The holder of this Contract is a member of Blue Cross® and Blue Shield® of South Carolina and is entitled to vote in person or by proxy at any and all meetings of said Corporation. This is a nonassessable contract and the holder is not subject to any contingent liability. The annual meeting of the members shall be held at the Home Office of the Corporation on the third Thursday in April at 11:00 a.m., Eastern Standard Time.

Business BlueEssentials℠ Health Insurance Contract

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

(Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans)
(www.SouthCarolinaBlues.com)

(A mutual insurer organized under the Laws of the State of South Carolina and hereinafter referred to as the Corporation)

HOME OFFICE: Columbia, South Carolina 29219

Client No. 55183
and all applicable groups

IN CONSIDERATION

of the Application made by

Bates Batteries DBA Batteries Plus Inc

(hereinafter called the Employer)

a copy of which is attached hereto and made part of this Contract, and in consideration of payment by the Employer of the premium as herein provided,

THE CORPORATION HEREBY AGREES TO PROVIDE

the coverage and benefits herein described for a period of one year beginning at 12:01 a.m., on the date indicated below, hereinafter called the Effective Date and from year-to-year thereafter, unless this Contract is terminated as provided herein. The premium shall be due and payable by the Employer in advance of the Effective Date and thereafter as provided herein. This Contract is issued and delivered in the State of South Carolina, is governed by the laws thereof and is subject to the terms and provisions recited over the signatures hereto affixed.

IN WITNESS WHEREOF, THE CORPORATION HAS caused this Contract to be signed this 1st day of December 2016

Scott Graves
President
Blue Cross and Blue Shield Division

APPLICATION FOR GROUP HEALTH INSURANCE
GROUP AND INDIVIDUAL DIVISION

BLUE CROSS® AND BLUE SHIELD® OF SOUTH CAROLINA
An Independent Licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.
COLUMBIA, SOUTH CAROLINA
www.SouthCarolinaBlues.com

Application is hereby made for group health insurance for the eligible Employees and Dependents or Members of the Group (herein referred to as the Applicant) for **Business BlueEssentials Chamber HDHP** (Product Name).

Name of Applicant: **Bates Batteries DBA Batteries Plus Inc**
(Company's correct legal name)

Upon approval, the Effective Date of the Contract under this application shall be 12:01 a.m., standard time on the 1st day of December 2016 _____, and such coverage will continue until terminated in accordance with the provisions of the Contract between the Applicant and Blue Cross and Blue Shield of South Carolina.

Classification and Participation Requirements:

1. Employees must meet the requirements shown on the attached Benefits Request Form to participate in the Group Health Plan.
2. The Waiting Period selected by the Applicant is shown on the attached Benefits Request Form.
3. The Employer/Applicant must affirm it will meet the Participation Requirements shown on the attached Benefits Request Form.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in the group health plan or the first day of the Waiting Period, whichever is earlier.

Late Enrollee: An Employee or Dependent who is eligible for enrollment at the initial enrollment by the Employer or during any open enrollment period but who declines enrollment and later seeks to enroll. Late enrollees may be excluded from coverage for a period of up to 12 months unless the exclusion period is shortened by the next open enrollment period.

Special Enrollment: Employees and/or Dependents who are eligible to enroll other than during the initial enrollment period or open enrollment as described in the Master Contract and the Certificate.

The statements furnished herein are true and correct to the best of my knowledge and belief, and they are offered to Blue Cross and Blue Shield of South Carolina, an independent licensee of the Blue Cross and Blue Shield Association, and/or Companion Life Insurance Company as part of an application for group insurance covering the employees or members of the firm or organization I represent. I understand that any misstatements or omission of information may be the basis for cancellation of any coverage granted.

It is understood and agreed that the Applicant shall pay Blue Cross and Blue Shield of South Carolina, in advance, the premiums specified in Schedule A of the Master Contract on behalf of the Applicant's Employees who meet the eligibility requirements specified. This application shall form a part of the Contract between Blue Cross and Blue Shield of South Carolina and the Applicant. Coverage is not effective until the initial premium is received at Blue Cross and Blue Shield of South Carolina's home office and the parties have agreed on the Effective Date of coverage. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from the policyholder's funds or from funds contributed by the insured persons, or from both.

The Applicant hereby expressly acknowledges its understanding that this application constitutes a Contract solely between the Applicant and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The "Association" permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Applicant for any of the Corporation's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

Dated at (City) Greer, South Carolina, this 1st day of December 2016

Bates Batteries DBA Batteries Plus Inc
Name of Applicant (Company's Name)

By:

(Authorized Signature)

BLUE CROSS AND BLUE SHIELD
OF SOUTH CAROLINA

By:

(Authorized Signature)

Schedule of Benefits for Business Blue℠ Chamber
HDHP 3
This Contract provides benefits for Covered Services received in-Network and out-of-Network.

Employer Name: Bates Batteries DBA Batteries Plus
Client Number: 55183
Client Effective Date: December 2016
Group Number: 661732701
Anniversary Date: December 1
Coverage Effective Date: December 1, 2016
Benefit Period: December 1st thru November 30th

Deductible – You Pay	Network Providers – $2,600 per Member or $5,200 per Family per Benefit Period. With Family coverage, once a Member meets a $2,600 Deductible, benefits will begin paying for that Member. Out-of-Network Providers –Deductible same as in-Network. The In-Network and Out-of-Network amounts do not apply to each other. The Deductible applies to the Maximum Out-of-pocket.
Maximum Out-of-Pocket – You Pay	Network Providers – $2,600 per Member or $5,200 per Family per Benefit Period. With Family coverage, once a Member meets a $2,600 Maximum Out-of-pocket, benefits are payable at 100% for that Member only. Out-of-Network Provider – $5,200 per Member or $10,400 per Family per Benefit Period. The In-Network and Out-of-Network amounts do not apply to each other. Covered Services will be paid at 100% from Network Providers after the Out-of-pocket Limit is met. The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It doesn't include premiums; charges in excess of the Allowed Amount; amounts exceeding any Maximum Payments for benefits; or any expense not allowed according to any provisions of this coverage.
Benefit Period Maximum – We Pay (All Benefit Period Maximums are per Member per Benefit Period)	60 days for Skilled Nursing Facility Services 60 visits for Home Health Care 6 months per episode for Inpatient and Outpatient Hospice Care 30 visits for Physical, Speech and Occupational Therapy Services combined – other than Inpatient $300 for physical exam services not included in other covered Preventive Screenings

There are no dollar limits on Essential Health Benefits.

All benefits payable on Covered Services are based on our Allowed Amount. All Covered Services must be Medically Necessary.

Admissions require Preauthorization. Certain other services also require Preauthorization. See the Preauthorization section of the Certificate for information concerning the Preauthorization requirement.

This Contract is intended to be used as a "qualified high deductible health plan" under Section 223 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Our plan has free language interpretation services available. We can also give you information in languages other than English, in large print or other alternate formats.

Schedule of Benefits for Business Blue℠ Chamber
HDHP 3
(continued)

Services that are covered for you	What you must pay when you get these services		
	In-Network *Retail Pharmacy*	In-Network *Mail-Order Pharmacy*	Out-of-Network *Retail Pharmacy*
Prescription Drugs – Must be purchased at Network Name Per prescription or refill			
Tier 1 Drugs and designated Over-the-counter Drugs – These drugs are most often generic and will generally cost you the least amount of money out of your pocket. Generic drugs have the same active ingredient(s) as brand-name drugs, may have different inactive ingredients and are not manufactured under a registered brand name or trademark.	0% after Deductible	40% after Deductible	Not covered
Tier 2 Drugs – Drugs in this tier are most often brand-name drugs and are sometimes referred to as "preferred" drugs because they usually cost less than brand-name drugs in higher tier levels.	0% after Deductible	40% after Deductible	
Tier 3 Drugs – Drugs on this tier are most often brand-name drugs that may have generic equivalents. They are sometimes referred to as non-preferred because there is usually a lower cost alternative available.	0% after Deductible	40% after Deductible	
Tier 4 Drugs – These are typically drugs that are used in the management of chronic or genetic disease, including but not limited to injectable, infused or oral medications; or, products that otherwise require special handling, refrigeration and special training. You will usually pay more for drugs in this tier than drugs in lower tiers.	0% after Deductible	Not covered	
If a Physician prescribes a Brand-name Drug and there is an equivalent Generic Drug available (whether or not the Physician allows substitution of the Brand-name Drug), then the Member must pay any difference between the cost of the Generic Drug and the higher cost of the Brand-name Drug. The difference you must pay between the cost of the Generic Drug and the higher cost of the Brand-name Drug does not apply to your Deductible or your Maximum Out-of-pocket.	Benefits are limited to a 31-day supply.	Benefits are limited to a 90-day supply.	No Benefits for Out-of-Network Mail-Order Pharmacy.

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Primary Care Physician, Specialist Services or Urgent Care Facility		
Office Visit Services – Office charges for the treatment of an accident or injury; injections for allergy and antibiotics; diagnostic lab and diagnostic X-ray services (such as chest X-rays and standard plain film X-rays), when performed in the Physician's office on the same date and billed by the Physician (excluding Maternity Care)	0% after Deductible	40% after Deductible
Inpatient Physician and Surgical Services	0% after Deductible	40% after Deductible
All Other Physician Services – Outpatient Hospital; Skilled Nursing Facility; Clinic; Lab, X-ray, and the reading/interpretation of diagnostic lab and X-ray services; Surgery, male sterilization; Second Surgical Opinion; consultation; anesthesia; dialysis treatment, chemotherapy, and radiation therapy and administration of Specialty Drugs .	0% after Deductible	40% after Deductible
Urgent Care Facilities – The facility must be licensed as an Urgent Care Facility.	0% after Deductible	40% after Deductible
Preventive Services		
The following are covered: • The United States Preventive Services Task Force (USPSTF) recommended Grade A or B screenings. • Immunizations as recommended by the Centers for Disease Control (CDC). • Screenings recommended for children and women by Health Resources and Services Administration (HRSA) • Preventive prostate screening and laboratory work according to the American Cancer Society (ACA) • Preventive yearly Pap Smear or more often if recommended by a Physician • Preventive Mammography • Lactation support and counseling. Includes breast pump when purchased through a doctor's office, Pharmacy or DME supplier and is limited to one pump every 12 months	$0	No Benefits
• Female sterilization - Physician, lab and X-ray charges directly related to ligation, transection or occlusion of fallopian tubes - Facility charges billed separately and directly related to ligation, transection or occlusion of fallopian tubes • The following contraceptive devices or services: generic injections, Mirena IUD, Nexplanon implant, Ortho Evra patch, Nuvaring, Ortho Flex, Ortho Coil, Ortho Flat, Wide-seal, Omniflex, Prentif and Femcap-vaginal	$0 $0 $0	40% after Deductible 40% after Deductible 40% after Deductible
All other covered contraceptive devices or services not specifically listed above	0% after Deductible	40% after Deductible
Services related to a physical exam not included in other covered Preventive Screenings (limited to $300 per Benefit Period. Services may be subject to age and visit limits.	$0	No Benefits

Schedule of Benefits for Business Blue℠ Chamber
HDHP 3
(continued)

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Laboratory and Diagnostic Services		
Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; Endoscopies (such as colonoscopy, proctoscopy and laparoscopy); High technology diagnostic services such as, but not limited to, MRIs, MRAs, PET scans, CT scans, cardiac catheterizations, and procedures performed with contrast or dye.	0% after Deductible	40% after Deductible
Hospital Services (other than Skilled Nursing Facilities or Rehabilitation Facilities)		
Inpatient	0% after Deductible	40% after Deductible
Outpatient Hospital	0% after Deductible	40% after Deductible
Emergency Services		
Emergency Room Charges	0% after Deductible	0% after Deductible
Ambulance, Out-of-Area (including Physician services)	0% after Deductible	40% after Deductible
Maternity		
Pre- and post-natal care including Physician. Hospital services are the same as shown above.	0% after Deductible	40% after Deductible
Newborn Care		
Post-natal care including Physician services. Hospital services provided as shown above. Benefits will be available only if the child is added to your Contract.	0% after Deductible	40% after Deductible
Rehabilitative Services		
Durable Medical Equipment (DME) – purchase or rental – excludes repair of, replacement of and duplicate DME.	0% after Deductible	No Benefits
Physical, occupational, speech and respiratory therapy	0% after Deductible	40% after Deductible
Rehabilitation including cardiac and pulmonary	0% after Deductible	40% after Deductible
Skilled Nursing and Rehabilitation Facilities	0% after Deductible	40% after Deductible
Medical Supplies	0% after Deductible	40% after Deductible

Schedule of Benefits for Business Blue℠ Chamber
HDHP 3
(continued)

Services that are covered for you	What you must pay when you get these services	
	Network	Out-of-Network
Mental Health/Substance Use Disorder Services		
Inpatient and Physician's Services	0% after Deductible	40% after Deductible
Outpatient and Physician's Services	0% after Deductible	40% after Deductible
Residential Treatment Centers	0% after Deductible	40% after Deductible
Physician's Office	0% after Deductible	40% after Deductible
Autism Spectrum Disorder - Behavioral modification using applied behavioral analysis (ABA) by a Board Certified Behavioral Analyst or approved Provider. Behavioral therapy does not include educational or alternative programs such as, but not limited to: TEACCH, auditory integration therapy, higashi schools/daily life, facilitated communication, floor time, relationship development intervention (RDI), holding therapy, movement therapies, music therapy and pet therapy. Preauthorization of the treatment plan by Companion Benefit Alternatives, Inc. is required. On behalf of Blue Cross and Blue Shield of South Carolina, Companion Benefit Alternatives preauthorizes Mental Health Services and Substance Abuse services. Companion Benefit Alternatives is a separate company that preauthorizes behavioral health benefits.	$0	No Benefits
Other Services		
Dental Services Related to Accidental Injury – Only when such care is for treatment, Surgery or appliances caused by accidental bodily injury (except dental injuries occurring through the natural act of chewing). It's limited to care completed within six months of such accident and while the patient is still covered under this Policy.	0% after Deductible	40% after Deductible
Home Health Care	0% after Deductible	40% after Deductible
Hospice Care	0% after Deductible	40% after Deductible
Out-of-Country Services including facility and Physician (Covered through a BlueCard® Provider Only)	0% after Deductible	40% after Deductible

Group Name: Bates Batteries DBA Batteries Plus Inc
Group Number: 661732701
Effective Date: December 1, 2016

SCHEDULE A

Premiums for the insurance applied for shall be as follows:

Monthly Premiums

Types of Membership	Single	Family	Emp/Spouse	Emp/Child
Comprehensive Preferred Personal Medical Expenses	$318.69	$1,253.24	$884.41	$687.52
Total Premiums	$318.69	$1,253.24	$884.41	$687.52

Initial charges shall be payable in advance of the Effective Date. Subsequent premiums shall be payable on or before the same date of each month thereafter. In no event shall coverage hereby applied for become effective until payment for the initial premiums is received by Blue Cross and Blue Sheild of South Carolina.

Blue Cross and Blue Shield of South Carolina may change the monthly premiums when benefits under the Contracts are changed by amendment or as of any monthly due date upon giving thirty-one (31) days prior written notice to Applicant, when such action is taken as to all Contracts in the class to which the Contract belong.

BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219-0001
803.788.0222

SouthCarolinaBlues.com

An Independent Licensee of the Blue Cross and Blue Shield Association

Bates Batteries DBA Batteries Plus Inc
20 Freedom Pond Road

Greer, SC 29650

Dear Benefits Coordinator:

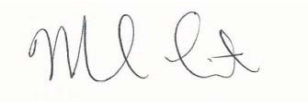
We are pleased to inform you that your group's health plan drug benefit is **creditable coverage**. That means your drug benefit is equal to or better than Medicare's prescription drug plan. The Medicare Modernization Act requires you to provide this information to Medicare-eligible employees enrolled in your group health plans.

Why is this important?
Medicare-eligible individuals who have creditable prescription drug coverage can enroll in a Medicare Part D prescription drug plan after their initial eligibility period and do not have to pay a late enrollment fee. However, if they drop or lose creditable coverage for 63 or more days in a row before enrolling, they will pay a late-enrollment penalty.

What do you need to do?
Please give the enclosed notice to your Medicare-eligible employees (and eligible dependents) covered under your plan. Also, each year you must notify the Centers for Medicare & Medicaid Services (CMS) that your group's coverage is creditable or not creditable to Medicare's prescription drug plan. We have enclosed guidelines that explain how you should notify CMS.

You and your employees can learn more about Medicare Part D at Medicare.gov. If you have questions, please contact BlueCross customer service toll free at 800-868-2500, ext. 41010.

Sincerely,



Manny Licata
Vice President of Operations
Group and Individual Products

Enclosure

Important Notice from BlueCross® BlueShield® of South Carolina About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BlueCross and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. **All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **BlueCross has determined that your prescription drug coverage is**, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered **Creditable Coverage.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you decide to enroll in a Medicare prescription drug plan and drop your BlueCross prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Here are the details of your current coverage:

Bates Batteries DBA Batteries Plus Inc
BlueCross Group Number: 661732701
Drug Plan: Yes
Medical Deductible: $2,600
Out-of-Pocket Maximum: $2,600

You should also know that if you drop or lose your coverage with BlueCross and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage:

Contact BlueCross customer service at 803-264-1010 or toll free at 800-868-2500, ext. 41010. **NOTE:** You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through BlueCross changes. You also may request a copy of this notice.

For more information about your options under Medicare prescription drug coverage:

Read the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. Medicare-approved prescription drug plans may also contact you directly. For more information about Medicare prescription drug plans:

- Visit Medicare.gov.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at SocialSecurity.gov, or you can call 800-772-1213 (TTY 800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: December 2016
Name of Entity/Sender: BlueCross BlueShield of South Carolina
Contact—Position/Office: Bates Batteries DBA Batteries Plus Inc
Address: 20 Freedom Pond Road

Greer, SC 29650

Phone Number: 864-469-7648

CMS NOTIFICATION GUIDELINES

How to notify CMS of your creditable or non-creditable coverage status

Who Must Provide the Disclosure Notice to CMS

All employers who provide group health coverage, offer prescription drug coverage and have Medicare-eligible individuals covered under their plans must notify the Centers for Medicare & Medicaid Services (CMS) annually as to whether their coverage is creditable or not creditable to Medicare's prescription drug plan.

These employers must complete the online Disclosure Notice and submit it to CMS annually and any time there is a change in the drug coverage that affects the creditable coverage status. At a minimum, employers must also provide the disclosure to CMS at these times:

1. For plan years that end in 2007 and beyond, disclosure of creditable coverage status must be submitted within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS.
2. Within 30 days after the termination of the prescription drug plan.
3. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Completing the CMS Disclosure Form

For more information about CMS requirements, go to the CMS Creditable Coverage Disclosure Web page at http://www.cms.hhs.gov/creditablecoverage. There you will find the Disclosure to CMS Guidance document. The Disclosure to CMS Form may be accessed under the "Related Links Inside CMS" heading on this page.

The form is also located at https://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp.
All employers must complete the online Disclosure Form. There is no paper (or printable) form available.

Facts About Medicare Prescription Drug Plans

What are Medicare prescription drug plans?
Since January 1, 2006, insurance companies and other private companies have been offering Medicare-eligible people new Medicare prescription drug plans with negotiated discounts on drug prices. These plans are not the Medicare-approved drug discount cards that were phased out May 15, 2006.

Medicare prescription drug plans provide insurance coverage for prescription drugs. As with other insurance, if you join you will pay a monthly Part D premium (in addition to your Part B premium) and pay a share of the cost of your prescriptions. Costs will vary depending on the drug plan you choose.

Drug plans may vary as to what prescription drugs are covered, how much you will pay, and which pharmacies you can use. Most plans will have a formulary, which is a list of drugs covered by the plan. This list must always meet Medicare's requirements, but it can change when plans get new information. Your plan must let you know at least 60 days before a drug you use is removed from the list or if the costs are changing. If your doctor thinks you need a drug that isn't on the list, or if one of your drugs is being removed from the list, you or your doctor can apply for an exception or appeal the decision.

What will be paid for under a Medicare prescription drug plan?
When you get Medicare prescription drug coverage, you will pay a premium each month to join the drug plan. If you have Medicare Part B, you also pay your monthly Part B premium. If you belong to a Medicare Advantage plan or Medicare Cost plan, the monthly premium you pay to the plan may increase if you add prescription drug coverage. Your plan must, at a minimum, provide a standard level of coverage as shown below. Some plans offer more coverage or lower premiums. Your costs will vary depending on which plan you choose.

<u>For Standard Coverage (the minimum coverage drug plans must provide):</u>

If you join in 2013, for covered drugs you will pay …

- A monthly premium (varies depending on the plan you choose).

You pay a copayment or coinsurance and the plan pays its share for each covered drug until total payment reaches $2,970.

Once you and your plan have spent $2,970 for covered drugs …

- You pay 47.5 of the costs of brand name drugs, including a dispensing fee.
- You pay 79 percent of the costs of generic drugs, until your out-of-pocket costs for the year reach $4,750.

After your out-of-pocket drug costs reach $4,750, you pay the greater of …

- $2.65 copayment for a generic drug (including name-brand drugs treated as generic) or $6.60 copayment for any other drug
- OR, 5 percent coinsurance

When can I join a Medicare prescription drug plan?
Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. Your coverage will be effective the first day of the month after the month you join. Even if you don't use a lot of prescription drugs now, you should consider joining a plan. If you don't join a plan when you are eligible, and you don't have a drug plan that covers as much or more than a Medicare prescription drug plan, you will have to pay more each month to join later.

What if I can't pay for a Medicare prescription drug plan?
Some people with an income at or below a set amount and with limited assets (including your savings and stocks, but not counting your home) will qualify for extra help. The type of extra help will be based on your income and assets. If you think you qualify for extra help, you can sign up with the Social Security Administration or your local Medicaid office.

Do Medicare prescription drug plans work with all types of Medicare health plans?
Yes. There will be Medicare prescription drug plans that add coverage to the original Medicare plan and private fee-for-service plans. Insurance companies and other private companies offer these plans. There are also other drug plans that are a part of Medicare Advantage plans (like HMOs) in some areas.

What if I already have prescription drug coverage?
If you have prescription drug coverage, either through an individual policy or through a group from an employer or union, you will get a notice that tells you whether that coverage is creditable or not. It is creditable coverage if your plan covers as much or more than a Medicare prescription drug plan.

If your current plan covers as much as or more than a Medicare prescription drug plan (it is creditable drug coverage), you can:

- Keep your current drug plan. If you join a Medicare prescription drug plan later your monthly premium won't be higher.
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your current drug plan back.

If your current plan covers less than a Medicare prescription drug plan (it is NOT creditable drug coverage), you can:

- Keep your current drug plan and join a Medicare prescription drug plan to give you more complete prescription drug coverage.
- Just keep your current drug plan. But, if you join a Medicare prescription drug plan later, you will have to pay more for the monthly premium.
- Drop your current drug plan and join a Medicare prescription drug plan, but you may not be able to get your current drug plan back.

When will I get more information?
Medicare has begun to provide more information about Medicare prescription drug plans, including how to choose and join a drug plan that best meets your needs. The "Medicare & You" handbook lists the Medicare prescription drug plans available in your area.

How can I get help choosing a Medicare prescription drug plan?
You can get personalized information at the Medicare website (**Medicare.gov**) or by calling 800-MEDICARE (800-633-4227) to help you make your best choice. TTY users should call 877-486-2048. Your State Health Insurance Assistance Program and other local and community-based organizations will also provide you with free health insurance counseling.