GROUP NAME: Palmetto Machine & Fabrication, Inc.

GROUP NUMBER: 65-24976-00

EFFECTIVE DATE: October 1, 2018

PLEASE REPLACE THE

APPROPRIATE PAGES OF YOUR

CONTRACT WITH THE CONTENTS

IN THIS ATTACHMENT.

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 HRA Silver 11 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. 57231
And all applicable groups.

IN CONSIDERATION

of the Application made by

Palmetto Machine & Fabrication, 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 October 2018 .

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 HRA Silver 11** _____(Product Name).

Name of Applicant: Palmetto Machine & Fabrication, 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 October 2018 _____, 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.

Blue Cross and Blue Shield of South Carolina complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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, because Companion Life is a separate company from Blue Cross and Blue Shield of South Carolina, Companion Life will be responsible for all services related to life insurance. 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) Florence, South Carolina, this 1st day of October 2018

Palmetto Machine & Fabrication, Inc.
Name of Applicant (Company's Name)

BLUE CROSS AND BLUE SHIELD
OF SOUTH CAROLINA

By: _____
(Authorized Signature)

By: _____
(Authorized Signature)

Member Schedule

Benefits are available In-Network and Out-of-Network.

Employer's Name:	Palmetto Machine & Fabrication, Inc.	**Client Number:**	57231
Effective Date:	October 1, 2018	**Group Number:**	65-24976-00
Anniversary Date:	October 1	**Coverage Effective Date:**	October 1, 2018
Benefit Period:	January 1st thru December 31st	**Client Effective Date:**	October 1, 2017

DEDUCTIBLE

Network Providers – $5,500 per Member per Benefit Period and $11,000 per family per Benefit Period. With family coverage, once one person meets a $5,500 Deductible, benefits will begin paying for that person.

Out-of-Network Provider – There is no Deductible

The Deductible applies to all Covered Services except Preventive Care and Primary Care Physician Office visit when the Copayment applies to that visit. The Deductible applies to the Maximum Out-of-pocket.

COINSURANCE

Network Providers – The Percentage of the Allowed Amount that you pay for Covered Services. You pay 40% of the Allowed Amount until you reach the Maximum Out-of-pocket.

Out-of-Network Providers – You pay 50% of the Allowed Amount.

COPAYMENTS

$0	per Primary Care Physician (PCP)* Office Visit for the 1st 4 visits combined with Mental Health & Substance Use Disorder Services then $30 for every visit after the 4th visit
$20	per Blue CareOnDemand℠ Visit
$60	per Specialist* Office Visit
$60	per Urgent Care Center Visit
$300	per Emergency Room Services Visit subject to the Deductible and Coinsurance
$500	per visit for surgery performed at an Ambulatory Surgical Center

*Copayments for PCP and Specialists are In-Network only

Copayments apply toward the Maximum Out-of-pocket and stops when the Maximum Out-of-pocket is reached.

Copayments do not apply to the Deductible.

MAXIMUM OUT-OF-POCKET

Network Providers – $7,150 per Member per Benefit Period and $14,300 per family per Benefit Period.

Covered Services will be paid at 100% of the Allowable Charges when you reach your Maximum Out-of-pocket. With family coverage, once one Member meets a $7,150 Maximum Out-of-pocket, benefits are payable at 100% for that Member only.

Out-of-Network Provider – There is no Out-of-Pocket Limit

The Maximum Out-of-pocket includes Copayments, Deductibles and Coinsurance. It does not include Premiums, Balance-billed charges or health care this Policy does not cover.

PRESCRIPTION DRUG COVERAGE

In-Network Retail: 30 day supply maximum

Tier 0: $0 Copayment
Tier 1: $0 Copayment
Tier 2: $50 Copayment
Tier 3: $100 Copayment
Tier 4: $300 Copayment

Out-of-Network Retail:

Tier 0: 50%
Tier 1/2/3: 50%
Tier 4: No Benefits

In-Network Retail Mail-Order: 90 day supply

Tier 0: $0 Copayment
Tier 1: $0 Copayment
Tier 2: $135 Copayment
Tier 3: $270 Copayment
Tier 4: No Benefits

Out-of-Network Retail:

No Benefits for Out-of-Network Mail-Order pharmacy.

Some drugs are considered specialty medications and must be filled at our Specialty Pharmacy. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see the Business BlueEssentials Covered Drug List for the list of drugs that must be filled with the Specialty Pharmacy.

BENEFIT PERIOD MAXIMUM — Per Member Per Benefit Period

60 days for Skilled Nursing Facility
60 visits for Home Health Care
6 months per episode for Inpatient and Outpatient Hospice Care
15 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
15 Habilitative visits for Physical, Speech and Occupational Therapy Services combined
$500 Sustained Health Benefit for physical exam services not included in other 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. Some services require preauthorization, including all hospital admissions, except maternity. See the preauthorization section of the Certificate for information concerning the preauthorization requirement.

For some services to be covered, you will be required to use a provider we designate, who may or may not be a Business BlueEssentials provider. These services include transplants, mammography, habilitation, rehabilitation and vision care.

This policy meets the actuarial requirements of the Silver level of benefits.

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.

Services That Are Covered For You

PRIMARY CARE PHYSICIAN, SPECIALIST OR URGENT CARE CENTERS

	In-Network	Out-of-Network
Office Visit Services – Office charges for the treatment of an illness, accident or injury; injections for allergy, tetanus 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). Includes mental health and substance use disorder services.	0% after Copayment for the 1st 4 visits combined with Mental Health & Substance Use Services then $30 for every visit after the 4th visit for PCP 0% after Copayment for Specialist	50%
Blue CareOnDemand℠	0% after Copayment	50%
Inpatient Physician and Surgical Services	40% after Deductible	50%
All Other Physician Services – Outpatient hospital; skilled nursing facility; clinics; 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, radiation therapy and the administration of specialty medications.	40% after Deductible	50%
Urgent Care Center – The facility must be licensed as an urgent care center.	0% after Copayment	50%

PREVENTIVE CARE FOR CHILDREN AND ADULTS

	In-Network	Out-of-Network
As outlined in your Contract as Preventive Care benefits. Includes some contraceptive devices or services.	$0	No Benefits
There are No Benefits for Preventive Care Out-of-Network.		
All other covered contraceptive devices or services not specifically listed in your Contract.	40% after Deductible	50%
Services related to a physical exam not included in other covered Preventive Screenings limited to $500 per Benefit Period. Services may be subject to age and visit limits.	$0	No Benefits
There are No Benefits for Sustained Health Out-of-Network.		

ROUTINE VISION SERVICES FOR MEMBERS AGE 19 AND YOUNGER

	In-Network	Out-of-Network
• Eye Exam – limited to one exam per benefit period.	$0 after $25 Copayment	No Benefits
• Eyeglasses – frames land lenses imited to once every benefit period.	$0 after $50 Copayment	
• Contacts only when Medically Necessary.		
Pediatric Vision Services are provided through VSP. VSP is an independent company that provides Pediatric Vision Services on behalf of BlueCross BlueShield of South Carolina. To find a VSP provider, go to www.vsp.com/advantage and enter your ZIP code. (This link leads to a third-party site. That company is solely responsible for the contents and privacy policies on its site.)		
There are No Benefits for Routine Vision Services Out-of-Network.		

LABORATORY AND DIAGNOSTIC SERVICES

	In-Network	Out-of-Network
Radiology, ultrasound and nuclear medicine; laboratory and pathology; ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing; eEndoscopies (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.	40% after Deductible	50%

HOSPITAL SERVICES

	In-Network	Out-of-Network
Inpatient and outpatient Hospital (other than Skilled Nursing Facilities, Rehabilitation Facilities or Emergency Room). Includes Mental Health and Substance Use Disorder Services.	40% after Deductible	50%
Ambulatory Surgical Center (ASC) - services and supplies provided at an ASC	0% after Copayment	50%

EMERGENCY SERVICES

	In-Network	Out-of-Network
Emergency room charges in- or out-of-network or out-of-area, including physician services in the Emergency Room (copayment applies only to Emergency Room charges)	40% after Copayment then Deductible	40% after Copayment then Deductible
Ambulance services in- or out-of-network or out-of-area, only when medically necessary	40% after Deductible	50%

MATERNITY

	In-Network	Out-of-Network
Pre- and post-partum care including Physician services. Hospital services provided as shown above.	40% after Deductible	50%

Expecting a new baby? Our free Maternity Care program can provide you with the tools and information you need to help get your baby off to a healthy start. To enroll, call 855-838-5897 and select option 4.

NEWBORN CARE

	In-Network	Out-of-Network
Post-natal care, including physician services. Hospital services provided as shown above. Benefits are available only if the child is added to your policy.	40% after Deductible	50%

REHABILITATIVE AND HABILITATIVE

	In-Network	Out-of-Network
Durable Medical Equipment (DME) - purchase or rental - excludes repair of, replacement of and duplicate DME.	40% after Deductible	No Benefits
There are no Out-of-Network benefits for DME		
Physical, occupational, speech and respiratory therapy	40% after Deductible	50%
Rehabilitation including cardiac and pulmonary	40% after Deductible	50%
Skilled nursing and rehabilitation facilities	40% after Deductible	50%
Medical supplies	40% after Deductible	50%

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

	In-Network	Out-of-Network
Inpatient and physician's services	40% after Deductible	50%
Outpatient and physician's services	40% after Deductible	50%
Residential treatment centers	40% after Deductible	50%
Physician's office (same as Primary Care Physician (PCP Office visit)	0% after Copayment for the 1st 4 visits combined with PCP Office Visits then $30 for every visit after the 4th visit	50%

OTHER SERVICES

	In-Network	Out-of-Network
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.	40% after Deductible	50%
Home health care	40% after Deductible	50%
Hospice care	40% after Deductible	50%
Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard® provider.	40% after Deductible	50%

Schedule A **Print Date: 10/04/18**

Group Number: 0133654 **Effective Date: 10/01/18**
AMMS Number: 65-24976-00 **Anniversary Date: 10/01/17**

PALMETTO MACHINE & FABRICATION
PO BOX 4597
FLORENCE SC 29502-4597

Premium Schedule

Benefit Information
Product Type: Blue Essentials Silver 11
Deductible: $5500
Out-of-Pocket Maximum: $7150
Drug Card: Included
Preventive: Sustained Health
Dental: No
Benefit Period: Calendar Year
Orthodontics: No
Office Visit Copay: 0/30

Medical Coverage

Age	Standard Rate	Tobacco Use (TU) Rate	Age	Standard Rate	Tobacco Use (TU) Rate	Age	Standard Rate	Tobacco Use (TU) Rate
Up to 14	$280.16	$280.16	33	$438.73	$526.47	49	$624.76	$749.72
15	$305.06	$305.06	34	$444.59	$533.50	50	$654.06	$784.87
16	$314.58	$314.58	35	$447.52	$537.02	51	$682.99	$819.59
17	$324.10	$324.10	36	$450.45	$540.54	52	$714.85	$857.82
18	$334.36	$401.23	37	$453.38	$544.05	53	$747.08	$896.50
19	$344.61	$413.53	38	$456.31	$547.57	54	$781.87	$938.25
20	$355.23	$426.28	39	$462.16	$554.60	55	$816.66	$979.99
21-24	$366.22	$439.46	40	$468.02	$561.63	56	$854.38	$1,025.26
25	$367.68	$441.22	41	$476.81	$572.18	57	$892.47	$1,070.96
26	$375.01	$450.01	42	$485.24	$582.28	58	$933.12	$1,119.74
27	$383.79	$460.55	43	$496.96	$596.35	59	$953.26	$1,143.91
28	$398.08	$477.69	44	$511.60	$613.92	60	$993.91	$1,192.69
29	$409.80	$491.76	45	$528.82	$634.58	61	$1,029.07	$1,234.88
30	$415.66	$498.79	46	$549.32	$659.19	62	$1,052.14	$1,262.57
31	$424.44	$509.33	47	$572.40	$686.88	63	$1,081.07	$1,297.28
32	$433.23	$519.88	48	$598.76	$718.52	64+	$1,098.64	$1,318.37

A rate will only be applied to the three oldest dependents under age 21. Dependents age 21 and over will be rated individually.

The tobacco usage (TU) rate will be applied on members / dependents 18 years of age or older where tobacco usage has been indicated.

Coverage Type(Medical)
I = Individual IS = Individual + Spouse IC= Individual + Child F = Family

South Carolina

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

Palmetto Machine & Fabrication, Inc.
2120 National Ave.

Florence, SC 29501

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

Enclosures

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 or not 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.

The details of your current coverage are as follows:

Effective Date of Coverge: October 1, 2018

Prescription Drug Plan: YES

BlueCross Group Number: 65-24976-00

You should also know that if you drop or lose your coverage with BlueCross and don't enroll in Medicar 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 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 its 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: October 1, 2018
Name of Entity/Sender: Palmetto Machine & Fabrication, Inc.
Contact - Position/Office:
Address: 2120 National Ave.

Florence, SC 29501

Phone Number: 843-398-1292

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.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-868-2500, Ext. 41010 to request a copy. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-868-2500, Ext. 41010 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$5,500 individual / $11,000 family for in-network providers. $0 individual / $0 family for out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services and office visits are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the maximum out-of-pocket limit for this plan?	Yes; $7,150 individual / $14,300 family for in-network providers. There is no out-of-pocket limit for out-of-network providers.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the maximum out-of-pocket limit?	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.	Even though you pay these expenses, they don't count toward the maximum out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see https://www.SouthCarolinaBlues.com/links/tools/findadoctorsc or call 1-800-810-2583	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/visit Deductible does not apply	50% coinsurance	Copay applies to 1st 4 visits; After 4th visit, you pay $15 copay/visit. Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.
	Specialist visit	$60 copay/visit Deductible does not apply	50% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, administration of specialty drugs, endoscopies and imaging.
	Preventive care/screening/immunization	No charge	Not covered	No charge for mammograms at a participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	NONE
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	No benefit if not preapproved.
If you need drugs to treat your illness or condition	Tier 1 Drugs	$0 copay/prescription (retail)$0 copay/prescription (mail-order) Deductible does not apply	50% coinsurance	Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy.
	Tier 2 Drugs	$50 copay/prescription (retail)$135 copay/prescription (mail-order)Deductible does not apply	50% coinsurance	Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **www.SouthCarolinaBlues.com/links/metallic/pharmacy/BusinessBlueEssentials**	Tier 3 Drugs	$100 copay/prescription (retail)$270 copay/prescription (mail-order)Deductible does not apply	50% coinsurance	Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy.
	Tier 4 Drugs	$300 copay/prescription Deductible does not apply	Not covered	Quantity limits may apply. Some drugs may require prior approval. No benefits if not approved. Drugs that are considered specialty drugs must be purchased from our Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty. Cosmetic surgery is not covered.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	50% reduction of allowed amount if not preapproved for hysterectomy or septoplasty. Cosmetic surgery is not covered.
If you need immediate medical attention	Emergency room care	$300 copay/visit, then 40% coinsurance	Facility charges only - $300 copay/visit, then 40% coinsurance. All other charges - 50% coinsurance.	NONE
	Emergency medical transportation	40% coinsurance	50% coinsurance	NONE
	Urgent care	$60 copay/visit Deductible does not apply	50% coinsurance	Copay doesn't include surgery, outpatient lab and X-ray services (except for standard plain film X-rays), second surgical opinion, dialysis, chemotherapy, radiation therapy, specialty drugs, endoscopies and imaging.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	50% coinsurance	Room and board denied if stay is not preapproved. No benefits for human organ/tissue transplant if not preapproved and at designated provider.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Physician/surgeon fee	40% coinsurance	50% coinsurance	No benefits for human organ/tissue transplant if not preapproved and at designated provider.
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	40% coinsurance	50% coinsurance	$0 copay applies to 1st 4 visits, then $30 copay/visit for in-network office visit. No benefits for psychological testing, repetitive Transcranial Magnetic Stimulation, intensive outpatient services, partial hospitalization and electroconvulsive therapy if not preapproved.
	Inpatient services	40% coinsurance	50% coinsurance	No benefits if not preapproved.
If you are pregnant	Office Visits	$0 copay/initial visit only Deductible does not apply	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	NONE
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	No benefits for termination of pregnancy, except in limited circumstances.
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Limited to 60 visits/year. No benefits if not preapproved.
	Rehabilitation services	40% coinsurance	50% coinsurance	Physical, occupational and speech therapy limited to 15 Rehabilitative visits/year combined. No inpatient benefits if not preapproved.
	Habilitation services	40% coinsurance	50% coinsurance	Physical, occupational and speech therapy limited to 15 Habilitative visits/year combined. No inpatient benefits if not preapproved.
	Skilled nursing care	40% coinsurance	50% coinsurance	Limited to 60 days/year. Room and board denied if stay is not preapproved.
	Durable medical equipment	40% coinsurance	Not covered	Excludes repair of, replacement of and duplicate. No benefits if not preapproved when cost is $500 or more.

Common Medical Event	Services You May Need	What You Will Pay		Limitations , Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Hospice service	40% coinsurance	50% coinsurance	Limited to 6 months/episode. No benefits if not preapproved.
If your child needs dental or eye care	Children's eye exam	$25 copay	Not covered	Limited to one eye exam per benefit period
	Children's glasses	$50 copay	Not covered	Limited to once per benefit period for frames and lenses. Contacts covered only when medically necessary.
	Children's dental check-up	Not covered	Not covered	NONE

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion services
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Private duty nursing
- Residential and custodial care
- Routine eye care (Adult)
- Routine foot care
- Varicose veins treatment
- Weight loss programs

*Abortion services (except in cases of rape, incest, or when the life of the mother is endangered)

Other Covered Services. (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (if purchased separately)
- Non-emergency care when traveling outside the U.S. See www.SouthCarolinaBlues.com/members/findaprovider.aspx

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The State Insurance Department, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the plan at 1-800-868-2500, Ext. 41010 or visit www.SouthCarolinaBlues.com, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, your state office of health insurance customer assistance at: 1-800-768-3467 or visit www.doi.sc.gov.

Does this Coverage Provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this Coverage Meet the Minimum Value Standard? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at www.SouthCarolinaBlues.com.

————————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.———————— ————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$0
Coinsurance	$5,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,260**

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$80
Copayments	$800
Coinsurance	$50
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$990**

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,500**
- **Specialist copayment** **$60**
- **Hospital (facility) coinsurance** **40%**
- **Other coinsurance** **40%**

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$1,100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697(TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入数字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید.
(Persian-Farsi)
