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 HD Gold 3 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. 62272
And all applicable groups.

IN CONSIDERATION

of the Application made by

Toadfish LLC

(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 January 2021 .

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 HD Gold 3** (Product Name).

Name of Applicant: Toadfish LLC
(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 January 2021, 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 below.

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.

Participation Requirements: The group must meet at least 70 percent participation. Group size and participation are determined after Employees with a valid waiver are removed. Valid waivers include coverage through other employer plans, Individual health insurance coverage, Medicare, Medicaid, or coverage through a veterans' or military program. A waiver is not considered valid if the person has no coverage, or for short-term health coverage, or mini-med products (not minimum essential coverage). Persons who are categorized as Section 1099 employees are not considered eligible for the group health plan.

Group Size	Enrollment	Participation Percent
2 or 3	All employees	100%
4	3	75%
5	4	80%
6 or 7	5	83% / 81%
8	6	71%
9 or 10	7	78% / 70%
11	8	73%
12	9	75%
13	10	77% / 71%
15	11	73%
16-50		70%

Employer must contribute a minimum of 50 percent of the single Employee cost. If the Employer contributes 100 percent of the single Employee premium, 100 percent of all eligible Employees must enroll in at least single coverage.

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.

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) Charleston, South Carolina, this 1st day of January 2021

Toadfish LLC
Name of Applicant (Company's Name)

By:

(Authorized Group Signature)

(Agent Signature)

BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA

By:

(Authorized Signature)

Member Schedule

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

Employer's Name: Toadfish LLC

Client Number: 62272

Client Effective Date: January 1, 2021

Group Number: 652758000

Anniversary Date: January 1

Coverage Effective Date: January 1, 2021

Benefit Period: January 1st thru December 31st

DEDUCTIBLE

Network Providers – $2,800 per Member per Benefit Period and $5,600 per family per Benefit Period. With family coverage, once one person meets a $2,800 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 0% of the Allowed Amount until you reach the Maximum Out-of-pocket.

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

COPAYMENTS

No Copayments for this Plan

MAXIMUM OUT-OF-POCKET

Network Providers – $2,800 per Member per Benefit Period and $5,600 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 $2,800 Maximum Out-of-pocket, before 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 31 day supply maximum:

Tier 0: $0 Copayment
Tier 1: 0% after Deductible
Tier 2: 0% after Deductible
Tier 3: 0% after Deductible
Tier 4: 0% after Deductible

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% after Deductible
Tier 2: 0% after Deductible
Tier 3: 0% after Deductible
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, Optum® Specialty Pharmacy. Although most specialty drugs are found in Tier 4, they could be Tier 1, 2 or 3. Please see your Certificate for a description of the Tiers for further clarification. Also 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
30 Rehabilitative visits for Physical, Speech and Occupational Therapy Services combined
30 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 Gold 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.

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. See Certificate of Coverage for more detailed information.

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 Deductible	50%
Blue CareOnDemand℠	0% after Deductible	50%
Inpatient Physician and Surgical Services	0% 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.	0% after Deductible	50%
Urgent Care Center – The facility must be licensed as an urgent care center.	0% after Deductible	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.	0% 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 and lenses limited 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; 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	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.	0% after Deductible	50%
Ambulatory Surgical Center (ASC) facility charge - An ASC is a free-standing facility not affiliated with a health system that is licensed for Outpatient Services only and doesn't provide overnight accommodations or around-the-clock care.	0% after Deductible	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)	0% after Deductible	0% after Deductible
Ambulance services in- or out-of-network or out-of-area, only when medically necessary	0% after Deductible	50%

MATERNITY

	In-Network	Out-of-Network
Pre- and post-partum care including Physician services. Hospital services provided as shown above.	0% 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.	0% 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.	0% after Deductible	No Benefits
There are no Out-of-Network benefits for DME		
Physical, occupational, speech and respiratory therapy	0% after Deductible	50%
Rehabilitation including cardiac and pulmonary	0% after Deductible	50%
Skilled nursing and rehabilitation facilities	0% after Deductible	50%
Medical supplies	0% after Deductible	50%

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES

	In-Network	Out-of-Network
Inpatient and physician's services	0% after Deductible	50%
Outpatient and physician's services	0% after Deductible	50%
Residential treatment centers	0% after Deductible	50%
Physician's office	0% after Deductible	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.	0% after Deductible	50%
Home health care (60-visit maximum)	0% after Deductible	50%
Hospice care (6 months per episode to include Inpatient and Outpatient care)	0% after Deductible	50%
Out-of-Country services including facility and physician for emergency and urgent care only, if covered through a BlueCard® provider.	0% after Deductible	50%

Schedule A **Print Date: 12/28/20**

Group Number: 0152515 **Effective Date: 01/01/21**
AMMS Number: 65-27580-00 **Anniversary Date: 01/01/21**

TOADFISH LLC
PO BOX 13748
CHARLESTON SC 29422-3748

Premium Schedule

Benefit Information
Product Type: Blue Essentials Gold Hd 3
Deductible: $2800
Out-of-Pocket Maximum: $2800
Drug Card: Included
Preventive: Sustained Health
Dental: No
Benefit Period: Calendar Year
Orthodontics: No
Office Visit Copay: D/100

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	$356.60	$356.60	33	$558.44	$670.13	49	$795.25	$954.30
15	$388.30	$388.30	34	$565.90	$679.08	50	$832.54	$999.05
16	$400.42	$400.42	35	$569.63	$683.56	51	$869.36	$1,043.24
17	$412.54	$412.54	36	$573.36	$688.03	52	$909.92	$1,091.90
18	$425.59	$425.59	37	$577.09	$692.51	53	$950.94	$1,141.13
19	$438.64	$438.64	38	$580.82	$696.98	54	$995.22	$1,194.27
20	$452.16	$452.16	39	$588.28	$705.93	55	$1,039.51	$1,247.41
21-24	$466.15	$559.38	40	$595.74	$714.88	56	$1,087.52	$1,305.02
25	$468.01	$561.61	41	$606.92	$728.31	57	$1,136.00	$1,363.20
26	$477.33	$572.80	42	$617.64	$741.17	58	$1,187.74	$1,425.29
27	$488.52	$586.23	43	$632.56	$759.07	59	$1,213.38	$1,456.06
28	$506.70	$608.04	44	$651.21	$781.45	60	$1,265.12	$1,518.15
29	$521.62	$625.94	45	$673.12	$807.74	61	$1,309.87	$1,571.85
30	$529.08	$634.89	46	$699.22	$839.06	62	$1,339.24	$1,607.09
31	$540.26	$648.32	47	$728.59	$874.30	63	$1,376.06	$1,651.28
32	$551.45	$661.74	48	$762.15	$914.58	64+	$1,398.43	$1,678.12

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

Toadfish LLC
1750 Signal Point Road
Building 9B
Charleston, SC 29412

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: January 1, 2021

Prescription Drug Plan: YES

BlueCross Group Number: 652758000

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: January 1, 2021
Name of Entity/Sender: Toadfish LLC
Contact - Position/Office:
Address: 1750 Signal Point Road
Building 9B
Charleston, SC 29412

Phone Number: 843-697-7643

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.