Brand	$15/$25	$15/$25	$15/$25	$60/$70
Rx Non-Pref. Brand	$30/$40	$30/$40	$30/$40	50%/60%
Rx Preferred Specialty	$30/$40	$30/$40	$30/$40	50%/60%
Rx Non-Pref. Specialty	$30/$40	$30/$40	$30/$40	50%/60%
Rx Mail order - 90 days	2 times copay	2 times copay	2 times copay	2 times copay
Composite - current	$1,350.03	$913.69	$1,822.48	$685.68
Composite - renewal	$1,416.19	$958.47	$1,911.79	$719.28
Estimated Current Premium	$1,631,296.20			
Estimated Renewal Premium	$1,711,242.96			
Additional Concessions	$0.00			
Renewal Premium (after concessions)	$1,711,242.96			
Renewal Premium Increase (after concessions)	4.90%			

Pressmen Welfare Fund

Plan Comparison Summary

Plan Design	CareFirst HMO Open Access Option 3	CareFirst Blue Choice Advantage Option 16	CareFirst HMO Open Access Option C	CareFirst HMO Open Access Option MV4
Carrier	CareFirst	CareFirst	CareFirst	CareFirst
Plan Type	HMO - PCP Required - No Referrals	PPO	HMO - PCP Required - No Referrals	HMO - PCP Required - No Referrals
In Network Deductible	None	$500/$1,000	$500/$1,000	$5,000/$10,000
Out of Network Deductible	N/A	$1,000/$2,000	N/A	N/A
In Network Coinsurance	0%	0%	0%	0%
Out of Network Coinsurance	N/A	20%	N/A	N/A
In Network Out of Pocket Maximum	$1,300/$2,600 medical and $4,500/$9,000 Rx (plan year)	$1,000/$2,000 (plan year)	$2,500/$5,000 medical and $3,500/$7,000 Rx (plan year)	$7,350/$14,700 (plan year)
Out of Network Out of Pocket Maximum	N/A	$2,000/$4,000 (plan year)	N/A	N/A
PCP Office Co-Pay	$10 copay	$20 copay in network/20% coinsurance after deductible out of network	$30 copay after deductible	$30 copay
Specialist Office Co-Pay	$20 copay	$30 copay in network/20% coinsurance after deductible out of network	$40 copay after deductible	$60 copay
Chiropractic Services	$20 copay (20 visits per plan year)	$30 copay in network (20 visits per plan year) /20% coinsurance after deductible out of network	$40 copay after deductible (20 visits per plan year)	$60 copay (20 visits per plan year)
Acupuncture Services	Not Covered	$30 copay in network (20 visits per plan year) /20% coinsurance after deductible out of network	Not Covered	$60 copay (20 visits per plan year)
Out Patient Diagnostic (lab and x-ray)	Covered in full. Must use LabCorp and a free standing facility for imaging.	Covered in full in network. Must use LabCorp/20% coinsurance after deductible out of network	Covered in full. Must use LabCorp and a free standing facility for imaging.	Covered in full. Must use LabCorp and a free standing facility for imaging.
Out Patient Diagnostic (CT,PET, MRI, MRA and nuclear medicine)	Covered in full. Must use LabCorp and a free standing facility for imaging.	$30 copay in network. Must use LabCorp/20% coinsurance after deductible out of network	Covered in full. Must use LabCorp and a free standing facility for imaging.	Subject to deductible. Must use LabCorp when applicable
Out Patient Surgical	Covered in Full	Subject to deductible in network/20% coinsurance after deductible out of network	Subject to deductible	Subject to deductible
In Patient Hospital	Covered in Full	$300 after deductible in network/20% coinsurance after deductible out of network	Subject to deductible	Subject to deductible
Emergency Room Co-Pay	$50 copay	$250 after deductible	$100 after deductible	$250 after deductible
Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Rx Deductible	None	None	None	None
Rx Generic	$15	$15	$15	$15
Rx Brand	$35	$35	$35	$50
Rx Non-Pref. Brand	$60	$60	$60	$100
Rx Preferred Specialty	50% to $100	50% to $100	50% to $100	50% to $100
Rx Non-Pref. Specialty	50% to $150	50% to $150	50% to $150	50% to $150
Rx Mail order - 90 days	2 times copay	2 times copay	2 times copay	2 times copay
Composite - current	N/A	N/A	N/A	N/A
Composite - renewal	$1,420.50	$1,144.99	$1,700.18	$749.95
Estimated Current Premium	N/A			
Estimated Renewal Premium	$1,867,730.52			
Additional Concessions	$155,644.21			
Renewal Premium (after concessions)	$1,712,086.31			
Renewal Premium Increase (after concessions)	4.95%			

Pressmen Welfare Fund

Plan Comparison Summary

Plan Design	UHC CK5P mod (OCI Modified)	UHC CK6D mod (OCI Modified)	UHC CK5U mod (OCI Modified)	UHC CK7B mod (OCI Modified)	UHC CLNC mod (Traditional Modified) - PA MEMBER ONLY
Carrier	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare	UnitedHealthcare
Plan Type	HMO - PCP and Referrals Required	HMO - PCP and Referrals Required	HMO - PCP and Referrals Required	HMO - PCP and Referrals Required	EPO - No PCP or Referral Required
In Network Deductible	None	$750/$1,500	$750/$1,500	$5,000/$10,000	None
Out of Network Deductible	N/A	N/A	N/A	N/A	N/A
In Network Coinsurance	0%	10%	20%	40%	0%
Out of Network Coinsurance	N/A	N/A	N/A	N/A	N/A
In Network Out of Pocket Maximum	$3,500/$9,400 (plan year)	$3,000/$6,000 (plan year)	$3,000/$6,000 (plan year)	$8,500/$17,000 (plan year)	$3,500/$9,400 (plan year)
Out of Network Out of Pocket Maximum	N/A	N/A	N/A	N/A	N/A
PCP Office Co-Pay	$15 copay	$15 copay	$20 copay	$70 copay	$15 copay
Specialist Office Co-Pay	$20 copay	$25 copay	$30 copay	$90 copay	$20 copay
Chiropractic Services	$15 copay (20 visits per plan year)	$15 copay (20 visits per plan year)	$20 copay (20 visits per plan year)	Not Covered	$15 copay (20 visits per plan year)
Acupuncture Services	$20 copay (12 visits per plan year)	$25 copay (12 visits per plan year)	$20 copay (12 visits per plan year)	Not Covered	$20 copay (12 visits per plan year)
Out Patient Diagnostic (lab and x-ray)	Covered in Full	Covered in Full	Covered in Full	Covered in Full	$60 copay
Out Patient Diagnostic (CT,PET, MRI, MRA and nuclear medicine)	$100 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	$100 copay
Out Patient Surgical	$50 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	$50 copay
In Patient Hospital	$100 copay	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	$100 copay
Emergency Room Co-Pay	$100 copay	$100 copay	$100 copay	40% coinsurance after deductible	$100 copay
Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Rx Deductible	None	None	None	None	None
Rx Generic	$10	$10	$10	$10	$10
Rx Brand	$35	$35	$35	$50	$35
Rx Non-Pref. Brand	$70	$70	$70	$100	$70
Rx Preferred Specialty	$70	$70	$70	$100	$70
Rx Non-Pref. Specialty	$70	$70	$70	$100	$70
Rx Mail order - 90 days	2.5 times copay	2.5 times copay	2.5 times copay	2.5 times copay	2.5 times copay
Composite - current	N/A	N/A	N/A	N/A	N/A
Composite - renewal	$1,218.93	$1,123.64	$1,100.68	$739.10	$1,357.96
Estimated Current Premium	N/A				
Estimated Renewal Premium	$1,757,655.84				
Additional Concessions	$0.00				
Renewal Premium (after concessions)	$1,757,655.84				
Renewal Premium Increase (after concessions)	7.75%				

Pressmen Welfare Fund
Comments and Conditions

1 Rates and premium calculations are based on census data provided:

	HMO (Signature)	DHMO (Signature)	DHMO (Select)	Minimum Value	Total
Total	43	78	1	7	129

2 Rates assume an effective date of October 1, 2022.

3 Rates subject to final underwriting and disclosure. This includes updated experience reports and census data.

4 Benefit summaries are not a complete outline of coverage. Please refer to carrier's benefit summaries.

Section Two

Rate Sheet—Medical/Pharmacy

CareFirst Family of health care plans

Pressmen Welfare Fund

	BlueChoice HMO Open Access Option MV4	BlueChoice Advantage Option 16	BlueChoice HMO Open Access Option 3	BlueChoice HMO Open Access Option C
In-Network				
Office Visit PCP/ Spec	$30 / $60	$20 / $30	$10 / $20	$30 / $40
I/P	$0	$300	$0	$0
ER	$250	$250	$50	$100
Deductible	$5,000	$500	$0	$500
Coinsurance	0%	0%	0%	0%
Out of Pocket	$7,350	$1,000	$1,300	$2,500
Out-of-Network				
Deductible	n/a	$1,000	n/a	n/a
Coinsurance	n/a	20%	n/a	n/a
Out of Pocket	n/a	$2,000	n/a	n/a
Pharmacy				
Retail Generic/ Preferred Brand/ Non-Preferred Brand	$15/50/100	$15/35/60	$15/35/60	$15/35/60
Retail Preferred Specialty	50% Coinsurance $100 Max	50% Coinsurance $100 Max	50% Coinsurance $100 Max	50% Coinsurance $100 Max
Retail Non-Preferred Specialty	50% Coinsurance $150 Max	50% Coinsurance $150 Max	50% Coinsurance $150 Max	50% Coinsurance $150 Max
Deductible	$0	$0	$0	$0
Out of Pocket	Integrated	Integrated	$4,500	$3,500
Enrollment				
Individual	5	45	13	0
Individual & Adult	0	0	0	0
Individual & Child(ren)	0	0	0	0
Family	2	34	28	1
Comp To Med	0	0	0	0
Total	7	79	41	1
Rates				
Individual	$473.80	$609.69	$593.56	$559.27
Individual & Adult	$1,089.73	$1,402.30	$1,365.19	$1,286.32
Individual & Child(ren)	$876.52	$1,127.94	$1,098.09	$1,034.65
Family	$1,440.34	$1,853.47	$1,804.43	$1,700.18
Comp To Med	$364.82	$469.46	$457.04	$430.63
Monthly Cost*	$5,249.68	$90,454.03	$58,240.32	$1,700.18
Yearly Cost*	$62,996.16	$1,085,448.36	$698,883.84	$20,402.16

Medical & Rx Cost* **$1,867,730.52**

CareFirst is pleased to offer a one-time premium credit for the policy period. The amount of the credit will be $117,000.
The maximum credit is based on the product and enrollment assumptions on this exhibit. The credit may not be used to reduce or satisfy any owed Producer Service Fee.
Your next renewal will be based on the total annual cost, less any producer service fee, and prior to any premium credit reductions.
Note that if you terminate your plan before the end of the first policy period, CareFirst reserves the right to be reimbursed for the credit within 60 days of termination.

A Wellness credit of $2,500 is available for the policy period.
*The Producer Service Fee, if any, is agreed to as set forth in the executed Producer Service Fee Collection Agreement.
CareFirst will not administer the Producer Service Fee without an executed Producer Service Fee Collection Agreement.

Broker Name | ID #
Dawn Welch

Producer Service Fee
Medical/Pharmacy: 0.00%

Commissions
Dental: N/A
Vision: N/A

FTE Count **129**

|X| These rates will be in effect from October 1, 2022 until September 30, 2023.
|X| Deductibles and maximums will apply on a Contract Year basis.
|X| The rates and costs shown above include both Premium and PSF as stated.
|X| The above benefits and rates are subject to guidelines listed on the caveats page.
|X| High Level Benefit Summary. Please refer to your plan summary for a more detailed description.
|X| **To realize whole health savings off your medical rate, consider purchasing a new employer-sponsored dental, vision, life or disability plan.**

Employer Identification Number

Authorized Signature

Print Name

Title

Date

*Rates and Cost include the Producer Service Fee and Premium
10455 Mill Run Cir, Owings Mills, MD 21117

MC

7/19/2022

0286704-05-5-6-7-8-0000

CareFirst
Family of health care plans

Limitations and Exclusions

Pressmen Welfare Fund

General Caveats

[X] CareFirst reserves the right to revise the rates if the actual enrollment or demographics varies by more than 10% from that used in the original rating.

[X] CareFirst reserves the right to revise the rates if applicable law or regulatory authority requires such revisions.

[X] CareFirst reserves the right to revise the rates upon receipt of information not previously disclosed.

[X] CareFirst BlueCross BlueShield (CareFirst) does not collect or pay commission for medical and prescription pharmacy benefits. At the policyholder's election, and in accordance with an executed CareFirst Producer Service Fee Collection Agreement, CareFirst BlueCross BlueShield (CareFirst) will administer the collection of a Producer Service Fee. The Producer Service Fee is not a component of the premium. The Producer Service Fee is negotiated directly between the policy holder and producer. CareFirst will not administer the Producer Service Fee without an executed Producer Service Fee Collection Agreement.

[X] Any bundling discounts will be removed immediately once the criteria for such discounts are no longer applicable.
For example, should the Group elect to terminate any ancillary product mid-contract period, the medical premium will be adjusted immediately to reflect only the bundled discounts, if any, that still apply.

Medical / Pharmacy Caveats

[X] CareFirst must be the sole health plan offered by the group to its employees.

[X] Rates are subject to change if the number of medical plans purchased differs from the number of plans on the rate sheet.

[X] These rates are valid upon receipt and review of a completed CareFirst Health Screening Questionnaire (not required if claims experience is provided).

[X] Unless the Notice of Intent of Grandfathered Status is completed and returned to CareFirst BCBS at time of sale, the health plan(s) listed will not be considered grandfathered plan(s) under the Patient Protection and Affordable Care Act.

10455 Mill Run Cir, Owings Mills, MD 21117

MC

7/19/2022

0286704-05-5-6-7-8-0000

CareFirst Producer Service Fee Collection Agreement

Group Name:	Group Number:

Representations

The Parties understand and hereby represent to CareFirst that:

1. The Group has 51 or more eligible employees and has purchased (or will purchase) fully insured large group health insurance issued by CareFirst in Maryland, the District of Columbia or Virginia. Alternatively, the Group may be an Entity that is sponsoring a Student Health Plan for the purpose of providing health services coverage for specified students.
2. The Producer is an independent contractor and is not an employee of a Group or CareFirst.
3. In connection with its purchase of health insurance, the Group has engaged the Producer to provide services ("Services") to the Group in exchange for a fee negotiated between the Group and Producer (the "Producer Service Fee" or "PSF"), in compliance with applicable state law. The Producer may also be entitled to receive a separate commission from the insurer for selling, soliciting, or negotiating the insurance. 38.2-1812.2
4. The Group and Producer understand and agree that the Producer Service Fee is neither consideration for, nor a condition of, receiving insurance from CareFirst. For Groups using a Producer, CareFirst does not:
   (a) Determine the amount of the Producer Service Fee;
   (b) Determine the services provided by Producer in exchange for such fee;
   (c) Participate in negotiations between the Group and Producer relating to such fee; or
   (d) Require that the Group use CareFirst to administer any fees that the Group has negotiated with the Producer.
5. CareFirst has no responsibility to provide the Services or to oversee the provision of the Services.

Agreement

The Parties agree as follows:

1. The Representations set forth above are true and accurate.
2. CareFirst will administer the PSF subject to the Terms and Conditions set forth in the attached Addendum, or as subsequently modified by CareFirst upon notice to the Parties, until CareFirst's administration is terminated as it was provided in this Agreement.
3. The Group recognizes that CareFirst may have an agreement with the Producer under which the Producer may be compensated for the performance of additional administrative services, or otherwise under programs offered by CareFirst to agents and brokers. Such compensation will be treated as an administrative expense of CareFirst and will not be an additional charge to the Group. CareFirst will be responsible for paying such compensation under the terms of the applicable compensation program.
4. The terms of this Agreement are binding upon the Parties, their successors and their assigns, and may be modified in writing executed by the Parties only.
5. The following outlines the terms of the Producer Service Fee to be administered by CareFirst:
   - **The Producer Service Fee Percentage** is the total premium for medical and prescription insurance purchased by the Group from CareFirst, in an amount up to 5%. This does not include dental, vision or ancillary insurance products.
   - **Effective Date:** The PSF will be effective beginning the date upon which this Agreement is executed (or the Group's effective date for new groups).

BOK0059-1E (1/21)

Producer and Group Will Enter Into this Agreement

The undersigned Producer and Group (collectively "the Parties") enter into this Agreement for purpose of authorizing CareFirst BlueCross BlueShield[1] and/or CareFirst BlueChoice, Inc. (collectively "CareFirst") to administer a Producer Service Fee on behalf of the Group.

The parties agree to the terms of this CareFirst Producer Service Fee Collection Agreement as set forth above.

SIGNATURES	
By and on behalf of Group:	**By and on behalf of Producer:**
Name of Group	Name of Producer (Agency Name Here)
Street Address	Street Address
City, State, Zip	City, State, Zip
Signature	Signature
Name of Signer	Printed Broker Name
Group Number	Producer Service Fee Percentage
Date	Date

Producer and Group Will NOT Enter Into this Agreement

☐ Only check this box if the Producer and Group will **NOT** enter into this Agreement to authorize CareFirst BlueCross BlueShield[1] and/or CareFirst BlueChoice, Inc. (collectively "CareFirst") to administer a Producer Service Fee on behalf of the Group. Please complete the below fields.

By and on behalf of Producer:

Group Name:	Group Number:
Signature:	Date:
Printed Name:	Agency:

Addendum to CareFirst Producer Service Fee Collection Agreement

CareFirst's administration of the Producer Service Fee ("PSF") is subject to the following terms and conditions:

1. CareFirst will only administer a PSF after receiving a fully executed Producer Service Fee Collection Agreement. No changes to the template agreement may be made.
2. The PSF will be administered as a percentage of the total premium on all medical and prescription insurance products purchased by the Group through CareFirst.
3. CareFirst will only administer a PSF for duly licensed and appointed Producers who have met CareFirst's credentialing requirements in accordance with the Producer's agreement with CareFirst. If CareFirst terminates the appointment of a producer, CareFirst may terminate its administration of the PSF upon termination of the appointment.
4. The total amount of the PSF administered by CareFirst will not exceed 5% of the total premium. Should the Group and Producer negotiate a fee in a higher amount, CareFirst will administer a PSF in the amount of 5% of premium and the Group is responsible for paying any additional amounts directly to the Producer.
5. The PSF is in addition to, and is not included in, the premium.
6. If the Group pays less than the total amount billed, the Group may instruct CareFirst how to divide the payment between the premium and the PSF. If Group instruction is absent, the Parties agree that the PSF will be reduced in proportion to what the Group pays.

[1] CareFirst BlueCross BlueShield is a trade name of Group Hospitalization and Medical Services, Inc. and CareFirst of Maryland, Inc.

7. If a premium refund is due to the Group, the Group may instruct CareFirst in writing how to adjust any PSF paid to the Producer. If Group instruction is absent, the Parties agree that CareFirst will off-set overpayments of the PSF to the Producer against future PSF payments.
8. For any PSF funds received by CareFirst, the Producer agrees that CareFirst is acting as the Producer's agent for the limited purpose of administering such funds, that the Producer constructively receives such funds when CareFirst receives them, and the Group's obligation to pay such funds to the Producer is discharged.
9. CareFirst is only responsible for administering PSF funds that are paid to CareFirst. The Producer will be responsible for collecting any unpaid PSF from the Group. CareFirst will have no obligation to pay any amounts to the Producer except valid PSF funds actually received from the Group.
10. CareFirst will pay any PSF funds to the Producer within sixty (60) days of the Group's payment. Any income earned on PSF funds in CareFirst's possession will be retained by CareFirst. CareFirst receives no other compensation in exchange for its administration of the PSF.
11. If Group instruction to the contrary is absent, CareFirst will provide the Producer with a Form 1099 on behalf of the Group and file the information with the appropriate taxing authorities. If applicable to the Group, CareFirst will provide the Group a summary of the PSF paid to the Producer on the Group's behalf for use in Form 5500 reporting. The Group agrees that CareFirst will not be liable to the Group under any legal theory for any action taken by CareFirst under this paragraph.
12. The Group or Producer may modify the amount of the PSF by executing a new Producer Service Fee Collection Agreement and providing the executed agreement to CareFirst. New Producer Service Fee Collection Agreements reflecting modified PSF amounts received between the 1st and 15th day of the month will be administered the first day of the month following receipt of the new Producer Service Fee Collection Agreement. New Producer Service Fee Collection Agreements received after the 15th of the month will be administered the first day of the second month following receipt of the new Producer Service Fee Collection Agreement. CareFirst will administer changes prospectively only. The Producer and Group must reconcile any under or overpayments as a result of a change not provided within the required notice period.
13. The Group or Producer may terminate CareFirst's administration of the PSF at any time upon thirty (30) days prior written notice to CareFirst.
14. If the Group notifies CareFirst in writing of a change in Producer, CareFirst may immediately terminate its administration of the PSF. CareFirst will not be obligated to administer the PSF for any new producer until CareFirst is provided with a Producer Service Fee Agreement executed by the Group and the new producer. Broker of Record changes and a new associated Producer Service Fee Agreement will be applied and administered upon the Broker of Record change effective date. CareFirst will administer changes prospectively only. The Producer and Group must reconcile any under or overpayments as a result of a change not provided within the required notice period.
15. In the event of termination of this Agreement, CareFirst will pay to the Producer all PSF funds that CareFirst received prior to the effective termination date.
16. In the absence of notice of termination of the PSF in accordance with these terms, CareFirst will continue to administer the PSF for as long as the Group purchases insurance products from CareFirst that are subject to the PSF.
17. CareFirst will have no duties or obligations pertaining to the PSF except as expressly set forth in the Producer Service Fee Collection Agreement, or the terms and conditions established by CareFirst for administration of the PSF. Upon notice to the Parties, CareFirst may change the terms of its administration of the PSF or may stop administering the PSF.
18. The Parties agree that this Agreement shall be modified, if and to the extent necessary, to meet applicable legal requirements as determined by CareFirst.
19. CareFirst may designate a Full Service Producer or third-party administrator the terms of this agreement, in which case all of the terms of this agreement shall apply to the Full Service Producer or third party.

Summary of Benefits and Coverage by Product

CareFirst Family of health care plans

Prepared For: Pressmen Welfare Fund

Quote ID: 0286704-05-5-6-7-8-0000
Effective Date: 10/01/2022

The Summary of Benefits and Coverage (SBC) was established under the Affordable Care Act (ACA) to provide group health plans and individuals with clear, consistent and comparable information about their health plan benefits and coverage.

For all benefit plans offered, the Group agrees to provide the Summary of Benefits and Coverage to participants and beneficiaries who are eligible to enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period, and to participants and beneficiaries who are eligible to enroll in group health plan coverage other than through an open enrollment period (for example, special enrollees and new hires) beginning on the first day of the special enrollment period. Below is the link to your SBC.

If you have other questions about Healthcare Reform, please visit www.carefirst.com

Summary of Benefits and Coverage (SBC)			
Product	**Option**	**Pharmacy**	**SBC Documentation URL - quote**
BlueChoice HMO Open Access	Option MV4	$15/50/100 $0 Ded	http://content.carefirst.com/sbc/BHAMCV04RXXMCV26N102022.pdf
BlueChoice Advantage	Option 16	$15/35/60 $0 Ded	http://content.carefirst.com/sbc/BAVMM011RXXMM402N102022.pdf
BlueChoice HMO Open Access	Option 3	$15/35/60 $0 Ded	http://content.carefirst.com/sbc/BHAMC01CRXXMCWKVN102022.pdf
BlueChoice HMO Open Access	Option C	$15/35/60 $0 Ded	http://content.carefirst.com/sbc/BHAMC01LRXXMCWKMN102022.pdf

CareFirst Diversified Benefits

Employee Assistance Program

When employees are happy in their personal lives, they can fully focus on their work. This leads to a more productive and fulfilled workforce. But when personal issues arise, as they naturally do, that can change.

Enter our employee assistance program (EAP), powered by LifeWorks.* The EAP can help members find the mental, physical, social or financial support they need to bounce back from life's ups and downs.

Help your workforce address personal issues

To help your employees be their best at home and at work, our EAP provides the support they need to overcome whatever life throws at them.

- Emotional Support—Anxiety, bereavement, depression, personal relationships, sleep management, sleep management, stress, and more.
- Everyday Support—Elder and childcare matching, financial support, legal services, relocation, and more.

Employees can access our EAP 24/7 by phone, online or the LifeWorks mobile app.

* LifeWorks (US) Ltd., is an independent company that provides employee assistance program (EAP) services to CareFirst members. LifeWorks does not provide BlueCross BlueShield products or services and is solely responsible for the EAP services it offers.

Through our online EAP platform, your employees will have anytime-anywhere access to:

- An extensive network of highly qualified counselors worldwide
- Thousands of clinically verified and trusted articles, toolkits, podcasts, self-assessments and more
- Exclusive perks and savings on brand name retail items

Help your workplace control healthcare costs

By supporting your workforce with life's troubles, you can help prevent minor problems from becoming bigger ones, even occasionally minimizing the need for more costly levels of care. At the same time, our EAP program provides support to help you better assist those you serve.

- Managerial Support—Employee referral, manager training, employee support for issues like bullying, sexual harassment, etc.
- Critical Incident Support—Get support for tragedies in the workplace for issues like natural disasters, industrial accidents, workplace violence, etc.

Provide emotional support your workforce needs

If your organization, like many others, is prioritizing mental and behavioral health services, our EAP can refer out employees with CareFirst medical coverage to:

- Our own network of providers, or
- Our behavior health digital resource—7 Cups of Tea (7 Cups).**

7 Cups is the world's largest behavioral health support system, featuring over 430,000 active listeners who provide 1-on-1 emotional support. This integration with 7 Cups can help produce clear-cut results and cost savings for both employees and employers like you.

EAP services

- Member website
- LifeWorks mobile app
- Online services
- Counseling via telephone, video or in-person
- Well-being content and self-assessments
- Program orientation and training*

* Additional charges may apply for employer services.

Ask your CareFirst sales representative for more information on how your organization can benefit from our employee assistance program, powered by LifeWorks.

** 7 cups will be available in late 2021.

SUM5826 (8/21)

CareFirst Diversified Benefits

2021 Employee Assistance Program (EAP)
Pricing Schedule

Standard services (prices are per employee per month)

Please select the box that corresponds to your company size and appropriate EAP session model.

Company Size	3 Sessions	5 Sessions	6 Sessions	8 Sessions
2–50 employees	☐ $1.52	☐ $1.70	☐ $1.80	☐ $1.95
51–199 employees	☐ $1.40	☐ $1.60	☐ $1.70	☐ $1.85
200–750 employees	☐ $1.35	☐ $1.55	☐ $1.65	☐ $1.80
751–1,500 employees	☐ $1.25	☐ $1.37	☐ $1.45	☐ $1.52
1,501–2,500 employees	☐ $0.95	☐ $1.18	☐ $1.28	☐ $1.38
2,501–3,500 employees	☐ $0.92	☐ $1.14	☐ $1.25	☐ $1.34
3,501–5,000 employees	☐ $0.90	☐ $1.11	☐ $1.21	☐ $1.29
Over 5,000 employees	Priced on a per request basis to incorporate size of employer, industry type, history of EAP utilization, etc.			

Session means an instance a particular service is provided to an eligible user. Session limits apply separately to each presenting issue and reset annually. Work-life consultations can occur one time per year per service category per presenting issue and do not apply against the session count.

Optional services

The below services are available to all clients electing standard EAP services for the documented pricing below. These services can also be purchased on a standalone basis. Please select the boxes below to purchase as standalone EAP services only.

Service	Fee
Training	☐ $595 per hour
Critical Incidents	☐ Under 24-hour response $367 per hour; over 24-hour response $270 per hour

Signature:	
Signer's Name:	Account Name:
Date of Signature:	Effective Date:

This pricing is contingent on an agreed upon, written contract between client and FirstCare, Inc.

CST1765-1E (8/21)

CareFirst
Family of health care plans

Notice of Nondiscrimination and Availability of Language Assistance Services

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - ☐ Qualified sign language interpreters
  - ☐ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - ☐ Qualified interpreters
  - ☐ Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax, or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	civilrightscoordinator@carefirst.com
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Updated 7/12/2018

CareFirst
Family of health care plans

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 and wait through the dialogue until prompted to push 0. When an agent answers, state the language you need and you will be connected to an interpreter.

አማርኛ(Amharic) ማሳሰቢያ፡- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò títí a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

CareFirst
Family of health care plans

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bàsɔ́ɔ̀-wùɖù (Bassa) Tò Ɖùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fũà-fũá-tìĭn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓéɖé wé jéɛ́ ɓě ɓɛ́ m̀ ké ɖɛ wa mó m̀ ké nyuɛɛ nyu hwɛ̀ ɓɛ́ wé ɓěa ké zi. ɔ mɔ̀ nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ móɛɛ dyé ɖé nì bíɖí-wùɖù mú ɓɛ́ m̀ ké se wíɖí ɖò pɛ́ɛ̀. Kpooɔ̀ nyɔ ɓě mɛ ɖá fũùn-nɔ̀ɓà nìà ɖé waà I.D. káàɔ̀ ɖeín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ ɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔ̀à 0 kɛɛ dyi pàɖàìn hwɛ̀. ɔ jŭ ké nyɔ ɖò dyi m̀ gɔ̃ jŭĭn, po wuɖu m̀ mó poɛ dyiɛ, ké nyɔ ɖò mu ɓó nìin ɓɛ́ ɔ ké nì wuɖuɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ: یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518 پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

CareFirst
Family of health care plans

اللغة العربية (Arabic) تنبيه: يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة. يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة. ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم. يمكن للآخرين الاتصال على الرقم
855-258-6518والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم 0. عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：
本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

CareFirst
Family of health care plans

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bił dahólǫ bee éédahózin béeso ách'ąąh naanil nik'ist'i'ígíí bá. Bił dahólǫǫ doo iiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyį́įlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'į́įh. Bee ná ahóót'i' díí bee ił hane' dóó nikáádoowoł t'áá ninizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihj[']. Aadóó náánáła' éí koj[' dahódoolnih 855-258-6518 dóó yii diiłts'į́įł yaltí'ígíí t'áá níléíjį́ áádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yáníłt'i'ígíí yii dilkił dóó ata' halne'é lá níká'ádoolwoł.

CareFirst
Family of health care plans

BlueChoice HMO Open Access

No referrals required

With BlueChoice HMO, your primary care provider (PCP) provides routine care and coordinates specialty care. This plan also allows you to visit specialists directly—no referrals needed. We also offer online tools and resources at **carefirst.com** that give you the freedom and flexibility to manage your health and wellness goals wherever you are.

Take advantage of your benefits

- A network of almost 47,000 CareFirst BlueChoice providers (PCPs, nurse practitioners, specialists, hospitals, pharmacies, urgent care centers, convenience care clinics and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care including a free 24-hour nurse advice line, video visits for physical and mental health, convenience care clinics and urgent care centers.
- $0 cost for comprehensive preventive healthcare visits.
- Predictable copays and deductibles (if applicable).
- The Away From Home Care® program allows you to take your plan benefits with you if you're out of the area for at least 90 days.
- Coverage for emergency or urgent care if you are outside CareFirst BlueCross BlueShield's service area (Maryland, Washington, D.C. and Northern Virginia).

Benefits at a glance

Preventive care and sick office visits
You are covered for all preventive care as well as sick office visits.

Large provider network
You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services
Your coverage includes services from specialists without a referral. Specialists are doctors who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage
Your plan covers prescription drugs.

Hospital services
You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all hospital services.

Labs, X-rays or specialty imaging
Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

BlueChoice HMO Open Access

Well-child visits
All well-child visits and immunizations are covered.

Maternity and pregnancy care
You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder
Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

CareFirst BlueCross BlueShield has the region's largest network for doctors, pharmacies, hospitals and other healthcare providers that accept our health plans. Networks vary among CareFirst health plans. It is important that you familiarize with your specific plan's network.

In-network doctors and healthcare providers are those that are part of your plan's network (also known as participating providers). When you choose an in-network provider, you'll pay the lowest out-of-pocket care costs.

Out-of-network providers and doctors have not contracted with CareFirst. If you choose to receive care from an out-of-network provider, you can expect to pay more and, in some cases, may be responsible for the entire amount billed.

Your benefits

Step 1: Select a PCP

Establishing a relationship with one doctor is the best way to receive consistent, quality healthcare. When you enroll in a BlueChoice HMO Open Access plan, you select a PCP—either a physician or nurse practitioner—to manage your primary medical care. Make sure you select a PCP for yourself and each of your covered family members. Your PCP must participate in the CareFirst BlueChoice provider network and must specialize in family practice, general practice, pediatrics or internal medicine.

To ensure that you receive the highest level of benefits and pay the lowest out-of-pocket costs for all services, see your PCP for preventive and routine care.

Step 2: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 3: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met as long as you visit participating CareFirst BlueChoice doctors and facilities. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

Should you reach your out-of-pocket maximum, CareFirst will then pay 100 percent of the allowed benefit for all covered services for the remainder of the benefit period.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

Labs, X-rays or specialty imaging

To get the most economical use out of your laboratory benefits, you must visit a LabCorp facility for any laboratory services. Services performed at a facility that isn't part of the LabCorp network will not be covered under your plan.

Also, any lab work performed in an out-patient hospital setting will require a prior authorization from your PCP.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. For locations near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

Diagnostic/imaging centers have equipment to produce various types of radiologic and electromagnetic images (such as X-rays, mammograms, CT and PET scans) and a professional staff to interpret the images. If you need X-rays or other specialty imaging services, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology.

Out-of-area coverage

Out-of-area coverage is limited to emergency or urgent care only. However, members and their covered dependents planning to be out of the CareFirst BlueChoice, Inc. service area for at least 90 consecutive days may be able to take advantage of a special program, Away From Home Care.

This program allows temporary benefits through another Blue Cross and Blue Shield affiliated HMO. It provides coverage for routine services and is perfect for extended out-of-town business or travel, semesters at school or families living apart.

For more information on Away From Home Care, please call Member Services at the phone number listed on your ID card.

Global coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you receive:

- Access to a worldwide network of traditional inpatient, outpatient, and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, Global Core connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network. If you receive non-emergency or urgent services from an out-of-network provider or facility, you will be responsible for paying the entire amount billed.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association.

FOL5088-1P (7/21) ■ 51+

CareFirst
Family of health care plans

BlueChoice Advantage

Offers you the freedom to choose

BlueChoice Advantage offers in- and out-of-network coverage to help control your out-of-pocket costs and there's no referral to see a specialist. We also offer online tools and resources at **carefirst.com** that give you the flexibility to manage your healthcare and wellness goals wherever you are.

Take advantage of your benefits

- $0 cost for comprehensive preventive healthcare visits.
- Choose any provider you want—no referrals required.
- A network of almost 47,000 CareFirst BlueChoice providers (primary care providers (PCPs), nurse practitioners, specialists, hospitals, pharmacies and diagnostic centers) in Maryland, Washington, D.C. and Northern Virginia.
- After-hours care, including a free 24-hour nurse advice line, video visits for physical and mental health, convenience care clinics and urgent care centers.
- If you need care outside the CareFirst BlueCross BlueShield (CareFirst) service area of Maryland, Washington, D.C. and Northern Virginia, you have access to the largest network across the country, with 96% of hospitals and 95% of physicians in-network.

Benefits at a glance

Preventive care and sick office visits
You are covered for all preventive care as well as sick office visits.

Large provider network
You can choose any doctor from our large network of providers. Our network also includes specialists, hospitals and pharmacies—giving you many options for your healthcare.

Specialist services
Your coverage includes services from specialists without a referral. Specialists are doctors or nurses who are highly trained to treat certain conditions, such as cardiologists or dermatologists.

Prescription drug coverage
Your plan covers prescription drugs.

Hospital services
You're covered for overnight hospital stays. You're also covered for outpatient services, those procedures you get in the hospital without spending the night. Your PCP or specialist must provide prior authorization for all inpatient hospital services and may need to provide prior authorization for some outpatient hospital services such as rehabilitative services, chemotherapy and infusion services.

Labs, X-rays or specialty imaging
Covered services include provider-ordered lab tests, X-rays and other specialty imaging tests (MRI, CT scan, PET scan, etc.).

Well-child visits
All well-child visits and immunizations are covered.

Maternity and pregnancy care
You are covered for doctor visits before and after your baby is born, including hospital stays. If needed, we also cover home visits after the baby's birth.

Mental health and substance use disorder
Your coverage includes behavioral health treatment, such as psychotherapy and counseling, mental and behavioral health inpatient services and substance use disorder treatment.

How your plan works

Receiving care inside the CareFirst service area

When you need care in Maryland, Washington, D.C. or Northern Virginia, select a provider in the CareFirst BlueChoice network to receive **in-network** coverage and pay the lowest out-of-pocket costs.

If you receive care within our service area but outside the BlueChoice network, your benefits will be paid at the **out-of-network** level, but you'll incur lower costs by using a participating national BlueCard PPO provider. To find a national participating provider, visit **bcbs.com**.

If you receive services from a provider outside of the BlueChoice or national BlueCard PPO provider network, you may have to:

- Pay higher out-of-pocket costs
- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a higher deductible and/or coinsurance amount

Receiving care outside the CareFirst service area

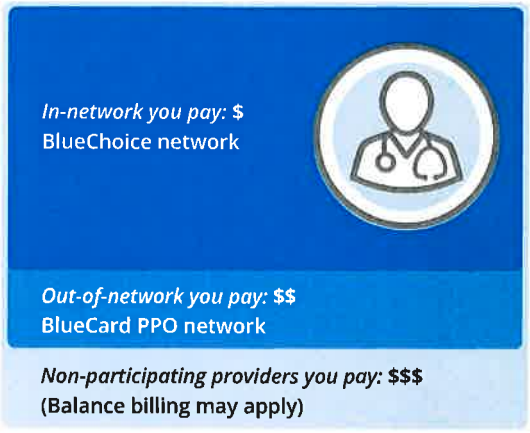
Members seeking care outside the CareFirst service area will pay the lowest costs by using a national BlueCard PPO provider. Members will still have the option to opt-out of this network but will pay a higher out-of-pocket expense.

If you receive services from a provider outside of the national BlueCard PPO network when you are out of the CareFirst service area, you will have to:

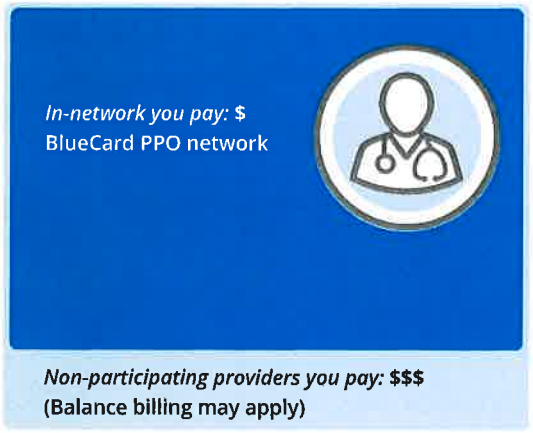
- Pay the provider's actual charge at the time you receive care
- File a claim for reimbursement
- Satisfy a deductible and coinsurance/copays

The choice is entirely yours. That's the advantage of this plan.

Inside the CareFirst service area



Outside the CareFirst service area



Hospital authorization

CareFirst BlueChoice providers will obtain any necessary admission authorizations for in-area covered services. You will be responsible for obtaining authorization for services provided by out-of-network providers and out-of-area admissions. Call toll-free at 866-PREAUTH (773-2884).

Prior authorization is not required for emergency admissions or maternity admissions.

Your benefits

Step 1: Meet your deductible (if applicable)

If your plan requires you to meet a deductible, you will be responsible for the cost of your medical care up to the amount of your deductible. However, this deductible does not apply to all services.

Examples of in-network services not subject to deductible*:

- Adult preventive visits with PCP
- Well-child care and immunizations with PCP
- OB/GYN visits and pap tests
- Mammograms
- Prostate and colorectal screenings
- Routine prenatal maternity services

Step 2: Your plan will start to pay for services

Your full benefits will become available once your deductible (if applicable) is met. However, the level of those benefits will depend on whether you see in-network or out-of-network providers. Depending on your particular plan, you may also have to pay a copay or coinsurance when you receive care.

You will have a different deductible amount for in-network versus out-of-network benefits and the in- and out-of-network medical deductibles contribute toward one another. For example, when you see in-network providers, your expenses will count toward both your in-network deductible and out-of-network deductible.

Deductible requirements vary based on whether your coverage is an individual or family plan. If more than one person is covered under your plan, please refer to your Evidence of Coverage for detailed information on deductibles.

Your out-of-pocket maximum

Your out-of-pocket maximum is the maximum amount you will pay during your benefit period. Any amount you pay toward your deductible (if applicable) and most copays and/or coinsurance will count toward your out-of-pocket maximum.

Just like your deductible, there are different in-network and out-of-network amounts and the in- and out-of-network out-of-pocket maximums contribute toward one another.

Please keep in mind that out-of-pocket requirements also differ if your coverage is an individual or family plan. Detailed information on out-of-pocket maximum amounts can be found in your Evidence of Coverage.

Labs, X-rays or specialty imaging

If you access laboratory services inside the CareFirst service area (Maryland, Washington, D.C. and Northern Virginia) you must use LabCorp as your lab test facility for in-network benefits. Services performed by any other provider, while inside the CareFirst service area, will be considered out-of-network.

LabCorp has approximately 100 locations throughout Maryland, Washington, D.C. and Northern Virginia. For locations near you, call 888-LAB-CORP (522-2677) or visit **labcorp.com**.

If you access laboratory services outside of Maryland, D.C. or Northern Virginia, you may use any participating BlueCard PPO facility and receive in-network benefits. To find laboratory service

* This is not a complete list of all services. For a comprehensive explanation of your coverage, please check your Evidence of Coverage.

providers outside of the CareFirst service area, visit our *Find a Provider* tool (**carefirst.com/doctor**) and search by *Labs*.

If you need X-rays or other specialty imaging services when inside the CareFirst service area, you must visit a participating freestanding/non-hospital diagnostic center such as Advanced Radiology. If you need X-rays or other specialty imaging services when outside the CareFirst service area, you may use any participating BlueCard PPO facility and receive in-network benefits.

Out-of-area coverage

You have the freedom to take your healthcare benefits with you across the country. BlueCard PPO, a program from the Blue Cross and Blue Shield Association, allows you to receive the same healthcare benefits while traveling outside of the CareFirst service area of Maryland, Washington, D.C. and Northern Virginia. The BlueCard program includes more than 6,100 hospitals and 600,000 other healthcare providers nationally.

Global coverage

If you travel outside of the United States for a period of less than six months, you have access to a worldwide network of traditional inpatient, outpatient and professional healthcare providers. With BlueCross BlueShield Global Core*, you'll receive:

- Access to a worldwide network of traditional inpatient, outpatient, and professional healthcare providers—more than 7,000 physicians and more than 2,000 hospitals.
- 24/7 care support via telephone.
- Seamless claims processing/reimbursement designed for occasional or short-term travel, the Core plan connects members with their home plan benefits to provide basic medical coverage outside of the United States.

For more information on Global Core, please call 800-810-BLUE (2583).

Important terms

ALLOWED BENEFIT: The maximum amount CareFirst approves for a covered service, regardless of what the doctor actually charges. Providers who participate in the CareFirst BlueChoice network cannot charge our members more than the allowed amount for any covered service.

BALANCE BILLING: Billing a member for the difference between the allowed charge and the actual charge.

COINSURANCE: The percentage of the allowed benefit you pay after you meet your deductible.

COPAY: A fixed-dollar amount you pay when you visit a doctor or other provider.

DEDUCTIBLE: The amount of money you must pay each year before your plan begins to pay its portion for the cost of care.

IN-NETWORK: Doctors, hospitals, labs and other providers or facilities that are part of the CareFirst BlueChoice network.

OUT-OF-NETWORK: Doctors, hospitals, labs and other providers or facilities that do not participate in the CareFirst BlueChoice network.

PRIMARY CARE PROVIDER (PCP): The doctor or medical professional you go to for primary care and who coordinates or arranges other services you need.

*BlueCross BlueShield Global is a brand owned by BlueCross BlueShield Association

FOL5099-1P (8/21) ■ 51+

Pressmen Welfare Fund

Section Three

UnitedHealthcare

Medical Proposed Rates for Pressmen Welfare Fund (MD)

Effective Date: 10/01/2022

UBUNDLE ELIGIBLE

• The numbers below are on an illustrative basis. Rates are subject to Underwriting approval.

	Option 1	Option 2	Option 3
Medical Plan Name	CK5P mod (OCI modified)	CK6D mod (OCI modified)	CK5U mod (OCI modified)
Rx Plan Name	Rx Plan: 0I	Rx Plan: 0I	Rx Plan: 0I
Product	OCI HMO HMO *	OCI HMO HMO *	OCI HMO HMO *
Option	Option 1	Option 2	Option 3
Plan Offering	Multiple Option	Multiple Option	Multiple Option
Multiple Option with:	2, 3, 4	1, 3, 4	1, 2, 4
HRA or HSA	No	No	No
Benefits*	Network Single/Family	Network Single/Family	Network Single/Family
Office Copay (PCP/SPC)	PCP $15, SPC $20	PCP $15, SPC $25	PCP $20, SPC $30
Hospital Copays	OP $50, IP $100	OP D&C, IP D&C	OP D&C, IP D&C
UC and ER	UC $20, ER $100	UC $25, ER $100	UC $30, ER $100
Major Diagnostics	MD $100	MD D&C	MD D&C
X-Ray and Lab	X-Ray $0, Lab $0	X-Ray $15, Lab $15	X-Ray $20, Lab $20
Other	30 visits PT,ST,OT	30 visits PT,ST,OT	30 visits PT,ST,OT
Deductible	N/A	$750/$1,500 (Emb)	$750/$1,500 (Emb)
Coinsurance	100%	90%	80%
Out-of-Pocket	$3,500/$9,400	$3,000/$6,000	$3,000/$6,000
Pharmacy	$10/$35/$70, 2.5 MO (Adv PDL), Natl	$10/$35/$70, 2.5 MO (Adv PDL), Natl	$10/$35/$70, 2.5 MO (Adv PDL), Natl
	Out of Network Single/Family	Out of Network Single/Family	Out of Network Single/Family
Deductible	N/A	N/A	N/A
Coinsurance	N/A	N/A	N/A
Out of Pocket	N/A	N/A	N/A
Enrollment			
Employee	14	44	0
Employee + Family	29	34	1
Total	43	78	1
Rates	Rates (Billed)	Rates (Billed)	Rates (Billed)
Employee	**$1,218.93**	**$1,123.64**	**$1,100.68**
Employee + Family	**$1,218.93**	**$1,123.64**	**$1,100.68**
Monthly Cost	**$52,414**	**$87,644**	**$1,101**
Annual Cost	**$628,968**	**$1,051,727**	**$13,208**

High level benefit summary. Please see your plan summary for more detailed benefit description.
POD = Benefit paid as follows: Per Occurrence Deductible, then plan deductible and coinsurance.
LTD # = the number of services covered at that copay, after the limit plan deductible and coinsurance will apply, note PCP and SPC may be combined (see benefit summary)
Day x# = the max number of days the copay will apply

For markets moving to service fees, current rates (for renewals only) include commission expenses. Proposed rates, for your convenience, include any applicable producer service fees. Producer service fees are not a contingency of obtaining insurance coverage but are fees agreed to between you (client) and your producer/service provider for service rendered on behalf of client.

For markets continuing to pay commissions, both the current (applicable for renewals only) and proposed rates include commissions.

UnitedHealthcare

Medical Proposed Rates for Pressmen Welfare Fund (MD)

Effective Date: 10/01/2022

UBUNDLE ELIGIBLE

• The numbers below are on an illustrative basis. Rates are subject to Underwriting approval.

	Option 4	Option 5
Medical Plan Name	CK7B mod (OCI modified)	CLNC mod (Traditional modified)
Rx Plan Name	Rx Plan: 997	Rx Plan: 0i
Product	OCI HMO HMO *	Choice Insurance *
Option	Option 4	PA Sub only
Plan Offering	Multiple Option	Single Option
Multiple Option with:	1, 2, 3	N/A
HRA or HSA	No	No
Benefits*	Network Single/Family	Network Single/Family
Office Copay (PCP/SPC)	PCP Ded+$70, SPC $90	PCP $15, SPC $20
Hospital Copays	OP D&C, IP D&C	OP $50, IP $100
UC and ER	UC $90, ER D&C	UC $20, ER $100
Major Diagnostics	MD D&C	MD $100
X-Ray and Lab	X-Ray $150, Lab $70	X-Ray $0, Lab $0
Other	30 visits PT,ST,OT	Lab: DDP Applies; 30 visits PT/OT/ST
Deductible	$5,000/$10,000 (Emb)	N/A
Coinsurance	60%	100%
Out-of-Pocket	$8,500/$17,000	$3,500/$9,400
Pharmacy	$10/$50/$100, 2.5 MO (Adv PDL), Natl	$10/$35/$70, 2.5 MO (Adv PDL), Natl
	Out of Network Single/Family	Out of Network Single/Family
Deductible	N/A	N/A
Coinsurance	N/A	N/A
Out of Pocket	N/A	N/A
Enrollment		
Employee	5	1
Employee + Family	2	0
Total	7	1
	Rates (Billed)	Rates (Billed)
Rates		
Employee	**$739.10**	**$1,357.96**
Employee + Family	**$739.10**	**$1,357.96**
Monthly Cost	**$5,174**	**$1,358**
Annual Cost	**$62,084**	**$16,296**

High level benefit summary. Please see your plan summary for more detailed benefit description.
POD = Benefit paid as follows: Per Occurrence Deductible, then plan deductible and coinsurance.
LTD # = the number of services covered at that copay, after the limit plan deductible and coinsurance will apply, note PCP and SPC may be combined (see benefit summary)
Day x# = the max number of days the copay will apply

For markets moving to service fees, current rates (for renewals only) include commission expenses. Proposed rates, for your convenience, include any applicable producer service fees. Producer service fees are not a contingency of obtaining insurance coverage but are fees agreed to between you (client) and your producer/service provider for service rendered on behalf of client.

For markets continuing to pay commissions, both the current (applicable for renewals only) and proposed rates include commissions.

UnitedHealthcare

Medical Quote Assumptions for Pressmen Welfare Fund (MD)

Effective Date: 10/01/2022

UBUNDLE ELIGIBLE

- *The numbers below are on an illustrative basis. Rates are subject to Underwriting approval.*

Medical Quote Assumptions

- Rates are guaranteed for the contract period of 10/1/22 through 9/30/23.
- Rates are based on your submitted census. UnitedHealthcare reserves the right to adjust the rates from audit date back to effective date if any of the following changes:
  - Enrollment +/- 10%
  - Average Contract Size +/- 10%
  - Area Factor +/- 7.5%
  - Age/Sex Factor +/- 10%
  - Any Material Changes
  - Cobra enrollees are more than 10% of enrollment
- This proposal assumes at least 100% of all benefit eligible employees (including spousal waivers) will enroll with United Healthcare. If this assumption is not accurate, we reserve the right to requote back to original effective date.
- Preferred Portfolio plans do not include a provision for 4Q deductible carryover or deductible credit from prior carrier.
- Rates include The Maryland Patients' Access to Quality Health Care Act of 2004, premium tax of 2% where applicable.
- OCI plans offered by Optimum Choice, Inc., and UHIC plans offered by UnitedHealthcare Insurance Company
- For all Maryland situs quotes with an effective date of 10/1/12 and forward, the monthly premium quoted on 2011 COC is based on Out-of-Network Reimbursement at 140% of Medicare
- This offer, unless otherwise stated herein, completely replaces all other previous offers or portions thereof. Any previous offers that may have been extended are hereby null and void.
- Subject to approval of the Employer Form by UHC medical underwriting.
- Please see your state disclosure form for all mandated disclosure information.
- Quote does not include Simply Engaged

- UnitedHealthcare reserves the right to adjust the rates and/or fees (i) in the event of any changes in federal, state or other applicable legislation or regulation; (ii) in the event of any changes in Plan design required by the applicable regulatory authority (i.e. mandated benefits) or by the Plan Sponsor; and (iii) as otherwise permitted in our policy.
- This premium may include state and federal taxes and fees.
- Premium rates and/or product forms included herein are subject to approval by regulators. If rates or product forms offered herein are subsequently modified by regulators we will immediately advise you of the change in plan design and retroactively adjust premium in subsequent billings.
- Plan design and corresponding premium rates offered represent a coverage option that is consistent with your current group size (based on most recent census or survey information) and closely matches your current coverage. Additional coverage options may be available to you.

- Agents may receive commissions and other compensation from us and these costs may be reflected in your premium or fee. Separately, you may have contracted with producers to provide services directly for your group and have agreed to pay them a 'service fee'. Since 'service fees' are not a contingency of the purchase of health insurance such fees are not part of your premium but may be included in your bill under total amount due.