

SUMMARY PLAN DESCRIPTION AND EVIDENCE OF COVERAGE

NRECA Medicare Part D Prescription Drug Plan— Enhanced Plus Plan

January 1 – December 31, 2009



NRECA Medicare Part D Customer Care

For help or information, please call Customer Care Monday through Saturday,
6:30 a.m. to 11:00 p.m. Central Time.

Toll-Free Phone: 866.586.7322 TTY/TDD: 866.236.1069

Web Site: <http://nreca.medicareplanrx.com>

Your NRECA Medicare Part D prescription drug coverage as a participant of the Enhanced Plus Plan

January 1 – December 31, 2009

This Summary Plan Description (SPD) and Evidence of Coverage explains the details about your Medicare Part D prescription drug coverage. It is an important legal document. Please keep it in a safe place.

NRECA Medicare Part D Customer Care

For help or information, please call Customer Care Monday through Saturday, 6:30 a.m. to 11:00 p.m. Central Time. Calls to this number are toll-free.

Toll-free phone: 866.586.7322
TTY/TDD: 866.236.1069
Web site: <http://nreca.medicareplanrx.com>
Mail: NRECA Part D Plan
c/o SilverScript, LLC
P.O. Box 659576
San Antonio, TX 78265-9576

NRECA Medicare Part D Grievance and Appeals Department

To file a grievance or request a coverage determination or an appeal, please contact Customer Care and ask for the Grievance and Appeals Department.

Toll-free phone: 866.586.7322
TTY/TDD: 866.236.1069
Fax: 866.884.9475
Mail: NRECA Part D Plan
c/o SilverScript, LLC
Appeal Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

Fraud Hotline

To report any potential Medicare prescription drug fraud, waste or abuse, please call:

NRECA Fraud Hotline: 888.FRAUD89 (888.372.8389)
Medicare: 800.MEDICARE (800.633.4227)
Health Integrity: 877.7SafeRx (877.772.3379)

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Introduction—Welcome to the NRECA Medicare Part D Drug Plans

We are pleased that you've chosen the **Enhanced Plus Plan**, one of NRECA's Medicare-approved Part D prescription drug plans.

Now that you are enrolled in the Enhanced Plus Plan, a NRECA Medicare Part D prescription drug plan, you are getting your Medicare Part D prescription drug coverage through NRECA.

Throughout the remainder of this Summary Plan Description (SPD) and Evidence of Coverage, we refer to the Enhanced Plus Plan as the "Plan."

This SPD and Evidence of Coverage explains how to get your Medicare Part D prescription drug coverage through our Plan

This SPD and Evidence of Coverage, together with your enrollment form and the Plan Document, riders and amendments that the Plan may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a participant of our Plan. It also explains our responsibilities to you. At all times, the Plan reserves the discretion to interpret the terms of the Plans and to determine eligibility for benefits.

The information in this SPD and Evidence of Coverage is in effect for the time period from January 1, 2009, through December 31, 2009.

This SPD and Evidence of Coverage gives you the details, including:

- what is covered in our Plan and what is not covered
- how to get your prescriptions filled, including some rules you must follow
- what you will have to pay for your prescriptions
- what to do if you are unhappy about something related to getting your prescriptions filled
- how to leave our Plan, including your choices for continuing Medicare Part D prescription drug coverage

How to contact our Plan's Customer Service

If you have any questions or concerns, please call or write to NRECA Medicare Part D Customer Care. We will be happy to help you.

Our business hours are Monday through Saturday from 6:30 a.m. to 11:00 p.m. Central Time.

CALL	866.586.7322. This number is also on the cover of this SPD and Evidence of Coverage for easy reference. Calls to this number are free.
TTY/TDD	866.236.1069. This number requires special telephone equipment. It is on the cover of this SPD and Evidence of Coverage for easy reference. Calls to this number are free.
FAX	866.884.9474
WRITE	P.O. Box 659576, San Antonio, TX 78265-9576

How to contact the Medicare program and the 800.MEDICARE (TTY/TDD 877.486.2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare program. CMS contracts with and regulates Medicare Part D prescription drug plans (including our Plan).

- Call 800.MEDICARE (800.633.4227) to ask questions or get free information booklets from Medicare. TTY users should call 877.486.2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government web site for Medicare information. This web site gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer.

State Health Insurance Assistance Program (SHIP)

SHIPs are organizations paid by the federal government to give free health insurance information, explain your Medicare rights and protections, help you make complaints about care or treatment, and help you straighten out problems with Medicare bills. SHIPs have different names depending on which state they are in.

You can find contact information for the SHIP in your state by calling Customer Care or visiting www.medicare.gov. Look under “Search Tools” and select “Find Helpful Phone Numbers and Websites”.

Quality Improvement Organization (QIO)

The QIO is a group of doctors and other health care experts in your state who are paid by the federal government to:

- review medical care
- handle quality-of-care complaints from patients with Medicare
- help improve the care given to Medicare patients

There is a QIO in each state. QIOs have different names, depending on which state they are in. You can find contact information for the QIO in your state by calling Customer Care.

Other organizations

Medicaid agency

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 800.772.1213; TTY/TDD users should call 800.325.0778.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 800.808.0772 (calls to this number are free). TTY/TDD users should call 312.751.4701. You can also visit **www.rrb.gov**.

Employer (Group) Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums or the open enrollment season.

State Pharmacy Assistance Program

Some states have State Pharmacy Assistance Programs (SPAPs), which provide financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. SPAPs may help pay premiums, coinsurance and copayments for those who qualify. Please contact your SPAP to find out what benefits may be available to you.

Please call Customer Care to locate the SPAPs in your state. These listings may change during the year. Please contact 800.Medicare to find out if there are new qualified SPAPs in your state.

Section 1—Plan Basics

What is the NRECA Enhanced Plus Plan?

The Enhanced Plus Plan is one of the Medicare Part D prescription drug plans offered by NRECA, and is a Medicare-approved Part D prescription drug plan. The Plan is a national plan located in all Medicare regions. This SPD and Evidence of Coverage explains your benefits and services, what you have to pay and the rules you must follow to get your prescription drugs covered.

Overview of Medicare Part D prescription drug coverage

Medicare Part D prescription drug coverage is insurance that helps pay for your prescription drugs, vaccines, specialty drugs, and some supplies not covered by Medicare Part B.

Generally, drugs listed in the Enhanced Plus Plan formulary will be covered as long as:

- the drug is medically necessary
- the prescription is filled at a Plan network pharmacy
- other coverage rules are followed

The Plan does not pay for drugs that are:

- covered by Medicare Part B
- excluded by Medicare

As a participant, all you have to do is:

- pay your monthly premium
- pay applicable coinsurance

The amount of the monthly premium is not affected by your health status or how many prescriptions you need.

If you have diabetes, certain Medicare Part B supplies are not covered under Medicare Part D, including lancets, test strips, glucometers, etc. Diabetic supplies that are covered under Medicare Part D include those items related to the injection of insulin, such as insulin syringes, needles, gauze, and alcohol swabs. Inhalers associated with the inhaled form of insulin are also covered under Medicare Part D.

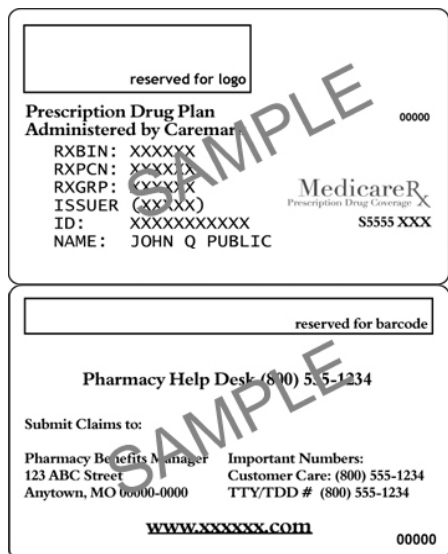
Help us keep your membership record up-to-date

The Plan has a file of information about you as a Plan participant. Pharmacists use this membership record to know what drugs are covered for you. The membership record has the information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 9 tells how NRECA protects the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Care know right away if there are any changes in your name, address or phone number, or if you go into a nursing home.

You are required to let us know about any other health insurance you may have, or any changes in health insurance coverage, such as:

- another employer’s plan
- your spouse’s employer’s plan
- workers’ compensation
- Medicaid
- liability claims such as claims from an automobile accident



Use your Plan ID card instead of your red, white, and blue Medicare card

Now that you are a participant of our Plan, you have a Plan membership identification (ID) card.

To the left is a sample card to show you what it looks like.

While you are a Plan participant and using Plan services, you *must* use your Plan membership card at network pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order for your prescription drugs to be paid by the Plan.

You should continue to use your red, white and blue card Medicare card to get covered services and items under original Medicare. If your membership card is ever damaged, lost, or stolen, call Customer Care right away and we will send you a new card.

Use Plan pharmacies so your prescription drugs are covered

With few exceptions, you must use network pharmacies for your prescription drugs to be covered.

What are network pharmacies?

A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them “network pharmacies” because they contract with our Plan.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You are not required to use the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

However, if you switch to a different network pharmacy, you either must get a new prescription from your doctor or have the previous pharmacy transfer your existing prescription to the new pharmacy if any refills remain.

What are “covered drugs”?

“Covered drugs” means all of the outpatient prescription drugs that are covered by our Plan. Most covered drugs are listed in the formulary. All generic drugs are covered even if they are not listed in the formulary, except those drugs excluded by Medicare.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your coinsurance). If this happens, you can submit a claim form to be reimbursed for the Plan’s share of the cost. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan network pharmacies

A Pharmacy Directory is a list of our network pharmacies. You should have received a list of network pharmacies with this mailing. You can use it to find a network pharmacy close to you. Customer Care can give you the most up-to-date information about changes in this Plan’s pharmacy network. In addition, you can find this information on our web site <http://nreca.medicareplanrx.com>.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy may leave the Plan’s network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy for your drugs to be covered. Please refer to your Pharmacy Directory or call Customer Care to find another network pharmacy in your area.

How do I fill a prescription through the Plan’s network mail-order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call “mail order drugs.” If prescribed by your doctor, you can get up to a 90-day supply of maintenance medications through mail order services. These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

You will need to get a new prescription from your doctor and send it to the mail-order pharmacy. You should ask your doctor for a prescription for a 90-day supply and three refills, if appropriate.

Generally, it takes us 10-14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If we anticipate a delay in shipment of more than 10 days, for any reason, we will call you within 24 hours of receiving and logging the prescription.

You can charge your mail order prescription to a credit or debit card, or SilverScript will bill you for your mail order prescription. However, if your unpaid mail order pharmacy account balance exceeds \$200 on a new order or in combination with a previous unpaid balance, your prescriptions and/or refill order will be delayed until a credit card or debit card payment is made.

You also can get up to a 90-day supply at retail network pharmacies. However, due to greater plan discounts on drug costs through mail order, you may save more in out-of-pocket costs by using mail for your maintenance medications.

Filling prescriptions outside the network

Generally, the Plan only covers drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when the Plan would cover prescriptions filled at an out-of-network pharmacy.

Before you fill your prescription in these situations, call Customer Care to see if there is a network pharmacy in the area where you can fill your prescription.

If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your coinsurance) when you fill your prescription. You can submit a claim form to be reimbursed for the Plan's share of the cost.

Also, you should submit a claim if you fill a prescription at an out-of-network pharmacy because any amount you pay will help you qualify for catastrophic coverage (see Section 5). To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

Note: If the Plan does pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you went to a network pharmacy.

Covered Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling where there is no network pharmacy.

The Plan will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- The prescriptions are related to care for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner because there are no network pharmacies within a reasonable driving distance that provide 24 hour service.
- You are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high cost and unique drugs).
- Some covered drugs administered in your doctor's office.

You will be reimbursed for the submitted charge for a prescription filled at an out-of-network pharmacy for any of the above reasons, less your share of the cost.

How do I submit a paper claim?

When you go to a **network pharmacy** and use your prescription drug membership card, your claim automatically is submitted to us by the pharmacy.

However, if you go to an **out-of-network pharmacy** for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 7.

To file your claim:

1. Go to **<http://nreca.medicareplanrx.com>** to download a paper claim form or call Customer Care to request a paper claim form
2. Complete your claim form
3. Attach your pharmacy receipt(s) – the receipt that includes the name of your prescription drug from the pharmacy, not the sales receipt
4. Send the claim form and pharmacy receipt(s) to:

NRECA's Part D Plan
c/o Caremark Pharmacy Service
Paper Claims Department
P.O. Box 52193
Scottsdale, AZ 85072-2193

If you have any questions, please call Customer Care for more information.

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 7 to learn more about requesting coverage determinations.

Additionally, if you get help from and pay coinsurance under a drug manufacturer patient assistance program outside our Plan's benefit, you may submit documentation for the amount you paid and have it count towards your true out-of-pocket cost. Please call Customer Care for more information.

Specialty pharmacies

Home infusion pharmacies

The Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan network pharmacy.

Please note: the Plan will cover the cost of the prescription drug but not the cost of other services and supplies associated with your home infusion therapy, such as nursing services and supplies. Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Customer Care.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the Plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Care.

Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies through the Plan's pharmacy network. Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Care.

Some vaccines and drugs may be administered in your doctor's office

The Plan may cover vaccines that:

- Are preventive in nature and are not already covered by Medicare Part B
- Are medically necessary and covered by our Plan, but are not already covered by Medicare Part B
- May be administered in your doctor's office, or by your pharmacist in some states

Please see Section 5, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.

Section 2— Who Is Eligible for Coverage

Individuals Eligible for Coverage

Individuals are eligible for the NRECA Medicare Part D Prescription Drug Plans (Plans) only if:

- They are entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and
- Medicare is their primary insurer. Your primary insurer is the insurance policy, plan, or program that pays first on a claim for medical care.

Please keep in mind that the Plans offer an individual benefit. Spouses or dependent children, if eligible (if enrolled in Medicare and Medicare is their primary insurer), will need to enroll separately in the Plan they choose.

Generally, individuals are eligible for Medicare if they:

- Are 65 years old or older,
- Are disabled at any age and currently receiving Social Security benefits. Eligibility for Medicare usually occurs after someone has been disabled for 29 months.
- Have been diagnosed with End-Stage Renal Disease (ESRD) at any age, or
- Have been diagnosed with Amyotrophic Lateral Sclerosis (ALS), commonly known as Lou Gehrig's Disease, at any age.

You are eligible to enroll in these Plans only if **Medicare is your primary insurer** (the primary payer of your medical claims). Thus, you are eligible to participate in these Plans **if you are enrolled in Medicare and you are a:**

- retiree,
- retired director,
- director who is a retired co-op employee and who is not covered by a group health plan, such as the NRECA Medical Plan
- disabled employee who has been receiving disability benefits from your employer for more than 6 months,
- employee diagnosed with ESRD who has been enrolled in Medicare for at least 30 months, or
- spouse or dependent child of any person listed above.

Individuals Not Eligible for Coverage

Please note that an individual's Medicare enrollment alone does not mean that he or she is eligible to participate in these Plans.

If a Medicare-enrolled individual is covered by the NRECA Medical Plan as:

- an active co-op employee,
- an active director,
- active employee diagnosed with ESRD who has been enrolled in Medicare for less than 30 months, or
- a covered spouse or dependent child of any person listed above,

then he or she is not eligible to enroll in this Plan because Medicare is not his or her primary insurer.

Similarly, you are not eligible to enroll in these Plans if your spouse's or another employer plan is your primary insurer.

You also are not eligible to participate in these Plans if you are currently enrolled in another Medicare Part D prescription drug plan.

A co-op retiree, retired director, director (who is a retired co-op employee without NRECA Medical Plan coverage), his or her spouse (or dependent child) or surviving spouse (or dependent child) may only enroll in this Plan if Medicare is each person's primary insurer.

No Family Coverage

This Plan is offered on an individual basis to Medicare-eligible individuals for whom Medicare is the primary insurer. Therefore, there is no dependent/family coverage.

Spouses and/or dependent children, if Medicare-eligible, will need to enroll separately in the Plan.

New Dependents

In order to participate in NRECA's Medicare Part D Prescription Drug Plans, you must be a retired or disabled employee or director, or a spouse, or surviving spouse, or child of a retired or disabled employee or director.

New dependents are eligible to participate in NRECA's Medicare Part D Prescription Drug Plans if they:

- Enroll **within 31 days** of marriage, birth, adoption, or placement for adoption, and
- Are enrolled in Medicare, and
- Otherwise meet the requirements for eligibility to participate in the Plan.

If the new dependent does not enroll within 31 days, he or she must wait until the next open enrollment period held every year from November 15 to December 31. The new dependent may still have to pay a late enrollment penalty if he or she did not have creditable prescription drug coverage for 63 or more consecutive days after first becoming eligible for Medicare.

However, to the extent that the Medicare enrollment rules provide longer timeframes for enrollment, those longer time frames apply.

What Are Your Options For Obtaining Prescription Drug Coverage If You Leave?

If you leave the NRECA Part D Plans, you may join:

- a non-NRECA Medicare Part D prescription drug plan
- a Medicare Advantage Plan with prescription drug coverage if
 - This type of plan is available in your area, and
 - They are accepting new members, and
 - You meet the eligibility requirements of the plan.

Whatever new plan option you might select, you are responsible for contacting that plan to obtain their enrollment information.

Medicare Prescription Drug Plan. You may choose to join another prescription drug plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another prescription drug plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the prescription drug plan.

Medicare Advantage Prescription Drug Plan. If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must obtain your Medicare prescription drug coverage through that Medicare Advantage Plan. If you choose a Private Fee For Service (PFFS) plan, you may enroll in a separate Part D plan for your prescription drug coverage. For more information on joining a Medicare Advantage Plan in your area, please contact 800.MEDICARE, TTY/TDD 877.486.2048 or visit www.medicare.gov.

Paying for Coverage

You and your employer may share in the cost of your coverage. Please note that the amount you must pay toward your coverage is for the 2009 Plan Year and is subject to change in future Plan Years.

Specific information regarding the amount you must pay toward your coverage will be provided to you before you enroll in one of the Plans, whether such enrollment is your initial enrollment, annual open enrollment, or special enrollment. Your cost of this coverage is subject to your employer's policies and can change at any time.

Please see your benefits administrator if you have any questions regarding your specific cost information.

Section 3—Extra Help with Drug Plan Costs for People with Limited Income and Resources

What Extra Help is available?

Medicare provides **Extra Help** to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car.

If you qualify, you will get help paying for your Medicare drug plan's monthly premium and prescription coinsurance. If you qualify, this Extra Help will count toward your out-of-pocket costs.

Do you qualify for Extra Help?

People with limited income and resources may qualify for Extra Help in one of two ways. The amount of Extra Help you get will depend on your income and resources.

1. **You automatically qualify for Extra Help** and do not need to apply if you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits. Medicare mails letters monthly to people who automatically qualify for Extra Help.
2. **You may apply and qualify for Extra Help.** You may qualify if your yearly income in 2008 is less than \$15,600 (single) or \$21,000 (married and living with your spouse), and your resources in 2009 are less than \$12,510 (single) or \$25,010 (married and living with your spouse). These resource amounts include \$1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car.

These yearly income amount is for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

If you think you may qualify, call the Social Security Administration at 800.772.1213, go to www.socialsecurity.gov web site, or apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

In September, Medicare mailed letters to those participants who were receiving Extra Help in 2008 and no longer qualify for Extra Help in 2009. If you receive this letter, you should reapply.

How do my costs change when I qualify for Extra Help?

The Extra Help you get from Medicare will help you pay for your Medicare drug plan's monthly premium and coinsurance or copayments. The amount of Extra Help you receive is based on your income and resources.

See the table below for the costs you pay at your copayment or coinsurance level. You are responsible for paying these costs any time you fill a prescription for a covered drug at a network pharmacy until your total out-of-pocket costs reach \$4,350.

Your Coinsurance or Copayment Level	Annual Deductible	Generic or Preferred Brand Name Drugs	Other Drugs
1	\$ 0.00	\$ 2.40	\$ 6.00
2	\$ 0.00	\$ 1.10	\$ 3.20
3	\$ 0.00	\$ 0.00	\$ 0.00
4	\$ 0.00	15%	15%

These copayment or coinsurance amounts would also apply to out-of-network pharmacy purchases, if you meet the conditions for out-of-network access. However, when you purchase the drug out-of-network you would probably have to pay the full price of the drug and then submit a claim form to be reimbursed by the Plan.

If you qualify for Extra Help, the Plan will send you by mail an *Addendum to the Medicare Part D Summary Plan Description/Evidence of Coverage*. This rider explains how much you will have to pay for your prescriptions. If the amount of your Extra Help changes during the year, the Plan will also mail you an updated Summary Plan Description rider.

What to do if you believe you have qualified for Extra Help and you believe that you are paying an incorrect copayment amount

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect copayment amount when you get your prescriptions filled at a pharmacy, our Plan has established a process that will allow you to either:

- request help in getting the necessary proof of the correct copayment you should be paying, or
- provide us with proof, if you already have it.

You can submit any of the following forms of evidence to the NRECA Plan, or they can be submitted by your pharmacist, advocate, representative, family member or other individual acting on your behalf:

- A copy of your Medicaid card that includes your name
- A copy of a state document that confirms active Medicaid status
- A print out from the State electronic enrollment file showing Medicaid status
- A screen print from the State's Medicaid systems showing Medicaid status
- Other documentation provided by the State showing Medicaid status
- A copy of the Social Security Administration award letter
- A remittance from the facility showing your Medicaid payment for a full calendar month
- A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month
- A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes.

When we receive the proof from Medicare showing your copayment level

- We will update our system or implement other procedures so that you can pay the correct copayment when you get your next prescription at the pharmacy.
- We will reimburse you if you paid a higher copayment by sending you a check in the amount of your copayment or by giving you a credit toward future copayments.

We will make the payment to

- the pharmacy if it hasn't collected a copayment from you and/or is carrying your copayment as a debt owed by you
- a state if the state paid on your behalf.

If you have any questions, please contact Customer Care.

How do you get more information?

For more information on who can get Extra Help with prescription drug costs and how to apply, call the Social Security Administration at 800.772.1213, or visit the www.socialsecurity.gov web site. TTY/TDD users should call 800.325.0778.

In addition, you can look at the *2009 Medicare & You* handbook, visit the www.medicare.gov web site, or call 800.MEDICARE (800.633.4227). TTY/TDD users should call 877.486.2048.

If you have any questions about our Plan, please refer to our Customer Care numbers listed on the cover and in the introduction section. Or, visit our web site <http://nreca.medicareplanrx.com>.

Section 4—Monthly Premium

Paying the Plan premium for your coverage as a participant of our Plan

How much is your monthly plan premium and how do you pay it?

In the Enhanced Plus Plan, you must pay a \$203.35 premium each month.

This monthly premium may be less if

- Your current or former employer, or your spouse's current or former employer, pays all or part of the premium.
- You qualify for Extra Help, also called the Low Income Subsidy or LIS, from Medicare.
- You are a member of a State Pharmacy Assistance Program (SPAP) or similar organization.

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about the premium for your Plan. Contact your benefits administrator for more information.

If you have any questions about your Plan premiums or the different options to pay them, please call your benefits administrator, or call Customer Care.

If you are getting Extra Help (LIS) with paying for your drug coverage from Medicare, the premium amount you pay as a participant in this plan is listed in your "Addendum to Medicare Part D Summary Plan Description/Evidence of Coverage". You can also get that information by calling Customer Care.

If you are a participant in a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states, the SPAP has another name.

What happens if you don't pay your plan premiums, or don't pay them on time?

We will tell you in writing when a 60-day grace period begins for Plan premiums that are past due.

If you do not pay past-due Plan premiums within the grace period, we will disenroll you and you will no longer be a participant in our Plan.

If this happens, you will not be able to enroll in another Medicare Prescription Drug Plan until the next annual open enrollment period, unless you qualify for a Special Enrollment Period. If you do not qualify, or do not have other creditable coverage, you may have to pay a late enrollment penalty the next time you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage.

If you should decide to re-enroll in this Plan during the next annual open enrollment period, or to enroll in another plan offered by us, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in our Plan.

Please see Section 8 or call Customer Care to find out more about enrollment periods.

Can your plan premiums change during the year?

Generally, your plan premium cannot change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year

- in your plan premiums
- in the amounts you will have to pay when you get your prescriptions covered.

If there are any changes for the next calendar year, they will take effect on January 1, 2010.

In limited circumstances, your plan premium may change during the calendar year. If you aren't currently receiving Extra Help but you qualify for it during the year, your monthly premium amount would go down. If you currently get Extra Help paying your plan premium, the amount of help you qualify for may change during the year.

Your eligibility for Extra Help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of Extra Help you get changes, your monthly premium would also change. For example, if you qualify for more Extra Help, your monthly premium amount would be lower.

Do you have to continue to pay your Part A or Part B premiums?

If you now pay a premium for Medicare Part A and/or Medicare Part B, you will need to continue paying this premium to remain a participant in this plan.

Some participants belong to a Medicare Savings Program, such as a

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Individual (QI)

These participants may be eligible to get Extra Help in paying their Medicare Part A and/or Part B premiums. Please see Section 3 or call Customer Care for more information.

What is the late enrollment penalty?

You will have to pay a late enrollment penalty for the months that you were not covered by a Medicare prescription drug plan if

- You did not enroll in a Medicare prescription drug plan when you are first eligible
- You did not have other creditable prescription drug coverage that is at least as good as Medicare's standard plan for 63 or more consecutive days.

This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for Extra Help, you will not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. This penalty is equal to 1 percent of the national basic premium for each month you are:

- eligible for Medicare, and
- not covered by a creditable prescription drug plan, such as an employer plan, and
- not enrolled in a Part D plan after May 15, 2006.

This late enrollment penalty is determined by Medicare and added each month to your premium for as long as you are enrolled in a Medicare prescription drug plan.

If you disagree with your late enrollment penalty, you may ask Medicare to reconsider (review) its decision. Call Customer Care to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had *creditable* prescription drug coverage—coverage that expects to pay at least as much as Medicare's standard coverage.
- The period of time that you didn't have creditable prescription drug coverage was less than 63 consecutive days.
- You had prescription drug coverage and you were not informed adequately that your prescription drug coverage was not creditable.
- You lived in an area affected by Hurricane Katrina in August 2005 *and* you signed up for a Medicare prescription drug plan by December 31, 2006 *and* you stay in a Medicare prescription drug plan.
- You received or are receiving Extra Help.

Your late enrollment penalty may be reduced or eliminated if you receive Extra Help in 2009 or afterwards.

Section 5—Prescription Drug Coverage

What drugs are covered by this Plan?

What is a formulary?

The Plan has a formulary that lists all drugs that it covers. The Plan will generally cover the drugs listed in our formulary as long as

- the drug is medically necessary
- the prescription is filled at a network pharmacy or through our network mail-order pharmacy service, and
- other coverage rules are followed.

You can get up to a 90-day supply of most prescription drugs, but specialty drugs are limited to a 30-day supply. For certain drugs, the Plan has additional requirements for coverage or limits on our coverage. These requirements and limits are described under “Drug Management Programs” later in this section.

The drugs on the formulary are selected by the Plan with the help of a team of health care providers. The Plan selects the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary.

All generic drugs are covered even if they are not listed on the formulary, except those drugs excluded by Medicare. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See “Drug Exclusions,” later in this section, for more information about the types of drugs that cannot be covered under a Medicare Part D prescription drug plan.) In other cases, the Plan has decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 1 (Plan Basics) for more information about filling prescription at out-of-network pharmacies.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary with your enrollment kit so you can find out what drugs will be covered in January, the start of the new plan year. You may call Customer Care to find out if your drug is covered or to request an updated copy of our formulary. You can also get updated information about the drugs the Plan covers by visiting our web site at <http://nreca.medicareplanrx.com>.

Can the formulary change?

The Plan may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription.

The formulary changes that the Plan may make include:

- Add drugs to the formulary
- Add prior authorizations, quantity limits, and/or step-therapy requirements for a drug
- Replace a brand-name drug with a new generic drug
- Remove a drug as a result of new information on the drug's safety or effectiveness

If the Plan removes drugs from the formulary or adds prior authorizations, quantity limits and/or step therapy on a drug — and you are taking the drug affected by the change — you will be notified by the Plan of the change on your monthly Explanation of Benefits (EOB) at least 60 days before the date that the change becomes effective. If the Plan doesn't notify you of the change in advance, you may ask for a 60-day supply of the drug when you request a refill of that drug.

However, if a drug is removed from our formulary because the drug has been recalled from the market, you will not be given 60 days notice before the drug is removed from the formulary nor will you be given a 60-day supply of the drug when you request a refill. Instead, the Plan will remove the drug from our formulary immediately and notify participants about the change as soon as possible.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug the Plan covers or request an exception (a type of coverage determination). If your physician determines that you need the drug that is being removed from our formulary and none of the drugs the Plan covers is medically appropriate for you, you or your physician may request an exception.

Similarly, if your physician determines that you are not able to meet a prior authorization, quantity limit, or step therapy requirement for medical necessity reasons, you or your physician may request an exception. See Section 7 to learn more about how to request an exception.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first check the web site—<http://nreca.medicareplanrx.com>—which is updated periodically. In addition, you can contact Customer Care to be sure it is not covered.

If Customer Care confirms that the Plan does not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Care or go to our formulary on the web site.
- You or your doctor can ask us to make a formulary exception to cover your drug. See Section 7 to learn more about how to request an exception.
- You can pay out-of-pocket for the drug and request that the Plan reimburse you by requesting a formulary exception (a type of coverage determination). This does not obligate the Plan to reimburse you if the exception request is not approved. If you pay out-of-pocket for the drug and your exception is approved by the Plan, you will be reimbursed. If the exception is not approved, you may appeal the Plan's denial. See Section 7 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan and your drug is not on our formulary, you may be able to get a temporary supply of a drug you were taking when you joined our Plan.

Transition Policy

New participants in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization, quantity limitations or step therapy. Current participants also may be affected by changes in our formulary from one year to the next if they change from one NRECA Part D plan to another NRECA Part D plan.

For the first 90 days you are enrolled in a plan, you may be eligible to receive a transition supply of a drug not on our formulary if you:

- Switched from one plan to another after January 1, 2009
- Enrolled in a new plan, effective January 1, 2009, during open enrollment held November 15 to December 31, 2008
- Are newly-eligible for Medicare and were covered by another plan immediately before enrolling in a Part D plan
- Reside in a long-term care facility, such as a nursing home

Please note: if you stay in the same Part D plan from one year to the next, you are *not* eligible for transition coverage.

During **your first 90 days** in the Plan, you may receive a one-time 30-day transition supply of a non-formulary drug to give you time to talk to your doctor about alternative medications. If you are new to the Plan and in a long-term health care facility, you may receive one transition supply of up to 31 days, and the Plan may honor two refills until the end of the 90-day transition period.

This transition supply is only available for non-formulary drugs covered by Medicare that are purchased at a network pharmacy, including formulary drugs subject to prior authorization (PA), quantity limits (QL), or step therapy (ST).

The transition policy cannot be used to purchase a non-Part D drug that is excluded by Medicare, or to purchase a covered drug at an out-of-network pharmacy unless the individual qualifies for out-of-network access.

If you find out that your drug will no longer be on the formulary, you should talk with the physician who prescribed the non-formulary drug about:

- Changing from a non-formulary drug to an alternative drug that is included on the formulary
- Getting any prior authorizations that may be required for certain alternative medications
- Requesting a coverage determination or formulary exception for a non-covered drug

It is your responsibility to check the formulary before getting your prescription filled to make sure that:

- Your medications are covered by your Part D plan
- You are aware of any Prior Authorizations that may be required
- You are aware of any Quantity Limitations
- You are aware that Step Therapy is required for your drug

Updated formularies are available on the NRECA Medicare Part D web site:
<http://nreca.medicareplanrx.com>. Click on the Drug List tab at the top of the home page.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Part D prescription drug plans. These drugs or categories of drugs are called “exclusions” and include:

Non-prescription drugs (or over-the-counter drugs), unless they are part of an approved step therapy	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
Benzodiazepines	Barbiturates

If you get drugs that are excluded by Medicare, you must pay for them yourself. The Plan won’t pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Medicare Part A or B, unless they are found upon appeal to be drugs that the Plan should have paid or covered (appeals are discussed in Section 7).

The amount you pay when you fill a prescription for these excluded drugs does not count towards your true out-of-pocket cost. In addition, if you are receiving Extra Help from Medicare to pay for your prescriptions, Extra Help will not pay for these drugs. Please call Customer Care if you have any questions.

Other drugs that are not covered by the Plan include:

- most compounded drugs
- a drug covered under Medicare Part A or Part B, such as drugs you receive while in a hospital or medical facility. See “How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?” below.

A Medicare prescription drug plan can cover off-label uses of a prescription drug. This means that a drug can be covered for uses other than those indicated on a drug's label as approved by the Food and Drug Administration. However, the Plan covers the off-label use only in cases where the use is supported these reference-book citations:

- American Hospital Formulary Service Drug Information
- the DRUGDEX Information System
- United States Pharmacopoeia-Drug Information (or its successor).

If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by our Plan.

Drug Management Programs

Utilization management

For certain prescription drugs, the Plan has additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our participants use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our participants. Please consult your copy of our formulary or the formulary on our web site for more information about these requirements.

Examples of utilization management tools are described below:

- **Prior Authorization:** The Plan requires you to get prior authorization for certain drugs. This means that your prescribing physician will need to get approval from us before you can fill your prescription. If you don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, the Plan limits the amount of the drug that it will cover per prescription or for a defined period of time. For example, the Plan will provide up to twelve units per 25 days of MAXALT.
- **Step Therapy:** In some cases, the Plan requires you to try first one drug to treat your medical condition before you are covered for another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, the Plan may require your doctor to prescribe Drug A first. If Drug A does not work for you, then the Plan will cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network retail pharmacies and mail-order service will automatically give you the generic version. However, if your doctor has specified brand name only and a generic drug is available, your retail pharmacy or mail-order service will not be authorized to fill your prescription. You will need to request a formulary exception and have it approved in order to receive the brand-name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary, using the formulary tool on our web site or by calling Customer Care.

If your drug does have these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medically necessary reasons, you or your physician can ask us to make an exception to our coverage rules.

Drug utilization review

The Plan uses its records to conduct drug utilization reviews regularly, including each time you fill a prescription, to make sure all participants are receiving safe and appropriate care. These reviews are especially important for participants who get prescriptions from more than one doctor. During these reviews, the Plan looks for medication problems such as:

- possible medication errors
- duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- drugs that are inappropriate because of your age or gender
- possible harmful interactions between drugs you are taking
- drug allergies
- drug dosage errors

If the Plan identifies a medication problem during a drug utilization review, the Plan will work with your doctor to correct the problem.

Medication therapy management programs

The Plan offers medication therapy management programs at no additional cost for participants who:

- have multiple medical conditions
- are taking many prescription drugs
- have high drug costs

Developed by a team of pharmacists and doctors, these medication therapy management programs are used to help the Plan provide better coverage for our participants. For example, these programs help the Plan make sure that our participants are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

The Plan offers several medication therapy management programs for participants that meet specific criteria. We may contact participants who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan.

In addition, if your drug would be covered by Medicare Part A or Part B, it cannot be covered by the Plan even if you choose not to participate in Part A or Part B.

Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases but never both at the same time. These drugs are marked “B/D” in your formulary and require prior authorization.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B. The *Medicare & You* handbook can be found at www.medicare.gov or you can request a copy by calling 800.MEDICARE (800.633.4227). TYY users should call 877.486.2048.

How much do you pay for drugs covered by the Enhanced Plus Plan?

When you fill a prescription for a covered drug, you may pay part of the cost for your drug. The amount you pay for your drug depends on:

- the coverage level (initial coverage level and catastrophic level)
- the type of drug
- whether you are filling your prescription at a network or out-of-network pharmacy

Your drug costs for each coverage level are described below. Refer to the plan formulary for your plan to see what drugs are covered. More information on the formulary is included in Appendix A.

If you qualify for Extra Help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the *Addendum to the Medicare Part D Summary Plan Description/Evidence of Coverage*. If you do not already qualify for Extra Help, see “Do you qualify for Extra Help?” in Section 1 for more information.

Initial Coverage Level

During the **initial coverage level**, the Plan will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the **coinsurance**. Your coinsurance may vary depending on the drug and where the prescription is filled.

	Retail Coinsurance (up to 90 day Supply)	Mail-Order Coinsurance (up to 90-day supply)
You pay:	15%	15%

Once your total costs for covered drugs reach \$29,000, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by you and the Plan. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

When your true out-of-pocket costs for covered drugs total \$4,350—from your coinsurance during the initial coverage level—you qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Part D prescription drug plans include catastrophic coverage for people with high drug costs. When the total amount you have paid toward your coinsurance reaches \$4,350, you will qualify for catastrophic coverage.

During catastrophic coverage you will pay nothing. The Plan pays the full cost.

Vaccines (including administration)

Your Plan covers vaccines, including the administration of that vaccine. The amount you pay will depend on how the vaccine is dispensed and who provides the treatment. Also, please note that in some situations, the vaccine and its administration will be billed separately.

If it is necessary for you to receive the vaccine from someone who is not part of the pharmacy network – such as your doctor – you will have to pay for the administration and cost of the vaccine and you may have to pay the entire cost in advance.

The chart below and on the next page describes some of these scenarios.

Vaccines (including administration)

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay the Part D coinsurance.
Your Doctor	Your Doctor	<p>You may pay the entire cost of the vaccine and its administration in advance.</p> <p>You are reimbursed this amount less the Part D coinsurance. You will also pay any difference between the amount the Doctor charges and what the Plan normally pays.</p> <p>Or, if your doctor agrees to submit your claim on your behalf, you pay the Part D coinsurance, plus any difference between the amount the Doctor charges and what the Plan normally pays.</p>

The Pharmacy	Your Doctor	<p>You pay the Part D coinsurance at the pharmacy and may pay the full amount charged by the doctor in advance for administering the vaccine.</p> <p>You are reimbursed for the doctor's charge less the Part D coinsurance, plus any difference between what the doctor charges for administering the vaccine and what the Plan normally pays.</p>
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If you receive Extra Help, the Plan will reimburse you for any difference between what your doctor charges for administering the vaccine and what the Plan normally pays.

Please call Customer Care before you go to your doctor if you have any questions or want more information about the costs associated with vaccines and their administration.

How is your true out-of-pocket cost calculated?

What prescription drug payments count toward your true out-of-pocket cost (TrOOP)?

Your coinsurance paid for covered drugs during the initial coverage level can count toward your true out-of-pocket cost and help you qualify for catastrophic coverage.

When you have spent a total of \$4,350 in these true out-of-pocket costs, you will reach the catastrophic coverage level.

To be considered a covered drug cost, the drug must:

- be a covered Part D drug or transition drug, and
- be on the formulary or you get a favorable decision on a coverage determination, exception request or appeal, and
- be filled at a network pharmacy or you have an approved claim from an out-of-network pharmacy, and
- otherwise meet the Plan's coverage requirements

What type of prescription drug payments will not count toward your true out-of-pocket cost?

The amount you pay for your monthly premium **does not** count towards your true out-of-pocket cost.

Any amount you pay for prescription drugs will **not** count toward your true out-of-pocket cost when the drugs are:

- purchased outside the United States and its territories
- not covered by the Plan
- not covered by Part D, including drugs excluded by Medicare
- purchased at an out-of-network pharmacy and not according to the Plan's out-of-network access policy
- paid by another health plan or insurance
- prescription drugs covered by Medicare Part A or Part B

Who can pay for your prescription drugs, and how do these payments apply to your true out-of-pocket costs?

When the following individuals or organizations pay your prescription drug costs, the payments will count toward your true out-of-pocket cost:

- family members or other individuals
- qualified State Pharmacy Assistance Programs (SPAPs). SPAPs have different names in different states. If you are unable to locate the SPAP in your state, contact Customer Care or call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.
- Medicare programs that provide Extra Help with prescription drug coverage
- most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually do not count toward your out-of-pocket costs.

Payments made by the following do not count toward your true out-of-pocket costs:

- group health plans
- insurance plans and government funded health programs (e.g. TRICARE, the Veterans Administration, the Indian Health Service, AIDS Drug Assistance Programs)
- third party arrangements with a legal obligation to pay for prescription costs (e.g., workers compensation).

If you have coverage from a third party that pays a part of or all of your true out-of-pocket cost, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

The Plan will be responsible for keeping track of your true out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage.

Every month in which you purchase covered prescription drugs through the NRECA Plan, you will get an Explanation of Benefits that shows your true out-of-pocket cost to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will receive every month you have had a prescription filled. It will tell you the total amount you have spent on your prescription drugs and the total amount the Plan has paid for your drugs for that month in detail and a summary for the year to date. If you do not receive an Explanation of Benefits, or wish to request a new copy, please contact Customer Care.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, if any, as well as the amount paid for each prescription
- Information about how to request a formulary exception and appeal our coverage decisions
- A description of changes to the formulary that will occur at least 60 days in the future
- A summary of your coverage this year, including information about:
 - **Annual Deductible** - The amount you and/or others pay before you start receiving prescription coverage. There is no deductible under the Enhanced Plan.
 - **Amount Paid For Prescriptions** - The amounts paid that count towards your initial coverage limit.
 - **Out-Of-Pocket Payments After You Reach the Initial Coverage Limit** - The amount you and/or others make during the coverage gap after you reach the initial coverage limit and before you qualify for Catastrophic Coverage. This will not apply if you are covered under this Plan.
 - **Total True Out-Of-Pocket Costs That Count Towards Catastrophic Coverage** - The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your coinsurance made on covered Part D drugs.

The True Out-of-Pocket Costs shown on your Explanation of Benefits does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.

When will you get your Explanation of Benefits?

You will get your Explanation of Benefits in the mail every month you have a prescription filled.

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Care.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital.

Once you are released from the hospital, the Plan should cover your prescription drugs as long as all coverage requirements are met, such as

- The drugs are part of the formulary
- They are purchased at one of our network pharmacies
- They aren't covered by Medicare Part A or Part B.

The Plan will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, the Plan will cover your prescriptions after Medicare Part A stops paying for your prescription drug costs, as long as

- The skilled nursing facility's pharmacy is in our pharmacy network, unless you meet the standards for out-of-network care, and
- The drug is not covered by Medicare Part B coverage.

When you enter, live in or leave a skilled nursing facility you are entitled to a special enrollment period. During a Special Enrollment Period, you will be able to enroll in or leave this Plan and join or leave a different Medicare Part D prescription drug plan. Please see Section 8 of this document for more information about leaving this Plan and joining a new Medicare Part D prescription drug plan.

Section 6—If You Have Other Prescription Drug Coverage

The Plan will send you a survey every year, asking you to update your personal information as well as let us know what other drug coverage you have in addition to the coverage you get through this plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back to us. If you have additional drug coverage, you must provide that information to our Plan.

The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Care to update your membership records.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a participant of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums or coinsurance. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare supplement (Medigap) policy that includes prescription drug coverage, you will need to tell your Medigap issuer you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium.

Each year before November 15, your Medigap insurance company must send you a letter that

- explains your options
- tells you whether the prescription drug coverage you have is creditable, meaning that the plan expects to pay at least as much as Medicare's standard prescription drug coverage, and
- explains how removing drug coverage from your Medigap policy will affect your premiums.

If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a participant in another employer or retiree group health plan

If you currently have prescription drug coverage through another employer (yours or your spouse's) or retiree group plan (not NRECA), please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from the NRECA Part D plan will be secondary to your employer or retiree group coverage.

Each year before November 15, your employer or other retiree group health plan should provide you with a disclosure notice that

- lets you know whether your prescription drug coverage is creditable, meaning it expects to pay at least as much as Medicare's standard prescription drug coverage, and
- explains the options available to you.

You should keep the disclosure notices that you get each year in your personal records. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

SECTION 7—Appeals and Grievances

What to do if you have complaints

Please let Customer Care know right away if you have questions, concerns, or problems related to your prescription drug coverage.

This section gives you the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan participant. The Medicare program has set some rules about what you need to do to make a complaint and what the Plan needs to do when someone makes a complaint. You cannot be disenrolled or penalized in any way if you make a complaint.

The Plan will handle a complaint as a grievance, coverage determination or an appeal, depending on the subject of the complaint.

What is a grievance?

A grievance is any complaint that expresses dissatisfaction with the Plan.

For example, you would file a grievance if you had a problem such as waiting times when you fill a prescription, or the way your network pharmacist or others behave. Other examples include being unable to reach someone by phone, difficulty getting the information you need, or the cleanliness of a network pharmacy.

Appeals, coverage determinations and redeterminations are not grievances. A grievance is different from a request for a coverage determination because it usually **does not involve coverage or payment for Part D prescription drug benefits**. Concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process.

What types of problems might lead to you filing a grievance?

- You feel that you are being encouraged to leave (disenroll from) our Plan
- Problems with the customer service you receive
- Problems with how long you have to spend waiting on the phone or in the pharmacy
- Disrespectful or rude behavior by pharmacists or other staff
- Cleanliness or condition of pharmacy
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination (a “fast appeal”)
- You believe our notices and other written materials are difficult to understand
- Failure to give you a decision within the required timeframe
- Failure to forward your case to the independent review entity if the Plan does not give you a decision within the required timeframe
- Failure by the Plan sponsor to provide required notices
- Failure to provide required notices that comply with CMS standards

How to file a grievance

In certain cases, you have the right to ask for a “fast grievance,” meaning your grievance will be decided within 24 hours. These fast-track grievances are discussed in more detail below.

If you have a grievance, you or your representative should call Customer Care first. The Plan will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, the Plan will respond in writing to you. If your complaint is related to quality of care, the Plan will respond in writing to you.

If your complaint cannot be resolved over the phone, there is a formal procedure to review your complaints. This is called the NRECA Grievance Process.

How soon must you file your grievance?

You need to file your grievance **within 60 calendar days from the date the incident occurred.** The Plan will not accept any grievances filed more than 60 days from the date the incident occurred.

How do I submit a grievance?

You may submit a grievance over the phone, by fax, or by letter.

1. To submit a grievance over the phone, call a grievance team member at 866.884.9478.
2. You may submit a grievance via fax at 866.788.5143.
3. Submit a grievance in writing to:

NRECA Medicare Part D Drug Plan
c/o Grievance Department
P.O. Box 280500
Nashville, TN 37228

What information do I need to provide when I submit my grievance?

1. Your name
2. Your ID number
3. The nature of the grievance
4. The date the grievance occurred
5. Your phone number
6. Your address if you are submitting the grievance in writing

The Plan needs your phone number (and address if in writing) to notify you of our decision.

When can you request a fast grievance?

You can request a fast grievance only if you disagree with our decision not to expedite your request for a fast (expedited) decision of an appeal, coverage determination, or coverage redetermination.

How soon must the Plan decide on your grievance?

The Plan must notify you of our decision within 24 hours of receiving your complaint if:

- You filed a grievance about our denial of your request for a fast (expedited) decision on a coverage determination or redetermination, and
- You have not yet purchased or received the drug in dispute.

For all other grievances, the Plan must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint.

The Plan may extend this timeframe up to 14 days if you request an extension, or if the Plan justifies a need for additional information and the delay is in your best interest.

How will you notify me of your decision?

For **phone complaints**, you will be notified by phone, unless your grievance is about a quality-of-care issue or you requested a written response, in which case we will inform you by letter.

For **written grievances** or grievances about quality-of-care issues, we will tell you of our decision by letter.

What if I disagree with your decision on my grievance?

Per CMS regulations, all grievance decisions are final and not eligible for review or appeal.

For quality-of-care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare Part D prescription drug plan under the grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

How to file a quality-of-care complaint with the QIO

Quality-of-care complaints filed with the QIO must be made in writing. You are not required to file the grievance within a specific time period. See the Introduction for more information about how to file a quality-of-care complaint with the QIO.

What is a Coverage Determination?

If you have problems getting the Part D drugs you request, or payment (including the amount you paid) for a Part D drug you already received, you have the right to ask the Plan to cover or pay for that drug. Whenever you ask for a Part D prescription drug benefit, the first step is called “requesting a coverage determination” or “initial determination”.

If your doctor or pharmacist tells you that a certain prescription drug is not covered, you or your physician must contact us if you want to request a coverage determination. When the Plan makes a coverage determination, it is making a **decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug.**

Coverage determinations include **exception requests.** You have the right to ask us for an “exception” if

- You believe you need a drug that is not on our list of covered drugs (formulary)
- You want the Plan to waive any restrictions or limits on your Part D drug, such as a prior authorization, quality limits or step therapy.

Generally, the Plan only approves your request for an exception if the alternative Part D drugs included on the Plan formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

If you request an exception, your doctor must provide a statement to support the medical necessity of your request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

How to request a coverage determination

You may request a coverage determination **if you have problems getting the prescription drugs you believe the Plan should provide** and you want to request a coverage determination.

We use the word “provide” in a general way to include such things as:

- authorizing prescription drugs
- paying for prescription drugs
- continuing to provide a Part D prescription drug that you have been getting

If your doctor or pharmacist tells you that the Plan will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- You are not getting a prescription drug that you believe may be covered by us.
- You have received a Part D prescription drug you believe may be covered by us while you were a participant, but the Plan has refused to pay for the drug.
- The Plan will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a “formulary”). You may request a formulary exception.
- You are not provided a drug because you and your prescribing doctor failed to obtain prior authorization. You may request a formulary exception.
- You are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- There is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- There is a requirement that you try another drug before the Plan will pay for the drug you are requesting.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

Who may ask for a coverage determination?

You can request a coverage determination yourself, or your prescribing doctor or someone you name may do it for you.

The person you name would be your **appointed representative**. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative.

This statement must be sent to us at:

NRECA's Part D Plan
c/o SilverScript, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

You can call Customer Care to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "Standard" or "Fast" Coverage Determination

A decision about whether the Plan will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You may ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or ability to function.

Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking the Plan to reimburse you for a benefit that you have already received.)

If you have not yet received your prescription drug, be sure to ask for a "fast," or "expedited" review. If your doctor requests or supports your request for a fast decision, and shows that waiting for a standard decision could seriously harm your health or your ability to function, the Plan will automatically give you a fast decision.

If you ask for a fast coverage determination without support from a doctor, the Plan will decide if your health requires a fast decision. If the Plan decides that your medical condition does not meet fast coverage requirements, you will be sent a letter telling you that the Plan will supply a fast decision if you get a doctor's support. The letter will also tell you how to file a grievance if you disagree with our decision. If the Plan denies your request for a fast review, it will give you its decision within the 72-hour standard time frame.

To ask for a standard or fast decision, you, your doctor, or your appointed representative should:

- call Customer Care Monday through Saturday from 6:30 a.m. to 11:00 p.m. Central Time, or
- send a written request by fax to 866.884.9475 or
- mail a written request to:

NRECA's Part D Plan
c/o SilverScript, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

What happens when you request a coverage determination?

What happens, including how soon the Plan will decide, depends on the type of decision you request.

For a **standard** coverage determination, the Plan has to give you a decision within 72 hours of receiving your request, or sooner if your health condition requires.

If the Plan does not give you an answer within 72 hours of receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If your request is for an exception—including a formulary exception, or an exception from utilization management rules, such as dosage, quantity limits, or step therapy requirement—the Plan has to decide **within 24 hours of receiving a supporting statement from your doctor**. Your doctor must explain why the non-formulary or non-preferred drug you are requesting is medically necessary.

If you qualify for a **fast** coverage determination about a Part D drug you have not received, the Plan will give you a decision **within 24 hours** — sooner if your health requires.

If the Plan decides you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens if the Plan decides completely in your favor?

If the Plan makes a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, including a request about payment for a Part D drug that you already received*

The Plan must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after it received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after it gets your doctor's supporting statement.

If you are requesting reimbursement for a drug that you already paid for and received, the Plan must send payment to you no later than 30 calendar days after it gets the request.

2. For a fast decision about a Part D drug that you have not received

The Plan must authorize or provide you with the benefit you have requested no later than 24 hours after receiving your request. If your request involves a request for an exception, the Plan must authorize or provide the benefit no later than 24 hours after it gets your doctor's supporting statement.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

You may call us at the phone numbers shown in Section 7 to ask for any of these requests

What happens if the Plan denies your request?

If your request is denied, the Plan will send you a written decision explaining the reason why your request was denied. The Plan may decide *completely* or only *partly* against you.

For example, if the Plan denies your request for payment for a Part D drug that you have already received, it may say that it will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if the Plan has not issued a coverage determination.

If the Plan issues an unfavorable coverage determination, you may file an appeal called a **redetermination** if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights.

How to request an appeal

If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

- You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit.
- You may appeal our decision not to reimburse you for a Part D drug that you paid for.
- You can appeal if you think you should have been reimbursed more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription.
- You can appeal if the Plan denies your exception request.
- You can appeal a covered determination if you disagree with our decision.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

Type of Appeal	Who reviews the appeal	Standard Process	Fast Process
Coverage Determination	Plan	Decision within 72 hours	Decision within 24 hours
Appeal Level 1	Plan	- Participant has 180 days to request appeal - Decision within 7 days	- Participant has 180 days to request appeal - Decision within 72 hours
Appeal Level 2	Independent review organization	- Participant has 60 days to request appeal - Decision within 7 days	- Participant has 60 days to request appeal - Decision within 72 hours
Appeal Level 3	Administrative Law Judge	- Participant has 60 days to request appeal - Minimum dollar amount for appeal to be reviewed - Decision made as soon as possible	
Appeal Level 4	Medicare Appeals Council	- Participant has 60 days to request appeal - Minimum dollar amount for appeal to be reviewed - Decision made as soon as possible	
Appeal Level 5	Federal District Court	- Participant has 60 days to request appeal - Minimum dollar amount for appeal to be reviewed - Decision made as soon as possible	

Who makes the decision at each level. You make your request for coverage or payment of a Part D prescription drug directly to us. The Plan reviews this request and makes a coverage determination. If our coverage determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our coverage determination.

If you are still dissatisfied with the outcome, you can ask for further review.

If you ask for further review, your appeal is sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Appeal Level 1: If the Plan denies all or part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an “appeal” or “request for redetermination.”

Please call Customer Care if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested.

When your request to reconsider the coverage determination is received, the Plan gives the request to people at our organization who were not involved in making the coverage determination. This helps ensure that your request will be given a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received).

If your appeal concerns a decision the Plan made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative or your prescribing doctor.

How soon must you file your appeal?

You need to file your appeal **within 180 calendar days** from the date included on the notice of our coverage determination. The Plan can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at:

NRECA’s Part D Plan
c/o SilverScript, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling Customer Care Monday through Saturday from 6:30 a.m. to 11:00 p.m. Central Time. Or, you can send a written request by fax to 866.884.9475 or mail it to the address above.

Be sure to ask for a “fast,” expedited,” or “72-hour” review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the Plan will automatically treat you as eligible for a fast appeal.

Getting the information to support your appeal

The Plan must gather all the information it needs to make a decision about your appeal. If the Plan needs your assistance in gathering this information, you will be contacted.

You have the right to get copies of all documents, records, and other information related to your denied claim free of charge. You also have the right to include additional information (written comments, records, documents and other information) to support your claim. For example, you may already have documents related to your request, or you may want to get your doctor’s records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

In writing: NRECA’s Part D Plan
c/o SilverScript, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

By fax: 866.884.9475

If it is a fast appeal, by telephone: 866.586.7322

In person: NRECA’s Part D Plan
c/o SilverScript, LLC
Appeals Department, MC109
9501 E. Shea Blvd.
Scottsdale, AZ 85260-6719

You also have the right to ask us for a copy of information regarding your appeal, using the contact information above.

How soon must the Plan decide on your appeal?

For a **standard decision** about a Part D drug, including reimbursement for a drug you have already paid for and received, the Plan has **up to 7 days after receiving your appeal** to give you a decision. The Plan will make it sooner if your health condition requires us to.

If the Plan does not give you a decision within 7 days, your request will automatically go to the second level of appeal, where an independent organization will review your case.

For a **fast decision** about a Part D drug that you have not received, the Plan has **up to 72 hours after it receives your appeal** to give you a decision. The Plan will make it sooner if your health requires us to. If you do not receive a decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens if the Plan decides completely in your favor?

1. For a decision about reimbursement for a Part D drug you already paid for and received

The Plan must send payment to you no later than 30 calendar days after it gets your request to reconsider the coverage determination.

2. For a standard decision about a Part D drug you have not received

The Plan must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after it gets your appeal.

3. For a fast decision about a Part D drug you have not received

The Plan must authorize or provide you with the Part D drug you have asked for as quickly as your health requires but no later than 72 hours after it received your appeal.

What happens next if the Plan denies your appeal?

If any part of your appeal is denied, the Plan will give you a notice that contains:

- Specific reasons why your appeal is denied
- Reference to the specific plan provisions on which the denied appeal is based
- Description of any additional information needed and why this information is needed
- Explanation of your rights under ERISA's claim and appeal rules

You or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the federal government and is not part of our Plan.

Appeal Level 2: If the Plan denies any part of your first appeal, you may ask for a review by a government-contracted independent review organization or you have the right to file a civil action under ERISA at any time within 12 months from the date of denial of your first appeal.

What is the independent review organization?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program.

The independent review organization has no connection to the Plan. You have the right to ask us for a copy of your case file that the Plan sent to this organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization **in writing within 60 calendar days** after the date you were notified of the decision on your first appeal. You must send your written request to the Independent Review Organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing doctor cannot file the request for you—**only you or your appointed representative may file the request.**

If you want to ask for a fast appeal, please follow the instructions under “Asking for a fast decision.” Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, the independent review organization will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. *For a standard request about a Part D drug, including a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to **7 calendar days** from the date it gets your request to give you a decision.*
2. *For a fast decision about a Part D drug that you have not received, the independent review organization has up to **72 hours** from the time it gets the request to give you a decision.*

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about reimbursement for a Part D drug you already paid for and received*

The Plan must pay within 30 calendar days from the date it gets notice reversing our coverage determination. The Plan will also send the independent review organization a notice that it has abided by their decision.

2. *For a standard decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 72 hours from the date it gets notice reversing the coverage determination. The Plan will also send the independent review organization a notice that it has abided by their decision.

3. *For a fast decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 24 hours from the date it gets notice reversing the coverage determination. The Plan will also send the independent review organization a notice that it has abided by their decision.

What happens if the review organization decides against you?

The independent review organization will notify you in writing of its decision and the reasons. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit meets the minimum requirement provided in the independent review organization's decision. **You have the right to file a civil action under ERISA at any time within 12 months from the date of denial of your second appeal.**

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You will need to request such a review **in writing within 60 days** after the date of the decision made at Appeal Level 2.

You may request that the Administrative Law Judge extend this deadline for good cause by sending a written request to the appropriate office:

CT, DE, DC, IL, IN, MA, MD, ME, MI, MN, NH, NJ, NY, OH, PA, PR, RI, VA, VT, WI, WV

The Office of Medicare Hearings and Appeals
Midwest Field Office
BP Tower, Suite 1300
200 Public Square,
Cleveland, OH 44114-2316

AL, AR, FL, GA, KY, LA, MS, NC, NM, OK, SC, TN, TX

The Office of Medicare Hearings and Appeals
Southern Field Office
100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100

AK, AZ, CA, CO, HI, IA, ID, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY

The Office of Medicare Hearings and Appeals
Western Field Office
27 Technology Drive, Suite 100
Irvine, CA 92618-2364

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel.

The Administrative Law Judge will not review your appeal if the dollar value of the contested Part D benefit does not meet the minimum requirement provided in the independent review organization's decision.

If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If the Plan has refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits.

The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the Plan year. Projected value includes your coinsurance and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you.
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2.
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2.
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received*

The Plan must send payment to you no later than 30 calendar days from the date it gets notice reversing the coverage determination.

2. *For a standard decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 72 hours from the date it gets notice reversing the coverage determination.

3. *For a fast decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 24 hours from the date it gets notice reversing the coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council **within 60 calendar days** after you were notified of the decision made by the Administrative Law Judge (Appeal Level 3).

The Medicare Appeals Council does not review every case. The Medicare Appeals Council will first decide whether to review your case. There is a minimum dollar value for the Medicare Appeals Council to hear your case.

If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received*

The Plan must send payment to you no later than 30 calendar days from the date it gets notice reversing the coverage determination.

2. *For a standard decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 72 hours from the date it gets notice reversing the coverage determination.

3. *For a fast decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 24 hours from the date it gets notice reversing the coverage determination.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review.

If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court **within 60 calendar days** after you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review, including who can file the appeal.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. The federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once the Plan gets notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received*

The Plan must send payment to you within 30 calendar days from the date it gets notice reversing the coverage determination.

2. *For a standard decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 72 hours from the date it gets notice reversing the coverage determination.

3. *For a fast decision about a Part D drug you have not received*

The Plan must authorize or provide you with the Part D drug you have asked for within 24 hours from the date it gets notice reversing the coverage determination.

If the Judge decides against you

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Section 8—Leaving this Plan and Your Choices for Continuing Prescription Drug Coverage after You Leave

What is “disenrollment”?

“Disenrollment” from our Plan means ending your membership with us. Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice):

- You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (See “When Can You Disenroll/Switch Prescription Drug Plans?” below).
- You cannot be asked to leave our Plan because of your health. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 800.MEDICARE (800.633.4227), which is the national Medicare help line. TTY users should call 877.486.2048. You may call 24 hours a day, 7 days a week.
- There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you did not pay your premiums or if you are not enrolled in Medicare Part A or Part B.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescription

You can choose to disenroll from your current plan during the open enrollment period held from November 15 through December 31 of every year. Any changes made during this time period will be effective on January 1st.

In certain cases, you can disenroll from your plan at other times of the year, such as, if

- You have Medicaid.
- You qualify for Extra Help.
- You move into or out of a nursing home.

After you request to disenroll, your plan will let you know, in writing, the date your coverage ends. If you don’t get a letter, call the Plan and ask for the date.

While you are waiting for your membership to end, you are still a participant and must continue to get your prescription drugs as usual through our Plan’s network pharmacies. In most cases, your prescriptions are covered only if

- They are filled at a network pharmacy or through our mail order pharmacy service.
- They are listed on our formulary.
- You follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please call Customer Care.

What are your options for prescription drug coverage if you leave our Plan?

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Part D prescription drug plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage *if*

- this type of plan is available in your area, and
- they are accepting new participants, and
- you meet the eligibility requirements of the Plan.

Medicare Part D prescription drug plan

You may choose to join another Medicare prescription drug plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Medicare prescription drug plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B and reside in the service area of the Medicare prescription drug plan.

Refer to the next section, “When can you disenroll or switch Medicare Part D prescription drug plans?” for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage

If you choose to join a **Medicare Advantage Plan**, check to make sure that it offers prescription drug coverage. You can not enroll in both a Medicare Part D prescription drug plan and a Medicare Advantage Plan. If your Medicare Advantage Plan does not offer prescription drug coverage, you will not be covered for prescription drugs. The only exception is a Private Fee For Service (PFFS) Plan.

If you choose to join a **Medicare Cost Plan**, check to make sure that it offers prescription drug coverage. You can not enroll in both a Medicare Part D prescription drug plan and a Medicare Cost Plan. If your Medicare Cost Plan does not offer prescription drug coverage, you will not be covered for prescription drugs.

For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 800.MEDICARE (TTY/TDD users call 877.486.2048) or visit www.medicare.gov. Refer to the next section, “When can you disenroll or switch Medicare Part D prescription drug plans?” for information on when you can make this change. You should contact the new plan in which you are interested for information on how and when you are able to join it.

Note: If you disenroll from our Plan and do not enroll in another Medicare prescription drug plan, or do not have other creditable prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a late enrollment penalty if you enroll in a Medicare prescription drug plan at a later date. Refer to Section 4 for more information on the late enrollment penalty.

When can you disenroll or switch Medicare Part D prescription drug plans?

In general, you may only disenroll or switch Medicare prescription drug plans every year during the annual open enrollment period, from November 15 through December 31 of each year, or under certain special circumstances.

The annual open enrollment period is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1.

Certain individuals can make changes at other times of the year, such as those with Medicaid, those who get Extra Help, or those who move into or out of a nursing home. For more information on when you can change your Part D plan, see the enrollment period table at the end of this section.

If you want to drop your coverage in our Plan during the annual open enrollment period, this is what you need to do:

- **If you are planning on joining another Medicare prescription drug plan:** Simply join the new Medicare prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on enrolling in a Medicare Advantage plan:** Request enrollment in the new plan. In most cases, you will be disenrolled automatically when your new plan's coverage begins on January 1.

EXCEPTION -- If you are planning on enrolling in a Medicare Advantage “Private Fee-for-Service” plan and that plan does not offer drug coverage, or a Medicare Medical Savings Account (MSA) Plan, your enrollment in that plan will not automatically disenroll you from our plan. Therefore, you will need to do the following:

- To join a new Medicare prescription drug plan, simply join the new Medicare prescription drug plan, or
 - If you do not want Medicare prescription drug coverage, request disenrollment from our plan by contacting us or calling 800.MEDICARE (800.633.4227) to request disenrollment from our plan. TTY users should call 877.486.2048.
- **If you would like to drop your coverage in our plan without joining any other Medicare health or prescription drug plan:** Contact us or call 800.MEDICARE (800.633.4227) to request disenrollment from our plan. TTY users should call 877.486.2048. Your enrollment in Original Medicare will be effective January 1.

Important Note: If you disenroll from our Plan and go without creditable prescription drug coverage (coverage that is at least as good as Medicare's standard drug coverage), you may have to pay a late enrollment penalty if you enroll in a Medicare prescription drug plan later.

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter from your Medigap issuer in the fall of 2005 and another one each fall prior to the annual open enrollment period explaining your options and explaining whether your coverage under the policy is creditable or not. If you did not get these letters or cannot find them, contact the issuer of your Medigap policy.

Annual Open Enrollment Period

During the **annual open enrollment period**—also called the **Annual Coordinated Election Period**—anyone with prescription drug coverage may disenroll from any Medicare prescription drug plan and

- enroll in another Medicare prescription drug plan
- join a Medicare Advantage Plan with prescription drug coverage
- choose not to have any Medicare prescription drug coverage.

For coverage beginning January 1, 2009, the annual coordinated enrollment period began on November 15, 2008, and ends on December 31, 2008.

Please remember that if you disenroll from our Plan and do not enroll in another Medicare prescription drug plan or Medicare Advantage Plan with prescription drug coverage during this election period, you may have to pay a higher premium for Medicare prescription drug coverage in the future.

If you join another Medicare prescription drug plan during the annual open enrollment period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective January 1 of the following year.

Special Enrollment Period

Generally, you may not disenroll from our Plan and enroll in a new Medicare prescription drug plan during other times of the year *unless* you qualify for a Special Enrollment Period.

In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- You have an involuntary loss of creditable prescription drug coverage. Please note that failure to pay your premium does not qualify as an involuntary loss of prescription drug coverage.
- You were not adequately informed about your loss of creditable prescription drug coverage.
- You were not adequately informed that you never had creditable prescription drug coverage.
- Your enrollment in our Plan was unintentional, inadvertent or a mistake, because of the error, misrepresentation or inaction of a federal employee.
- You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.
- Our Plan's contract with the Centers for Medicare & Medicaid Services (Medicare) is terminated.
- You were a participant of a Medicare Advantage Plan with prescription drug coverage and decided to join a Medicare prescription drug plan during the Medicare Advantage Plan's open election period.
- You are able to demonstrate that our Plan has substantially violated a material provision in its contract. This includes, but is not limited to: 1) Our Plan failed to provide you with prescription drug coverage in a timely manner, 2) Our Plan failed to provide your prescription drug coverage with applicable quality standards.
- You are able to demonstrate that our Plan misrepresented itself in its marketing.
- You are enrolling in or disenrolling from a Medicare Part D prescription drug plan sponsored by your current or former employer or by your spouse's current or former employer.

- In certain cases in which our Plan is sanctioned by the Centers for Medicare & Medicaid Services.
- You enroll in or disenroll from your state's Program of All-Inclusive Care for the Elderly, if applicable.
- You move into or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital or certain other hospitals.
- You get Extra Help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.
- Other limited circumstances may provide a special enrollment period opportunity. Please call Customer Care if you have questions.

In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please call Customer Care and we will assist you.

How do you disenroll?

If you wish to leave our Plan, and you are not enrolling in another Medicare prescription drug plan, you will need to submit a disenrollment request.

Your request should include:

- your name
- Medicare number
- Social Security number
- date of birth
- requested disenrollment date

Please note that the Plan may not be able to disenroll you on the date you request. Please remember to sign and date the request and to include a phone number where we can reach you in case the Plan needs additional information.

If you were enrolled by SilverScript, you can mail a letter to us at:

NRECA Medicare D Enrollment
P.O. Box 52067
Phoenix, AZ 85072

If you were enrolled through your co-op, you should contact your benefits administrator for more information about obtaining and submitting disenrollment forms. Or, to get a copy of our disenrollment form, please call Customer Care or go to <http://nreca.medicareplanrx.com>.

You may also disenroll by calling 800.MEDICARE (800.633.4227), TTY/TDD users should call 877.486.2048. You may only disenroll during the annual open enrollment period (November 15 through December 31) unless you qualify for a Special Enrollment Period.

If you are joining another Medicare prescription drug plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your “disenrollment date”).

Remember, you are still a participant of our Plan until your disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.

When can the Plan disenroll you?

Our Plan can disenroll you for the following reasons:

- You are no longer eligible for Medicare Part D prescription drug coverage.
- If our Plan is no longer contracting with Medicare.
- You materially misrepresent third-party reimbursement.
- You fail to pay your Plan premium.
- You engage in disruptive behavior, provided fraudulent information when you enrolled, or abuse your enrollment card.

If you are no longer eligible for Medicare Part D prescription drug coverage

If you lose your eligibility for Medicare Part D prescription drug coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in the Plan’s service area.

When the Plan is no longer contracting with Medicare

If the Plan leaves the Medicare program you will be notified in writing. If this happens, your membership in our Plan will end and you will have to enroll in another Medicare Part D prescription drug plan to continue your prescription drug coverage. All of the benefits and rules described in this SPD and Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan’s network pharmacies until your membership ends.

Your choices include joining another Medicare Part D prescription drug plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new participants. Once the Plan has notified you in writing that it is leaving the Medicare program, you may enroll in another plan. See “When Can You Disenroll/Switch Prescription Drug Plans?” above for specific information on special enrollment periods.

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

You materially misrepresent third-party reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to disenroll you. In addition, if you are disenrolled from our Plan for misrepresentation of third-party reimbursement, our Plan has the right to decline your future enrollment in our Medicare Part D prescription drug plan.

You do not pay the Plan premium

If you fail to pay your Plan premium, our Plan has the right to disenroll you. Our Plan will send you a written notice in an effort to collect the unpaid premium(s). Failure to comply with payment will result in disenrollment from Plan.

In addition, if you are disenrolled from the Plan for failure to pay your premium, the Plan has the right to decline your future enrollment in our Medicare Part D prescription drug plan until your debt has been paid.

If you are disenrolled due to not paying your premium and you do not have drug coverage that, on average, is at least as good as the standard Medicare prescription drug coverage for 63 consecutive days or longer, then you will pay a late enrollment penalty the next time you enroll in a Medicare prescription drug plan.

You engage in disruptive behavior, provide fraudulent information when you enrolled, or abuse your enrollment card

You may be asked to leave our Plan in the following circumstances:

- If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are participants of our Plan. You cannot be asked to leave (i.e., be disenrolled from) our Plan for this reason unless the Plan gets permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before you are asked to leave (i.e., disenroll from) our Plan for this reason, the Plan must refer your case to the Inspector General, and this may result in criminal prosecution.

You cannot be asked to leave our Plan because of your health

No participant of any Medicare prescription drug plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a participant takes. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 800.MEDICARE (800.633.4227; TTY/TDD 877.486.2048), the national Medicare help line.

You have the right to make a complaint if you are asked to leave our Plan

If you are asked to leave our Plan, you will be told the reasons in writing and explain how you can file a complaint against the Plan if you want. Refer to Section 7 for more information.

COBRA Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), when you experience a “qualifying event” that causes you to lose eligibility for prescription drug coverage under the Plans, you have the option of continuing that coverage at your own expense (known as COBRA coverage).

COBRA coverage is also available to your qualified beneficiaries who lose coverage due to a qualifying event.

Please note: COBRA coverage is available only for the NRECA Medicare Part D prescription drug plan coverage you had at the time of the qualifying event.

- **Qualified beneficiaries**—Qualified beneficiaries are individuals who are plan participants on the day before a qualifying event occurs. Generally, this applies to:
 - you,
 - your spouse,
 - your dependent children, and
 - a child born to, or placed for adoption with, you during the period of COBRA coverage.

Individuals who have terminated coverage under this plan because they have other coverage are not considered qualified beneficiaries for COBRA.

- **Qualifying event**—A qualifying event is a specific event that causes you or your covered dependents to lose coverage under this Plan. There are several types of qualifying events for employees, their spouses and dependent children, such as:
 - Termination (voluntary or involuntary) of employment for any reason other than gross misconduct;
 - Reduction in work hours that results in loss of medical coverage; or
 - Your employer files for bankruptcy.

In addition to the above, if you are the spouse, qualifying events include any of the following:

- your divorce;
- your spouse’s death;
- your spouse’s hours of employment are reduced resulting in a loss of coverage; or
- your spouse’s employment ends for any reason other than his or her gross misconduct.

In addition to the qualifying events that affect the employee/retiree and spouse (listed above), qualifying events for your dependent children include any of the following.

The loss of a child’s dependent status as defined under the terms of this plan:

- The employee/retiree-parent dies;
- The employee-parent’s hours of employment are reduced;
- The employee-parent’s employment ends for any other reason other than gross misconduct;
- The parents become divorced; or
- The child becomes ineligible for coverage under the Plan as a dependent child

Please note the following:

- Coverage for a student under this Plan will cease immediately when the student graduates from college, is no longer a full-time student, or otherwise fails to be eligible for medical coverage, whichever occurs first, or unless otherwise specified under this Plan.
- Your right to post-retirement benefits is subject to the policies of your employer and can change at any time.

Failure to elect COBRA coverage may affect your future portability of coverage, guaranteed access to other coverage or other plan rights and privileges.

When your prescription drug coverage or COBRA coverage ends, you will receive a certificate of creditable coverage. (Certification will also be provided for a dependent's loss of coverage once the Plan is aware that the dependent's coverage has ended. Please keep your employer informed if your dependents become ineligible for coverage.)

Procedures for Notifying Your Employer of Qualifying Events

Failure to follow the following procedures for notifying your employer may result in the loss of eligibility for COBRA coverage.

Which Qualifying Events Require Employer Notification?

You or your spouse must notify your employer of the following qualifying events:

- your divorce
- loss of dependent eligibility for your dependent child
- your death
- determination by the Social Security Administration ("SSA") that you, your spouse or your dependent child is disabled
- determination by the SSA that you, your spouse or your dependent child is no longer disabled
- second qualifying event (that is, a qualifying event that you, your spouse or your dependent child experiences during the 18-month COBRA coverage period that follows an employment-related qualifying event)

Who Must Receive the Notification at your Employer?

You must notify the person who is named in the *General Notice of COBRA Continuation Rights* as the Plan Information Contact.

When Your Employer Must be Notified

You or your spouse must provide notice to your employer within 60 days after the date of the qualifying event or the second qualifying event.

In the event of a SSA disability determination and you (your spouse and/or your dependent children) want to elect to extend the initial 18-month continuation period for an additional 11 months, your employer must be notified within 60 days after the later of the SSA disability determination (but before the end of the initial 18-month period) or the date of the qualifying event.

In the event that the SSA has determined that you, your spouse or your dependent child is no longer disabled, your employer must be notified within 30 days after the SSA determination.

How Your Employer Must be Notified

The required information for notification of your employer must be provided on the form and in the format specifically required by your employer for this purpose.

This form, required by your employer, will be available at no cost upon request from the Plan Information Contact named in the *General Notice of COBRA Continuation Rights*.

What Information and/or Documentation the Notification Must Include

- Name of the qualified beneficiary(ies)
- Address of the qualified beneficiary(ies)
- Telephone number(s) of the qualified beneficiary(ies)
- Qualifying event
- Date of the qualifying event

Your employer will require additional information or documentation as proof of the qualifying event. Examples of such additional information or documentation include:

- If the qualifying event is divorce, copies of the first and last page of the divorce decree.
- If the qualifying event is loss of dependent eligibility, a statement as to the reason (for example, age or loss of student status).
- If notifying the employer of a SSA disability determination, a copy of the SSA determination letter.
- If the qualifying event is the death of the employee, a copy of the death certificate.

Your employer reserves the right to request additional information or documentation if the information or documentation you provided is not sufficient for your employer to make its determination.

Who May Provide the Notification

- You as a covered employee/retiree may provide notice on behalf of yourself, your spouse and/or your dependent children.
- Your spouse may provide notice on behalf of him/herself and/or your dependent children.
- Your dependent child may provide notice on his/her own behalf.
- Any representative acting on behalf of you, your spouse, and/or your dependent children may provide notice.

Notice provided to your employer by one qualified beneficiary is considered notice on behalf of all related qualified beneficiaries.

How You Will Be Notified by Your Employer If COBRA Coverage Is Available

If COBRA coverage is available as a result of an initial qualifying event, your employer will provide you (your spouse and/or your dependent children) with an election notice and an election form. The election notice contains information regarding COBRA rights to continued coverage. The election form is an administrative form to continue NRECA-sponsored health coverage.

If the COBRA coverage period will be extended due to a second qualifying event (including a SSA disability determination), you will be notified by your employer of the extended coverage period.

If COBRA does not apply, your employer will send you (your spouse and/or your dependent children) a Notice of Unavailability of Coverage, explaining the reasons why COBRA coverage is not available.

Electing COBRA Coverage

Once the benefits administrator receives notice that a qualifying event has occurred, you will receive a notice describing your right to elect COBRA coverage.

Each qualified beneficiary will have an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and you or your spouse may elect COBRA coverage on behalf of your children.

If you (your spouse and/or your dependent children) wish to continue coverage under the Plan they are in, you (or they) must respond to the notice within 60 days of the date you (or they) receive the notice or the date of the qualifying event, whichever is later. Failure to respond to the notice within this 60-day period will result in the loss of the right to elect to continue coverage under the Plans.

You must give this notice to your benefits administrator. For your benefit administrator information, please see the “Important Plan Administrator Information” found at the end of this document.

Length of COBRA Coverage

If you and/or your eligible dependents elect COBRA coverage, the coverage begins on the date of the qualifying event.

If you and/or your eligible dependents decide not to elect COBRA coverage, you and/or your eligible dependents may still decide to elect COBRA coverage within the 60-day COBRA election period. In this case, the COBRA coverage begins on the date you and/or your eligible dependents make the election, not on the date of the qualifying event.

COBRA coverage is temporary. Depending upon the qualifying event, the duration of coverage is as follows:

- **18-Month COBRA Coverage Period**

If the qualifying event is your termination of employment (except for gross misconduct) or reduction in hours, you, your spouse and/or your dependent children are entitled to elect COBRA coverage for a maximum period of 18 months after the qualifying event.

- **36-Month COBRA Coverage Period**

If the qualifying event is divorce, your death (see *Special Rules for Death as a Qualifying Event, below*), or the loss of dependent eligibility, your spouse and/or your dependent children are entitled to elect COBRA coverage for a maximum period of 36 months after the qualifying event.

- **Disability Extension for 18-Month COBRA Coverage Period**

If you, your spouse or your dependent child:

- (i) has elected COBRA coverage,
- (ii) is determined by the Social Security Administration to be disabled and
- (iii) notifies the benefits administrator in a timely fashion,

then you, your spouse and your dependent children may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months.

The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA coverage.

- **Second Qualifying Event Extension for 18-Month COBRA Coverage Period**

If you or your eligible dependents experience another qualifying event during the 18-month COBRA coverage period that would otherwise entitle your spouse and/or dependent children to 36 months of COBRA coverage, the 18-month period will be extended to a maximum of 36 months for your spouse and/or dependent children, if notice of the second qualifying event is properly given to the Plans.

The second qualifying event may be your death (see *Special Rules for Death as a Qualifying Event, below*), your divorce or your dependent child's loss of dependent status under the plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

To qualify for this extension you, your spouse or your eligible dependents must notify your employer within 60 days of the second qualifying event.

Special Rules for Death as the Qualifying Event

If the qualifying event is your death, COBRA coverage will continue for the surviving spouse until the later of the date of his or her death, remarriage or the end of the COBRA coverage period.

A dependent child may continue COBRA coverage until the later of the date the dependent child loses dependent eligibility or the end of the COBRA coverage period.

Cost of COBRA Coverage

If you elect COBRA coverage under the Plans, you must pay the full cost of that coverage (including both the share you now pay, if any, and the share your employer now pays).

You may also be required to pay a 2% administrative fee, for a total of 102% of the cost. If you are disabled, this administrative fee may be higher than the 2% but no more than 50% of the cost of coverage.

After you elect COBRA coverage, you will receive a bill for the initial premium. This initial premium must be paid in full within 45 days of the date you elect COBRA coverage. Each subsequent premium must be paid in full within 31 days of the first day of each month (for example, the premium for May must be paid in full on or before May 31). Failure to pay the initial or subsequent premiums on time will result in the termination of your COBRA coverage.

When COBRA Coverage Ends

Qualified beneficiaries will lose COBRA coverage if any of the following occurs:

- Your premiums are not paid in full within the required payment periods. You have 45 days from the date you elect COBRA coverage to pay your initial premium, and 31 days from the first of each month to pay each subsequent premium.
- Your former employer terminates group prescription drug coverage for all employees/retirees.
- A qualified beneficiary becomes covered under another group prescription drug plan after electing COBRA coverage, and the other group prescription drug plan does not have a pre-existing condition exclusion or limitation that would affect the qualified beneficiary.
- A qualified beneficiary reaches the end of the 18-month, 29-month, or 36-month COBRA coverage period (in general), whichever applies.

Please remember that in order to protect your family's rights, you should keep the benefits administrator informed of any changes in the addresses of your family members. You should also keep for your records copies of any notices you send to the benefits administrator.

If you have questions concerning the Plans or your COBRA coverage rights, please contact your benefits administrator. For your benefit administrator information, please see the "Important Plan Administrator Information" found at the end of this document.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Section 9—Your Rights and Responsibilities as a Plan Participant

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a participant of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected.

If you want Medicare publications on your rights, you may call and request them at 800.MEDICARE (800.633.4227). TTY/TDD users should call 877.486.2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. The Plan must obey laws that protect you from discrimination or unfair treatment. The Plan doesn't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. Customer Care can help if you need to file a complaint about access (such as wheel chair access).

If you think you have been treated unfairly due to your race, color, national origin, disability, age or religion, please let us know. You can also reach the Office for Civil Rights at 800.368.1019 or TTY/TDD 800.537.7697, or call the Office for Civil Rights in your area.

If you need help with communication, such as help from a language interpreter, please call Customer Care, or NRECA's Member Contact Center at 866.673.2299 (TTY 402.484.9555) Monday through Friday, from 7 a.m. to 7 p.m. Central Time.

Our plan is required to have individuals and translation services available to answer questions from non-English speaking plan participants and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have any difficulty obtaining information from NRECA's Customer Care Center based on a language or disability, call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. The Plan keeps your personal health information private as protected under these laws (see information under Health Insurance Portability and Accountability Act of 1996).

Any personal health information that you give us when you enroll in this plan is protected. The Plan will make sure that unauthorized people do not see or change your records.

Generally, the Plan must get written permission from you (or from someone you have given legal power to make decisions for you) before it can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. The Plan is required to provide you with a notice that tells you about these rights and explains how it protects the privacy of your health information.

For example, you have the right to look at your medical records held at the Plan and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, the Plan will review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes.

NOTE: As a participant of the Plan, personal information, including prescription drug event data, will be released to Medicare, who may release it to researchers pursuant to all applicable privacy laws, for research purposes.

If you have questions or concerns about the privacy of your personal information and medical records, please call Customer Care.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this SPD and Evidence of Coverage, you should get all of your prescriptions filled from a network pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any network pharmacy in order to get your prescriptions filled at the benefit level.

You have the right to timely access to your prescriptions. “Timely access” means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a network pharmacy to get your prescriptions filled.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness.

Using a special form, you can choose to

- give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself
- give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

This special form that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.

Regardless of where you get this form, **keep in mind that it is a legal document**. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with your State Department of Health or State Medical Society.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different medication management treatment programs the Plan offers and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a network pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request a coverage determination. Coverage determinations are discussed in Section 7.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation (see Section 7).

If you make a complaint, the Plan must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the appeals and grievances that participants have filed *against* us in the past. To get this information, call Customer Care.

Your right to get information about your drug coverage and costs

This SPD and Evidence of Coverage tells you what you have to pay for prescription drugs as a participant in our Plan. If you need more information, please call Customer Care.

You have the right to an explanation from the Plan about any bills you may get for drugs not covered by the Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 7 for more information about filing an appeal.

You also have the right to receive an explanation from the Plan of any utilization-management requirements, such as prior authorization, quantity limits or step therapy that may apply to your plan. If you have any questions please go to <http://nreca.medicareplanrx.com> or call Customer Care.

Your right to get information about our Plan and our network pharmacies

You have the right to get information about NRECA's Medicare Part D prescription drug plans and the Enhanced Plus Plan. This includes information about the Plan's financial condition and network pharmacies. To get this information, call Customer Care.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Care. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (see the Introduction for information on how to contact the SHIP in your state).

In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 800.MEDICARE (800.633.4227). TTY/TDD users should call 877.486.2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly due to your race, color, national origin, disability, age or religion, please let us know. You can also reach the Office for Civil Rights at 800.368.1019 or TTY/TDD 800.537.7697, or call the Office for Civil Rights in your area.

For concerns or problems related to your Medicare rights and protections described in this section, you can call Customer Care. You can also get help from your State Health Insurance Assistance Program, or SHIP (see the Introduction for information on how to contact the SHIP in your state).

What are your responsibilities as a participant of our Plan?

Along with the rights you have as a participant of our Plan, you also have some responsibilities.

Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a participant. You can use this SPD and Evidence of Coverage and other information the Plan gives you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Customer Care at the phone number listed on the cover if you have any questions.
- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.
- Using all of your insurance coverage. If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a participant in our Plan to pay your prescription drug expenses. This is called “coordination of benefits” because it involves coordinating all of the drug benefits that are available to you.
- You are required to tell our Plan if you have additional drug coverage by calling Customer Care.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan identification card to the provider.
- Notifying us if you move. We need to keep your membership record up-to-date.
- Pay your plan premiums and any coinsurance you may owe for the covered drugs you receive. You must also meet your other financial responsibilities that are described in Section 4.

Please call Customer Care to let us know if you have any questions, concerns, problems, or suggestions.

Your Rights Under ERISA

As a participant in any of the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

- Receive information about the Plan and its benefits
- Examine, without charge, at the Plan Administrator's office or at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD and Evidence of Coverage. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

ERISA also provides that all Plan participants will be entitled to:

- Continue prescription drug coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this SPD and Evidence of Coverage and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan.
- You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.
- Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate your Plan, called fiduciaries of the Plan(s), have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in Federal court.

In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court after exhausting all mandatory appeal procedures under the Plan. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after exhausting all mandatory appeal procedures under the Plan.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court.

The court will decide who should pay the costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please remember that you may not file a lawsuit in federal or state court to enforce your rights until you have exercised, and exhausted, all administrative claim and appeal rights described in the Plan and in this document.

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the

- Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or
- Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

How do the HIPAA privacy rules protect my confidential health information?

The HIPAA privacy rules govern how health information about you may be used and provide you with certain rights with respect to your health information. The privacy rules became effective April 14, 2003.

Privacy Practices

NRECA and Cooperative Benefit Administrators, Inc. (CBA) have always taken steps to protect the privacy of your personal health information. NRECA has amended the Group Benefits Program to add the provisions described below to comply with federal privacy regulations issued under HIPAA.

Privacy Obligations

The Group Benefits Program is required by federal law to protect the privacy of your individually identifiable health information that it creates or receives (“Protected Health Information”) and to provide you with information about its legal duties and privacy practices. When the Group Benefits Program uses or discloses your Protected Health Information, it is required to abide by its privacy practices.

It is important to note that these practices apply to the Group Benefits Program and not to the employers participating in the Group Benefits Program.

Use and Disclosure of Your Protected Health Information

The Group Benefits Program may use or disclose your Protected Health Information to others without your authorization for purpose of treatment, payment or health care operations of the Group Benefits Program.

- Treatment includes providing, coordinating, and managing your health care and related services.
- Payment includes obtaining payment for your coverage, administering claims, coordinating benefits and aiding other health plans or health care providers in obtaining payment for their services.
- Health care operations include using or disclosing information for business planning, quality assessment, case management and disease management.

The Group Benefits Program may also disclose your Protected Health Information to a limited group of employees of NRECA or CBA to carry out the Plan Sponsor’s responsibilities to administer plan payment and health care operations.

The Group Benefits Program may not disclose your Protected Health Information to NRECA or CBA for any other reason without your authorization. However, health information derived from other sources, for example in connection with an application for disability benefits or a leave qualifying under the Family and Medical Leave Act, is not protected by HIPAA.

The Group Benefits Program is not restricted from using or disclosing any health information that does not identify an individual. The Group Benefits Program may also disclose summary health information to NRECA in order for NRECA to obtain premium bids or to modify, amend or terminate the Group Benefits Program.

Your eligibility and enrollment information may also be used by or disclosed to NRECA or CBA. The Group Benefits Program may also use or disclose your Protected Health Information without your authorization for the following purposes:

- to comply with the law;
- for public health and health oversight activities;
- in connection with judicial and administrative proceedings;
- to law enforcement and government officials;
- for health or safety purposes; or
- for workers’ compensation purposes.

In most other cases, the Group Benefits Program cannot use or disclose your Protected Health Information without your authorization.

If you choose to authorize additional uses and disclosures of your Protected Health Information, you may revoke your authorization at any time.

Your Rights

You may request additional restrictions on the use and disclosure of your Protected Health Information for payment and health care operations; however, the Group Benefits Program does not have to grant your request.

You may request that you receive your Protected Health Information by an alternative means of communication or at another location if receiving Protected Health Information through the standard method of communication will endanger you.

You have a right to inspect and copy your Protected Health Information; however, the Group Benefits Program may deny your request under certain circumstances.

You have a right to request that the Group Benefits Program amend your Protected Health Information in any system maintained by or for it, however the Group Benefits Program may deny your request under certain circumstances. If your physician or other health care provider created the information that you desire to amend, you should contact the provider directly.

You may obtain an accounting of certain disclosures of your Protected Health Information made after April 14, 2003. You may be charged if you request an accounting more than once within a 12-month period.

Notice of availability of HIPAA Notice of Privacy Practices

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) govern how health information about you may be used, and provide you with certain rights with respect to your health information. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact NRECA's Privacy Officer:

Privacy Officer
NRECA
4301 Wilson Blvd, MAS8-118
Arlington, VA 22203-1860
Telephone: 703.907.6601
Fax: 703.907.6602
E-mail: privacyofficer@nreca.coop

The Plan's Notice of Privacy Practices is also available at <http://nreca.medicareplanrx.com>.

Section 10—Legal Notices

Notice about governing law

Many different laws apply to this SPD and Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document.

The law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS).

The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. Section 1001 et seq., also applies to this Plan in its entirety. The Plan retains discretion to determine eligibility for benefits and to interpret the terms of the Plan and its documents. Consult your SPD and Evidence of Coverage for more information about ERISA and your ERISA rights.

In addition, other federal laws may apply and, under certain situations, the laws of your state may also apply.

Notice about nondiscrimination

When the Plan makes decisions about the provision of health care services, it does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin.

All organizations that provide Medicare Part D prescription drug plans, like us, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

Other important legal notices

Drug names listed are the registered and/or unregistered trademarks of third-party pharmaceutical companies unrelated to and unaffiliated with NRECA or its affiliates. These trademarks are included here for informational purposes only and are not intended to imply or suggest affiliation between NRECA and such third-party pharmaceutical companies.

Section 11— Important Administrative Information

Here is some important administrative information about this Plan.

- This Plan operates under the official name of the NRECA Group Benefits Program. Its Plan Number is 501.
- Coverage under the Plan is self-insured and funded through contributions made solely by the NRECA (address below), or by NRECA, the participating cooperatives, and the participants, or any such combination thereof:

National Rural Electric Cooperative Association
Group Benefits Trust
4301 Wilson Blvd
Arlington, VA 22203-1860

The name and address of the Plan Sponsor is:

National Rural Electric Cooperative Association
4301 Wilson Blvd
Arlington, VA 22203-1860

NRECA, as the Plan Sponsor, must abide by the rules of the Plan when making decisions related to how the Plan operates and how benefits are paid.

- The Plan Sponsor's Employer Identification Number is 53-0116145
- Type of Plan: Group Prescription Drug Plan
- The Plan Year: Calendar Year
- The Plan Trustee is:

State Street Bank and Trust Company
225 Franklin Street
Boston, MA 02101

- Except where pre-empted by ERISA or other U.S. laws, the validity of the Plan and any other provisions will be determined under the laws of the Commonwealth of Virginia.

Not a Contract of Employment

These Plans must not be construed as a contract of employment and does not give any employee a right of continued employment.

Non-Assignment of Benefits

You cannot assign, pledge, borrow against or otherwise promise any benefit payable under the Plans before you receive it. The one exception to this provision is in the case of a Qualified Medical Child Support Order (QMCSO) that requires you to provide benefits under this Plan to a dependent child.

Mistakes in Payment

Although every effort is made to pay your benefits from the Plans accurately, mistakes can occur. If a mistake is discovered, SilverScript, as the Claims Administrator will make corrections that are deemed appropriate. You will be notified if a mistake is found.

Recovery of Overpayment

If a Plan makes an overpayment, it will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or to offset a future claim payment by the amount of the overpayment.

Changing or Terminating the Plan

The Plan Administrator reserves the right to make changes to this Plan or terminate this Plan at any time, for any reason. This includes the right to change the cost of coverage. These changes may be made with or without advance notice to Plan participants.

Medicare Contact Information

Call 800.MEDICARE or 800.633.4227, available 24 hours a day, or www.medicare.gov.

SilverScript Contact Information

Where to Call for Information:

About your plan design, formulary or drug coverage, cost-share, account balance, request a hard copy of your formulary, mail-order status, or general questions about your drug benefit, call the NRECA Medicare Part D Customer Care Team located in San Antonio, TX, toll free at:

By Phone: 866.586.7322 (Monday-Saturday, 6:30 a.m. - 11:00 p.m., CT)

By Fax: 210.403.8201

Where to Mail Your Completed Mail Order Form:

Caremark
P.O. Box 94467
Palatine, IL 60094-4467

Note: If you receive a mail order form from Caremark or SilverScript with an order and the mailing address is different than the above address, you may mail it to the address pre-printed on the mail order form.

Where Your Mail Orders Are Filled:

All NRECA Medicare D prescription orders will be dispensed from the following Caremark Mail Service Facility:

Caremark
Fort Lauderdale Pharmacy (MC FTL)
15800 SW 25th Street
Miramar, FL 33027

Note: Questions about your mail order, i.e. order status, price, cost-share etc. should be directed to the NRECA Medicare D Customer Care Team at:

By Phone: 866.586.7322

By Fax: 210.403.8201

Where to file a Grievance:

By Phone: 866.884.9478

By Fax: 866.788.5143

By Mail: SilverScript Prescription Drug Plan
Grievance Department
P.O. Box 280500
Nashville, TN 37228

Where to File a Coverage Determination or Appeal:

By Phone: 866.586.7322 (Fast Appeal)

By Fax: 866.884.9475

By Mail: SilverScript
Appeals Department
MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

Prevention, Detection and Correction of Fraud, Waste and Abuse

The Plans are committed to the prevention, detection, and correction of fraud in the delivery of pharmaceutical benefits to participants and beneficiaries.

Please report any potential situation in which you believe that fraud, waste or abuse is occurring. Call NRECA, CMS or Health Integrity, a contractor that has been hired by Medicare to monitor Part D plans and investigate fraud, waste and abuse claims for the government. The numbers to call are:

Number to Call

Name of Organization

888.FRAUD89 (888.372.8389)

NRECA Fraud Hotline

800.Medicare (800.633.4227)

Centers for Medicare and Medicaid Services

877.7SafeRx (877.772.3379)

Health Integrity

Types of Fraud

There are many types of fraud, so be careful when you are considering or are contacted about a Medicare prescription drug plan.

Fraud, waste or abuse complaints may include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks you for your Medicare or Social Security number, bank account number, credit card number, money, etc.
- Someone asks you to sell your Medicare prescription drug card.
- Someone asks you to get drugs for them using your Medicare prescription drug card.
- You feel that a Medicare Part D prescription drug plan has discriminated against you. For instance, they did not let you sign up for a plan because of your age, health, race, religion, or income.
- You are encouraged to drop your plan.
- You are offered cash to sign up for a Medicare Part D prescription drug card.
- You are offered a gift worth more than \$15 to sign up for a Medicare Part D prescription drug plan.
- Your pharmacy does not give you all of your medications and has no plans to provide you with the drugs for your prescription at a later time.
- You are billed for drugs that you didn't receive.
- You believe that you have been charged more than once for your premium.
- Your Medicare Part D prescription drug plan does not pay for your covered drugs.
- You receive a different drug than your doctor ordered and your doctor did not allow substitution.

Remember: You do not have to pay to enroll in any Medicare Part D Plan.

If you receive a telephone call offering to enroll you in Medicare Part D in exchange for payment, do not send them any money, do not send them a check, do not use your credit card, and do not give them your account number. Instead, please call NRECA or Medicare and report potential fraud.

People who are really working with Medicare:

- Can not charge a fee to enroll a person in a plan
- Can not come to a person's home uninvited to sell or endorse any Medicare-related product
- Can call to tell you about Medicare drug plans, but they can not call if you have listed your number on the FTC's Do Not Call Registry. Call 888.382.1222 or visit www.donotcall.gov
- Can not enroll you into a drug plan over the telephone unless you called the plan, or unless you are adding prescription drug coverage to a Medicare Advantage Plan or other Medicare plan you already have
- Can not ask you for payment over the telephone or web. The plan must send a bill.
- Can not send you unwanted email

Participant or Beneficiary Fraud

You – the participant in a Medicare prescription drug plan or Medicare beneficiary – are committing fraud against the Plan if you:

- Provide false information on your enrollment form in a way that affects your eligibility to participate.
- Misrepresent personal information, such as medical condition or eligibility
- Allow someone else to use your enrollment card to get prescription drugs, services, or supplies
- Forge prescriptions
- Resell drugs on black market

You may be involuntarily disenrolled from the Plan if it is determined that you committed fraud.

It is everyone's responsibility to prevent fraud, waste, and abuse. The Plan's fraud, waste and abuse policies and procedures, which are incorporated into this Combined SPD and Evidence of Coverage by reference, specify individual responsibilities and actions regarding fraud and dishonest acts.

Call the Hotline at 888.FRAUD.89

The Fraud, Abuse and Privacy Hotline (the Hotline) is a toll-free number available 24 hours per day, 365 days a year for you to use to confidentially and anonymously report suspected wrongdoing including waste, fraud, abuse, and violations of any Plan rule or federal or state law.

All calls are confidential and do not require you to identify yourself; however, there are instances where confidentiality or anonymity cannot be preserved, such as when law enforcement is involved in an investigation.

When you call the Hotline, you will be asked to describe the suspected problem in as much detail as possible. Upon completion of your call, the information will promptly be relayed to the NRECA Medicare Compliance Officer for investigation.

Results of the investigation are reported to the Compliance Officer and to the government where appropriate. Corrective action plans are then implemented as soon as possible to resolve the problem as well as prevent it from happening again. The specific action taken will depend on the nature and severity of the violation.

While calls to the Hotline should be made in good faith to report misconduct rather than dissatisfaction, most instances of fraud, abuse and privacy violations are discovered through tips and complaints from honest people who are not sure of all the facts.

If you are unsure whether something might be fraudulent, we encourage you to report it. The Plan has policies and procedures pursuant to federal and state laws that protect individuals who provide confidential information regarding possible illegal activities.

Section 12—Definitions

For the terms listed below, this section either gives a definition or directs you to a place in this SPD and Evidence of Coverage that explains the term

Annual Coordinated Election Period—Term used by Medicare to describe the annual open enrollment period held from November 15 through December 31 of each year. During this time period, you can enroll, disenroll or change plans.

Appeal—An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for a Part D drug benefit or payment for a Part D drug benefit you already received. There is a specific process that your Part D Plan Sponsor must use when you ask for an appeal. Section 7 explains what appeals are, including the process involved in making an appeal.

Brand-Name Drug—A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are sometimes not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage—The benefit phase where you will pay nothing for your covered drugs after you or other qualified parties on your behalf have spent \$4,350 in costs for covered drugs during the calendar year. Please see Section 5 of this document.

Centers for Medicare & Medicaid Services (CMS)—The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coinsurance—The percentage of the cost of you pay when you receive your covered drugs.

Copayment—The flat dollar amount you pay when you receive your covered drugs.

Coverage Determination—A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the Plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, you have the right to ask for a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Coverage Gap—The period after you reach the initial coverage limit and before catastrophic coverage begins when you pay 100% of the cost for covered drugs until your True Out-of-Pocket (TrOOP) costs for the year total \$4,350. There is no Coverage Gap for the Enhanced Plus Plan.

Covered Drugs—The general term used to mean all of the prescription drugs covered by the Plan.

Creditable Prescription Drug Coverage—Prescription drug coverage you have from another source (such as your spouse's employer or union plan, the Veterans Administration or TRICARE) that is as good as the standard Medicare prescription drug coverage and that expects to pay out, on average, as much as or more than Medicare's standard prescription drug coverage.

Customer Care—A department responsible for answering your questions about your membership, benefits, grievances and appeals. See the front of this booklet or the Introduction for information about how to contact Customer Care.

Custodial Care—Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible—The amount of money you must first pay each year before the Plan pays any part of the cost for covered drugs. There is no deductible for the Enhanced Plus Plan.

Disenroll or Disenrollment—The process of dropping your coverage and ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 8 discusses disenrollment.

Durable Medical Equipment—Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen. Generally, durable medical equipment and supplies are not covered under Medicare Part D.

Evidence of Coverage and Disclosure Information—This document, along with your enrollment form and any other attachments which explain your coverage, defines our obligations and explains your rights and responsibilities as a participant of our Plan.

Exception—A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help—Medicare program providing financial assistance to those participants who have limited income and need help paying for their covered drugs.

Formulary—A list of covered drugs provided by the Plan.

Generic Drug—A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance—A type of complaint you make about the Plan or one of our pharmacy providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 7 for more information about grievances.

Initial Coverage Period—The period after you meet the annual deductible (if you have one) and before your total drug expenses have reached the initial coverage limit (\$29,000 in 2009 for the Enhanced Plus Plan), including amounts you have paid and what the Plan has paid on your behalf.

Initial Coverage Limit—The maximum limit of coverage under the initial coverage period. The 2009 initial coverage limit for the Enhanced Plus Plan is \$29,000.

Late Enrollment Penalty—An amount added to your monthly premium for Medicare prescription drug coverage if you don't enroll in a Medicare prescription drug plan—or have creditable prescription drug coverage from another plan—when you're first eligible to enroll in Medicare. There are some exceptions, such as if you qualify for Extra Help. You pay this higher amount as long as you have Medicare. If you do not have creditable prescription drug coverage, you will have to pay this late enrollment penalty in addition to your monthly plan premium.

Medicare—The Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant) or Lou Gehrig's Disease (ALS).

Medicare Advantage Plan with Prescription Drug Coverage—A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area.

Medicare Health Plan—A benefit package offered by an insurance company that contracts with Medicare. The Plan is available to anyone who lives in the Plan's service area and who has Medicare Parts A and B, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D)—Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap Policy—A Medicare supplement insurance policy sold by private insurance companies to fill gaps in the original Medicare Plan (Parts A and B). Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the original Medicare Plan.

Network Pharmacy—A network pharmacy is a pharmacy where participants of our Plan can get their prescription drug benefits. They are called "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare Plan—("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy—A pharmacy that does not have a contract with our Plan to coordinate or provide covered drugs to participants of our Plan. As explained in this SPD and Evidence of Coverage, most services you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part C—see "Medicare Advantage (MA) Plan"

Part D—The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs—Drugs that Congress permitted our plan to offer as part of a standard Medicare prescription drug benefit. The Plan may or may not offer all Part D drugs, see your formulary for a specific list of covered drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, were specifically excluded by Congress from the standard prescription drug package (see Section 5 for a listing of these drugs). These drugs are not considered Part D drugs.

Participant—A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Prior Authorization—Approval in advance to get certain drugs that may or may not be on our formulary. Some services are covered only if your doctor or other plan provider gets prior authorization from us. Covered services that need prior authorization are marked in the formulary with a “PA” next to them. Those drugs that may be paid by either Part B or Part D and require prior authorization are marked with a “B/D” next to them.

Quantity Limits—A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that the Plan covers per prescription or for a defined period of time. Covered drugs that have quantity limits are marked in the formulary with a “QL” next to them.

Service Area—A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan. The service area for the NRECA Medicare Part D prescription drug plans is nationwide and not limited to a certain region.

Step Therapy—When you are required to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI)—A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

True Out-of-Pocket Cost (TrOOP)—The amount you pay for your share of the cost of covered drugs before you are eligible for catastrophic coverage—including deductible (if any), coinsurance or copayments, and the full cost during the coverage gap if your plan has this feature. Your monthly premiums are not included in the true out-of-pocket cost. The TrOOP for 2009 is \$4,350. TrOOP is the the same as “OOP” – meaning “Out-of-Pocket” costs. You may see this term in materials from Medicare and other Medicare prescription drug plans.

Appendix A—Preferred Brand Drug List

This is a **partial list** of covered brand-name drugs in the NRECA Medicare Part D Prescription Drug Plan. Visit <http://nreca.medicareplanrx.com> to view the formulary – a complete list of the drugs we cover – or call Customer Care.

PLEASE NOTE: this Preferred Brand Drug List is *not* a complete list of drugs covered by the Plan. The formulary is a list of most drugs covered by your Plan, including most generic drugs, and identifies which drugs require prior authorization (PA) or step therapy (ST), have specific quantity limits (QL), or may be covered by Medicare Part B or Part D (B/D) depending upon your diagnosis.

Generics should be considered the first line of prescribing.

A

ABILIFY
ACTHIB
ACTONEL
ACTOPLUS MET
ACTOS
ADACEL
ADDERALL XR
ADVAIR
AGGRENOL
ALBENZA
ALDACTAZIDE 50/50 mg
ALINIA
ALKERAN inj
ALORA
ALPHAGAN P
ALREX
ALTABAX
AMITIZA
AMOXIL drops
ANCOBON
ANDRODERM
ANDROGEL
ANTABUSE 250 mg
ANTIVERT 50 mg
APTIVUS
ARICEPT
ARIMIDEX
ARIXTRA
AROMASIN

ASACOL
ASMANEX
ASTELIN
ATROVENT HFA
ATTENUVAX
AVALIDE
AVANDAMET
AVANDARYL
AVANDIA
AVAPRO
AVELOX
AVODART
AZASAN
AZELEX
AZILECT
AZMACORT
AZOPT

B

BACTROBAN crm
BARACLUDE
BETOPTIC-S
BICILLIN C-R
BICILLIN L-A
BICNU
BIDIL
BLEPHAMIDE S.O.P.
BOOSTRIX
BUSULFEX
BYETTA

C

CAMPATH
CAMPRAL
CANASA
CANCIDAS
CARAC
CARAFATE susp
CARBATROL
CARDIZEM CD 360 mg
CASODEX
CATAPRES-TTS
CEENU
CELEBREX
CELLCEPT
CELONTIN
CHANTIX
CILOXAN oint
CIPRO susp
CLEOCIN cap 75 mg
CLEOCIN vaginal
sup 100 mg
CLEOCIN soln
CLIMARA PRO
COGENTIN inj
COMBIGAN
COMBIPATCH
COMBIVENT
COMBIVIR
COMTAN
COMVAX
COREG CR

COSMEGEN
COSOPT
COUMADIN
COZAAR
CREON
CRIXIVAN
CUPRIMINE
CYKLOKAPRON inj
CYMBALTA
CYSTADANE
CYSTAGON
CYTOMEL
CYTOVENE

D
DAPTACEL
DARAPRIM
DAUNORUBICIN HCL
DAUNOXOME
DECAVAC
DENAVIR
DEPAKOTE
DEPO-PROVERA
400 mg
DERMA-SMOOTHIE/
FS SCALP OIL
DERMOTIC
DESOWEN oint
DETROL LA
DIAMOX
DIFFERIN
DILANTIN
DILAUDID liquid
DIOVAN
DIOVAN HCT
DIPENTUM
DOVONEX crm
DROXIA
DUETACT

E
EFFEXOR XR
ELIDEL
ELIXOPHYLLIN
ELLECE
ELMIRON
ELSPAR
EMCYT
EMEND
EMSAM
EMTRIVA
ENABLEX
ENGERIX-B
ENTOCORT EC
EPIPEN
EPIVIR
EPIVIR-HBV
EPZICOM
ERYPED DROPS
ESTRADERM
EURAX
EVISTA
EVOXAC
EXELON
EXFORGE

F
FARESTON
FASLODEX
FAZACLO
FEMARA
FLOMAX
FLOVENT HFA
FLUOROPLEX
FLUOROURACIL inj
FML S.O.P.
FORADIL AEROLIZER
FOSAMAX PLUS D
FOSAMAX soln

G
GABITRIL
GAMASTAN S/D
GARDASIL
GASTROCROM
GEMZAR
GEODON
GLUCAGEN HYPOKIT
GLUCAGON
EMERGENCY KIT
GRIS-PEG
GYNODIOL 1.5 mg

H
HAVRIX
HECTOROL
HEPSERA
HIBTITER
HUMALOG
HUMULIN
HYCAMTIN
HYZAAR

I
IFEX
IMITREX
IMOVAX RABIES (H.D.C.V.)
INDOCIN susp
INFANRIX
INTAL inhaler
INTELENCE
INVANZ
INVEGA
INVIRASE
IPOL INACTIVATED IPV
ISORDIL TITRADOSE 40 mg

J

JANUMET
JANUVIA
JE-VAX

K

KALETRA
KENALOG spray
KEPPRA

L

LACRISERT
LANTUS
LEUKERAN
LEVAQUIN
LEVEMIR
LEXAPRO
LEXIVA
LIALDA
LIDODERM
LIPITOR
LIPRAM
LOPROX SHAMPOO
LOTREL 5/40 mg & 10/40
mg
LOTRONEX
LOVENOX
LUMIGAN
LUNESTA
LYRICA
LYSODREN

M

MACRODANTIN 25 mg
MALARONE
MARPLAN
MATULANE
MAXALT
MEDROL 2 mg
MEGACE ES

MENACTRA

MENOMUNE-A/C/Y/W-
135
MERUVAX II
MESNEX 400 mg tab
MESTINON
METROGEL
MIACALCIN
MIGRANAL
MIRAPEX
M-M-R II W/DILUTENT 10
DOSE
MOBAN
MUSTARGEN
MYCOBUTIN

N

NAMENDA
NARDIL
NASACORT AQ
NASONEX
NATACYN
NAVANE 20 mg
NECON 10/11-28
NEORAL
NEURONTIN soln
NEXIUM
NIASPAN
NICOTROL INHALER
NILANDRON
NITRO-DUR 0.3 mg/hr,
0.8 mg/hr
NITROLINGUAL spray
NITROSTAT
NORPACE CR 100 mg
NORVIR
NOVOLIN
NOVOLOG
NUVARING

O

ONCASPAR
ONTAK
OPANA ER
ORACEA
ORAP
ORTHO EVRA
ORTHO TRI-CYCLEN LO
OVIDE
OXSORALEN ULTRA
OXYCONTIN
OXYTROL

P

PACERONE 100 mg & 300
mg
PANCRELIPASE tab
PANCRELIPASE cap 4500U
PANGESTYME
PANOKASE
PARCOPA
PATADAY
PATANOL
PEDIARIX
PEDVAX HIB
PEGANONE
PEPCID susp
PHOSLO
PHOTOFRIN
PILOPINE HS
PLAN B
PLARETASE 8000
PLAVIX
PRANDIN
PREDNISONE INTENSOL
PREMARIN
PREMPHASE
PREMPRO
PREVACID

PREVPAC
PRILOSEC 40 mg
PRIMAXIN
PROAIR HFA
PROCANBID
PROGLYCEM
PROGRAF
PROQUAD
PROTOPIC
PROVENTIL HFA
PROVIGIL

Q

QUALAQUIN
QVAR

R

RABAVERT
RANEXA
RAPAMUNE
RAZADYNE
RECOMBIVAX HB
REGONOL
RELION
RELPAX
RENAGEL
RENVELA
RESCRIPTOR
RESTASIS
RETROVIR inj
REYATAZ
RHEUMATREX
RIDAURA
RISPERDAL CONSTA
RISPERDAL M-TAB
RISPERDAL SOLUTION
ROBAXIN inj
ROTATEQ
ROXICET soln
RYTHMOL SR

S

SANCTURA
SANCTURA XR
SANDIMMUNE cap
SANTYL
SENSIPAR
SEREVENT DISKUS
SEROQUEL
SEROQUEL XR
SINGULAIR
SKELAXIN
SOLARAZE
SOLTAMOX
SOLU-CORTEF 250 mg &
500 mg
SPIRIVA HANDIHALER
STALEVO
STRATTERA
SUBOXONE
SUBUTEX
SURMONTIL 100 mg
SUSTIVA
SYMBICORT
SYMLIN
SYNAREL
SYNTHROID
SYPRINE

T

TABLOID
TAMIFLU
TARKA
TEGRETOL-XR
TEKTURNA
TEKTURNA HCT
TESTIM
TETANUS TOXOID
ADSORBED
TEXACORT lotn 2.5%
THALITONE

THEO-24
THIOLA
TIKOSYN
TINDAMAX
TOBREX oint
TOPAMAX
TRANSDERM-SCOP
TRAVATAN
TRAVATAN Z
TRELSTAR DEPOT
TRELSTAR LA
TRICOR
TRIHIBIT
TRILEPTAL susp
TRIPEDIA
TRISENOX
TRIZIVIR
TRUSOPT
TRUVADA
TWINRIX
TYPHIM VI
TYZEKA
TYZINE

U

ULTRASE
UROXATRAL
URSO 250
URSO FORTE

V

VAGIFEM
VALTREX
VANCOGIN HCL
VAQTA
VARIVAX
VESICARE
VIBRAMYCIN susp & syrup
VIDEX EC cap 125 mg
VIDEX PEDIATRIC soln

VIGAMOX
VIOKASE
VIRACEPT
VIRAMUNE
VIREAD
VIVACTIL
VIVELLE-DOT
VIVOTIF BERNA
VYTORIN

W

WELCHOL

X

XIBROM
XOPENEX
XYREM

Y

YF-VAX

Z

ZERIT
ZETIA
ZIAGEN
ZONALON
ZOSTAVAX
ZOSYN
ZOVIRAX crm & oint
ZYPREXA

Appendix B—Prior Authorization, Part B or Part D, Quantity Limit, Step Therapy Drug List

These are drugs covered by your plan that have special requirements.
Please refer to Section 5 of this booklet for more information.

To find out if a specific drug is covered by your plan, call Customer Care or go to
<http://nreca.medicareplanrx.com> for a copy of the latest formulary.

Drugs Requiring Prior Authorization (PA)

ADDERALL XR ANDRODERM ANDROGEL ARANESP avita CELEBREX CONCERTA Dextroamphetamine sulfate dextroamphetamine sulfate cr dextrostat DIFFERIN ENBREL	EPOGEN FORTEO GENOTROPIN HUMATROPE HUMIRA INCRELEX INFERGEN itraconazole METADATE CD methylin/methylin er methylphenidate hcl NEULASTA NEUPOGEN NORDITROPIN	NUTROPIN/NUTROPIN AQ octreotide acetate oxandrolone PEGASYS PEG-INTRON PROCRIT PROVIGIL REBETOL SOLUTION REGRANEX REMICADE RETIN-A LIQUID/MICRO GEL REVATIO	REVLIMID ribapak ribasphere ribatab ribavirin caps RITALIN LA SAIZEN SANDOSTATIN LAR SOMATULINE DEPO SOMAVERT terbinafine TESTIM THALOMID tretinoin topicals
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Drugs Covered By Part B or Part D (B/D)

acetylcysteine albuterol sulfate AMINESS AMINOSYN AZASAN azathioprine CELLCEPT chorionic gonadotropin CLINIMIX clinisol sf colistimethate sodium cromolyn sodium cyclophosphamide cyclosporine	DECAVAC diphtheria/tetanus toxoid EMEND ENGERIX-B FREAMINE GAMMAGARD LIQUID GAMUNEX gengraf granisetron hcl granisol hepatamine HEPATASOL INTRALIPID ipratropium bromide	ipratropium bromide/ albuterol sulfate IV nutrition drugs NEORAL NEPHRAMINE novamine ondansetron hcl ondansetron odt PREMASOL PROCALAMINE PROGRAF PROSOL PULMICORT PULMOZYME	RAPAMUNE RECOMBIVAX HB RENAMIN SANDIMMUNE tetanus/diphtheria toxoids TETANUS TOXOID ADSORBED TOBI TRAVASOL TROPHAMINE VENTAVIS XOPENEX
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Drugs with Quantity Limits or requiring Step Therapy can be found on the next page.

Drugs with Quantity Limits (QL)

ADVAIR DISKUS ADVAIR HFA albuterol sulfate ALINIA ASMANEX ASTELIN ATROVENT HFA AVINZA AZMACORT COMBIVENT cromolyn sodium dronabinol EMEND fentanyl FLOVENT HFA	flunisolide fluticasone propionate FORADIL gabapentin IMITREX INTAL ipratropium bromide ipratropium bromide/ albuterol sulfate LUNESTA LYRICA MAXAIR AUTOHALER MAXALT MAXALT MLT MIGRANAL	morphine sulfate NASACORT AQ NASONEX NEURONTIN NEXIUM omeprazole OPANA ER OXYCONTIN pantoprazole sodium PREVACID PRILOSEC PROAIR HFA PROVENTIL HFA PULMICORT FLEXHALER	QVAR RELPAX RHINOCORT AQUA SEREVENT DISKUS SPIRIVA SYMBICORT XOPENEX XOPENEX HFA zaleplon ZEGERID zolpidem tartrate ZOMIG ZOMIG ZMT
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Drugs Requiring Step Therapy (ST)

ELIDEL PROTOPIC			
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Notes:

For more information, please visit our web site at
<http://nreca.medicareplanrx.com>

Call 866.586.7322,
Monday-Saturday, 6:30 a.m. to 11:00 p.m. Central Time,
TTY/TDD users should call 866.236.1069.

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