




**National Rural Electric
Cooperative Association**

A Touchstone Energy® Cooperative 

**NRECA
Medicare
Part D**
PRESCRIPTION DRUG PLANS
an Employer PDP

Medicare_{Rx}
Prescription Drug Coverage



SUMMARY PLAN DESCRIPTION AND EVIDENCE OF COVERAGE

Basic Plan

January 1 – December 31, 2010



NRECA Medicare Part D Customer Care

For help or more information, please call Customer Care
Monday through Saturday, 6:30 a.m. to 11:00 p.m. Central Time
Toll-Free Phone: 1-866-586-7322 TTY: 1-866-236-1069
Web Site: <http://nreca.medicareplanrx.com>

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

January 1 – December 31, 2010

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

This plan is offered by NRECA, referred throughout the SPD/EOC as “we”, ”us” or “our”. NRECA is a Medicare-approved Part D Plan sponsor. The NRECA Medicare Part D Prescription Drug Plan is an Employer PDP.

To get this information in a different language or format, please call **NRECA Medicare Part D Customer Care** at the numbers below.

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 free.

Toll-free phone: 1-866-586-7322
TTY: 1-866-236-1069
Web site: <http://nreca.medicareplanrx.com>
Mail: NRECA Part D Plan
c/o CVS Caremark Part D Services, 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: 1-866-586-7322
TTY: 1-866-236-1069
Fax: 1-866-884-9475
Mail: NRECA Part D Plan
c/o CVS Caremark Part D Services, 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: 1-888-FRAUD89 (1-888-372-8389)
Medicare: 1-800-MEDICARE (1-800-633-4227)
TTY 1-877-486-2048
Health Integrity: 1-877-7SafeRx (1-877-772-3379)

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Introduction—Welcome to the NRECA Medicare Part D Drug Plans

We are pleased that you've chosen the **Basic Plan**, one of NRECA's Medicare-approved Part D prescription drug plans. The NRECA Medicare Part D Prescription Drug Plan is an Employer PDP.

Now that you are enrolled in the Basic Plan, you are getting your Medicare Part D prescription drug coverage through NRECA. You are covered by Original Medicare (Part A and/or Part B) for your health coverage and have chosen to get your Medicare prescription drug through the NRECA Medicare Part D Prescription Drug Basic Plan.

Throughout the remainder of this Summary Plan Description and Evidence of Coverage (SPD/EOC), we refer to the Basic Plan as the "Plan" or "our Plan." The word "coverage" and "covered drugs" refers to the prescription drug coverage available to you as a participant in the NRECA Medicare Part D Prescription Drug Basic Plan. The words "we", "us", or "our" refer to NRECA.

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

This Summary Plan Description and Evidence of Coverage (SPD/EOC) is part of 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 Plan and to determine eligibility for benefits.

Other parts of this contract include your enrollment form, the formulary (list of covered drugs), the Plan Document and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called "riders" or "amendments."

The information in this SPD/EOC is in effect from January 1, 2010, through December 31, 2010. Our contract with you is in effect only for the months in which you are enrolled in the Plan.

This SPD/EOC gives you the details of the Plan, 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.

Medicare must approve our Plan every year

The Centers for Medicare & Medicaid Services (Medicare) must approve the NRECA Medicare Part D Prescription Drug Plans each year. You can continue to get Medicare drug coverage as a participant in our plan only as long as we choose to continue to offer the plan and Medicare renews its approval of the Plan.

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** **1-866-586-7322.** This number is also on the cover of this SPD/EOC for easy reference. Calls to this number are free.
- TTY** **1-866-236-1069.** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. It is on the cover of this SPD/EOC for easy reference. Calls to this number are free.
- FAX** **1-866-884-9474**
- WRITE** P.O. Box 659576
San Antonio, TX 78265-9576
- WEB SITE** <http://nreca.medicareplanrx.com>

How to get help and information directly from Medicare

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 (ESRD), permanent kidney failure requiring dialysis or a kidney transplant, or amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease.

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** **1-800-MEDICARE (1-800-633-4227).** Calls to this number are free. Customer service representatives are available 24 hours a day, 7 days a week.
- TTY** **1-877-486-2048.** The TTY number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
- WEB SITE** **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 Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. There are booklets you can print directly from your computer and tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this web site using its computers. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the web site, print it out, and send it to you.

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 (see front cover) 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 located. You can find contact information for the QIO in your state by calling Customer Care (*see front cover*).

Other organizations

Medicaid agency

Medicaid is a joint federal and state program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact the SHIP in your state or visit www.medicare.gov. Look under “Search Tools” and select “Find Helpful Phone Numbers and Websites”.

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
- Extra Help if you have limited income
- benefits for the aged, blind, and disabled.

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 years or older, or who have a disability, end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS) and meet certain conditions, are eligible for Medicare.

If you are already receiving Social Security checks, enrollment into Medicare is automatic. If you are not receiving Social Security checks, you have to enroll in Medicare and pay the Part B premium. To apply for Medicare, you can call the Social Security or visit your local Social Security office.

CALL **1-800-772-1213.** Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use the automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY **1-800-325-0778.** The TTY number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.

WEB SITE **www.ssa.gov**

Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get benefits from the Railroad Retirement Board, and have any questions about those benefits, please contact the agency.

CALL **1-877-772-5772.** Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY **1-312-751-4701.** The TTY number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

WEB SITE **www.rrb.gov**

Employer (Group) Coverage

If you or your spouse get your benefits from your or your spouse's current or former employer or retiree group – other than NRECA – call **that group's employer/union benefits administrator** or member/customer service phone number if you have any questions.

You can ask about your or your spouse's employer or retiree health or drug benefits, plan premiums or the open enrollment period/season. The benefit administrator can help you determine how your current prescription drug coverage will work with our Plan.

State Pharmaceutical Assistance Program

Some states have State Pharmaceutical Assistance Programs (SPAPs), which help low-income and medically needy senior citizens and individuals with disabilities with prescription drug costs. SPAPs may help pay premiums, deductibles, 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 (*see front cover*) to locate the SPAPs in your state. These listings may change during the year. Or, you may call **1-800-MEDICARE** (1-800-633-4227), available 24 hours a day, 7 days a week to find out if there are new qualified SPAPs in your state. TTY users call 1-877-486-2048.

Section 1—Plan Basics

What is the NRECA Basic Plan?

The Basic 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/EOC explains

- what coverage is available
- your benefits and services
- what you have to pay
- the rules you must follow.

If you are a new plan participant, it's important for you to learn how the plan works. We encourage you to set aside some time to look through this SPD/EOC. If you are confused or concerned or just have a question, please contact NRECA Medicare Part D Customer Care (*see front cover*).

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 Basic 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 A or Part B
- excluded by Medicare.

Original Medicare (Medicare Part A and Part B) covers some drugs. Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility. Medicare Part B covers certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. To find out more about this coverage, see your *Medicare & You* handbook.

As a participant, all you have to do is:

- pay your monthly premium
- pay your annual deductible and 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 also are 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. Your 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.

The pharmacists in the Plan's network need to have correct information about you. They use your membership record to know what drugs are covered for you. Because of this, it is very important that you help us to keep your information up to date.

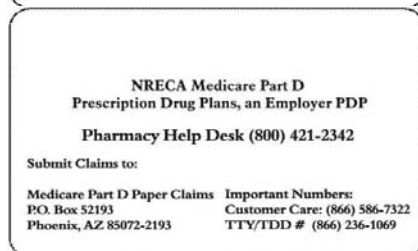
Please contact Customer Care (*see front cover*) right away if there are any changes in your name, address or phone number, or if you go into a nursing home. You are required to let us know about any other health insurance you may have, or any changes in health insurance coverage, such as:

- 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 ID card at network pharmacies. Please carry your ID 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.

A network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription. If you don't have your ID card with you when you fill your prescription, ask the pharmacy to call the Plan to get the necessary information.

If the pharmacy is unable to get the necessary information, you may have to pay the full cost of the prescription and then file a paper claim to request reimbursement from the Plan.

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.

You should continue to use your red, white and blue card Medicare card to get covered services and items under Original Medicare. If your ID card is ever damaged, lost, or stolen, call Customer Care (*see front cover*) 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. NRECA has a national network of retail pharmacies, as well as its special rural pharmacy network, making it convenient for you to find a pharmacy wherever you are in the United States or its territories.

Even though CVS Caremark is the pharmacy benefit manager for NRECA, there are other pharmacies available in NRECA's pharmacy network, in addition to CVS.

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.

Each year we will send you a list of the pharmacies near where you live. You can call Customer Care (*see front cover*) to get up-to-date information about changes in our pharmacy network. You can also locate all network pharmacies by using the pharmacy search tool on our web site at <http://nreca.medicareplanrx.com>.

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"?

The plan has a list of covered drugs, called a **formulary**. "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.

The drugs on this list are selected by the Plan with the help of a team of doctors and pharmacists. The list must meet Medicare's requirements. Medicare has approved the NRECA Medicare Part D Prescription Drug Plan formulary drug list.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan ID card at one of our network pharmacies.

If you do not have your ID 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 (*see front cover*) can give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information by visiting our web site at <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 (*see front cover*) 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 CVS Caremark Part D Services, LLC 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.

As a participant in the Basic Plan, you MUST use the mail-order pharmacy for refills of medications for chronic conditions. You may fill your maintenance drug prescription two times at a retail pharmacy, but after that you must use the mail-order pharmacy for additional refills. This provision does not apply for participants who are residents in a long-term care facility. They may get their prescription drugs filled through one of the Plan's network of long-term care pharmacies.

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 (*see front cover*) 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 ID 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.

It's a good idea to make a copy of your receipts for your records. 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 (*see front cover*) 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 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 (*see front cover*) for more information. You can find out how much the Plan will reimburse you, or you can call if you want to give us more information about a request for payment you have already sent us.

Plan determines if the drug is covered and its share of the cost

When the Plan receives your request for payment, we will let you know if we need any additional information from you. We will consider your request and decide whether to pay your claim and how much to reimburse you.

- If the Plan decides that the drug is covered and you followed all the rules for getting the drug, the Plan will pay for its share of the cost. We will mail your reimbursement to you.
- If the Plan decides that the drug is *not* covered, or you did *not* follow all the rules, the Plan will not pay for its share of the cost. Instead, you will receive a letter that explains the reasons why the Plan is not sending the payment you have requested and your rights to appeal that decision.

If the Plan does not pay for the drug, you can appeal

If you think the Plan made a mistake by deciding that your drug was not covered, you can appeal.

If you appeal, it means you are asking the Plan to change its decision that your drug was not covered and pay its share of the cost.

There may be times when you need to ask the Plan to pay you back, such as:

- You used an out-of-network pharmacy to get a prescription filled.
- You didn't have your Plan ID card with you and you had to pay the full cost for a prescription
- Other situations when you pay the full cost for a prescription.

For the details on how to make this appeal, go to Section 7 of this booklet. The appeals process is a legal process with detailed procedures and important deadlines.

If making an appeal is new to you, you will find it helpful to start by reading the “What to do if you have complaints” section of Section 7. This section is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” After you read this section, you can go to the “How to request an appeal” in Section 7 for a step-by-step explanation of how to file an appeal.

Your doctor may need to provide the Plan with information to support your request if you submit a paper claim asking the Plan to reimburse you for a prescription drug that is

- Not on our formulary
- Subject to prior authorizations, step therapy or quantity limits.

See Section 7 to learn more about requesting coverage determinations.

When to send your receipts to the Plan

There are times when you should let the Plan know about payments you have made for your drugs. In these cases, you are not asking for payment. Instead, you are telling the Plan about your payments so that your true out-of-pocket costs (TrOOP) can be calculated correctly and you may qualify for Catastrophic Coverage more quickly.

1. When you buy the drug for a price that is lower than the plan's price

Sometimes when you are paying your annual deductible, or you are paying the full cost while in the Coverage Gap, you may be able to buy your drug **at a network pharmacy** for a price that is lower than the plan's price. For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.

In this case, save your receipt and send a copy to us so that your out-of-pocket expenses can be added to your TrOOP and help you qualify for Catastrophic Coverage. You must use a network pharmacy and your drug must be on our formulary, the list of covered drugs, in order to count toward your TrOOP.

Please note: The Plan does not pay for any share of these drug costs if you are paying your annual deductible or the full cost while in the Coverage Gap. But, sending in your receipts will help you qualify for Catastrophic Coverage faster.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

You may be enrolled in a patient assistance program offered by a drug manufacturer that is not covered by the Plan. You may pay a copayment for any drugs you receive through the manufacturer's patient assistance program.

In this case, save your receipt and send a copy to the Plan so that your out-of-pocket expenses can be added to your TrOOP and help you qualify for Catastrophic Coverage.

Please note: The plan will not pay for part of these drug costs because you are getting your drug through the patient assistance program. But, sending in your receipts will help you qualify for Catastrophic Coverage faster.

Since you are not asking for payment in these two situations, they are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

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 (*see front cover*).

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 (*see front cover*).

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 (*see front cover*).

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

You are eligible for the NRECA Medicare Part D Prescription Drug Plan (Plan) only if:

- You are entitled to Medicare benefits under Part A and/or currently enrolled in Part B,
- You reside permanently in NRECA's service area, the United States and its territories, and
- Medicare is your primary insurer. Your primary insurer is the insurance policy, plan, or program that pays first on a claim for medical care.

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Medicare Part A generally covers services provided while you are in the hospital or a skilled nursing facility, or visits from home health agencies. Medicare Part B is for most other medical services, such as physician's visits and other outpatient services.

The NRECA Medicare Part D Prescription Drug Plan is a national plan and the Plan's service area is the United States and its territories. You must live within this national service area to be covered by the Plan.

If you move, you must call Customer Care (*see front cover*) to update your information. If you move permanently outside the United States or its territories, you can no longer be a participant in the NRECA Medicare Part D Prescription Drug Plan.

Please keep in mind that the Plan offers 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 the Plan only if **Medicare is your primary insurer** (the primary payer of your medical claims). Thus, you are eligible to participate in the Plan **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 the Plan.

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.

Domestic Partners are not eligible for coverage under this plan.

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 the NRECA Medicare Part D Prescription Drug Plan, 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 the NRECA Medicare Part D Prescription Drug Plan 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 still may 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 Medicare enrollment rules provide longer timeframes for enrollment, those longer time frames apply.

Under the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you and your dependents may be eligible for a special opportunity to enroll (or withdraw) in our group health plan, as applicable, if you are enrolled in Medicare and meet the requirements for eligibility to participate in the Plan.

These conditions are:

- If you or your dependents lose coverage under your State CHIP or Medicaid, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after the termination of your State CHIP or Medicaid coverage.
- If you or your dependents become eligible for a premium assistance subsidy under your State CHIP or Medicaid coverage, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 60 days after eligibility is determined.
- If you or your dependents become eligible for coverage under your State CHIP or Medicaid, you and your dependents have the right to withdraw from this plan the first day of the month after you give notice to your co-op.

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

If you leave the NRECA Part D Plan, 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, a Medicare Savings Account (MSA) or a Cost 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 **1-800-MEDICARE** (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048 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 2010 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 and when your premium payments are due.

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 have limited income and resources. 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, annual deductible and prescription coinsurance. In addition, you do not have to pay a late enrollment penalty or the full cost of your prescription drugs during the Coverage Gap.

If you qualify, this Extra Help will count toward your true out-of-pocket costs (TrOOP).

Do you qualify for Extra Help?

People with limited income and resources may qualify for Extra Help, sometimes call the “low income subsidy” or LIS.

The amount of Extra Help you get will depend on your income and resources. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

If you think you may qualify for Extra Help,

- call the Social Security office at 1-800-772-1213
- go to the www.ssa.gov/prescriptionhelp
- 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 and what you need to do next.

In September, Medicare mailed letters to those participants who were receiving Extra Help in 2009 and no longer qualify for Extra Help in 2010. 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, deductible and coinsurance or copayments. The amount of Extra Help is based on your income and resources.

See the table on the next page 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 – including the amount paid by Extra Help – reach \$4,550.

Your Coinsurance or Copayment Level	Annual Deductible	Generic or Preferred Brand-name Drugs	Other Drugs
1	\$ 0.00	\$ 2.50	\$ 6.30
2	\$ 0.00	\$ 1.10	\$ 3.30
3	\$ 0.00	\$ 0.00	\$ 0.00
4	\$ 63.00	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 LIS Rider, which is an addendum to this 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 also will mail to you an updated LIS 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 (*see front cover*).

How do you get more information?

For more information on who can get Extra Help with prescription drug costs if you have limited income and how to apply, call the **Social Security Office** at 1-800-772-1213, Monday through Friday, from 7 a.m. to 7 p.m. TTY users call 1-800-325-0778 or visit the www.ssa.gov web site.

In addition, you can look at the *2010 Medicare & You* handbook, visit the www.medicare.gov web site, or call **1-800-MEDICARE** (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

If you have any questions about our Plan, please contact **Customer Care** (*see front cover*). Or, visit our web site <http://nreca.medicareplanrx.com>.

State Pharmaceutical Assistance Program

Many states have State Pharmaceutical Assistance Programs (SPAPs), that help pay for prescription drugs based on your financial need, age, or medical condition. Each state has different rules to provide drug coverage. Please contact your SPAP to find out what benefits may be available to you.

Please call Customer Care (*see front cover*) to locate the SPAPs in your state. These listings may change during the year. Please contact **1-800-MEDICARE** (1-800-633-4227), available 24 hours a day, 7 days a week to find out if there are new qualified SPAPs in your state. TTY users call 1-877-486-2048.

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 Basic Plan, you must pay a \$28.60 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.

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 (*see front cover*).

There are programs to help people with limited resources pay for their drugs and premiums. Section 3 tells you more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you already are enrolled and getting Extra Help with paying for your drug coverage from Medicare, the premium amount you pay as a participant in this plan is listed in your LIS Rider. If you do not have the LIS Rider, you can also get that information by calling Customer Care (*see front cover*).

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 prescription drug 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 NRECA, 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 (*see front cover*) to find out more about enrollment periods.

If you have trouble paying for your coverage

If you are having trouble paying your premium on time, please contact Customer Care (*see front cover*) to see if we can direct you to programs that may help you with your plan premium.

If we end your membership with the plan (disenroll you) because you have not paid your Part D premiums,

- You will not have prescription drug coverage. You will not be able to enroll in another Part D Plan until the next open enrollment period. At that time, you may join either a stand-alone prescription drug plan or a health plan that also provides drug coverage.
- You will have coverage under Original Medicare (Part A and/or Part B).
- You may still owe us for premiums you have not paid. If you want to enroll in our Plan again in the future, you will need to pay these late premiums before you can enroll.

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, 2011.

In limited circumstances, your plan premium may change during the calendar year:

- If you currently are not receiving Extra Help but you qualify for it during the year, your monthly premium amount would go down.
- If you currently receive Extra Help, the amount of help you may receive could change during the year.

Your eligibility for Extra Help might change if

- There is a change in your income or resources.
- 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.

Your copy of *Medicare & You 2010* tells about these premiums in the section called “2010 Medicare Costs.” This explains how the Part B premiums differ for people with different incomes.

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 (*see front cover*) for more information.

Everyone receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up for Medicare. You can get a copy by

- downloading a copy from Medicare’s web site (<http://www.medicare.gov>)
- calling 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TYY users call 1-877-486-2048.

What is the Part D “late enrollment penalty”?

You may have to pay an extra cost, 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 were 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 average 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.

Here's how it works:

1. First, determine if you did not have creditable prescription drug coverage for more than 63 days because
 - You did not enroll in a Medicare drug plan after you were eligible to enroll, or
 - You did not have prescription drug coverage that expected to pay at least the same as the Medicare standard plan.
2. Count the number of full months after any period of more than 63 consecutive days without creditable prescription drug coverage.
3. Determine the penalty – 1% for every month that you did not have creditable coverage. For example, if you did not have coverage for 14 months, then the penalty will be 14%.
4. Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2010, this average premium amount is \$31.94.
5. You multiply the penalty by the average premium amount, and round it to the nearest 10 cents.
6. In our example, you would multiply 14% by \$31.94 (0.14 x 31.94). This equals \$4.47. Round it to the nearest 10-cents and your penalty is \$4.50 for 2010. This is the amount that will be added to your monthly premium.

There are three important things to note about this monthly premium penalty:

1. First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium increases, your penalty will increase.
2. Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
3. Third, if you are **under 65** and currently receiving Medicare benefits, **any late enrollment penalty you are paying will be eliminated when you reach age 65**.

After age 65, your late enrollment penalty will be based only on the months that you do not have coverage after your age 65 initial enrollment period for Medicare.

When your first enroll in the Plan, we let you know the amount of the penalty.

If you disagree with your late enrollment penalty, you may ask Medicare to reconsider (review) its decision. Call Customer Care (*see front cover*) 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. Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Talk to your insurance company or your human resources department to find out if your current drug coverage is at least as good as Medicare's.
- 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 didn't receive enough information to know whether or not your previous prescription drug coverage was not creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (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 from Medicare.

Your late enrollment penalty may be reduced or eliminated if you receive Extra Help in 2010 or later.

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. The list must meet requirements set by Medicare.

Medicare has approved the Plan’s formulary list. The drugs on the formulary are only those covered under Medicare Part D.

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 (*see front cover*) 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 a drug is recalled because it is found to be unsafe or for other reasons, the Plan will immediately remove the drug from the formulary.

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. This notice will be in your monthly Explanation of Benefits (EOB) at least 60 days before the date that the change becomes effective. See the section in your EOB.

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.

If a prescription drug you are taking at the beginning of the year is removed from the formulary later in the same year, you may be covered for that drug for the rest of the calendar year.

Likewise, if a prescription drug you are taking at the beginning of the year has restrictions added during the year, such as prior authorization, quantity limit or step therapy, then you will not be affected by the change until January 1, the start of the next plan year.

There are two exceptions:

- When a new generic drug becomes available, or
- When new information is released stating that the drug may not be safe or effective.

When a brand-name drug you are taking is replaced by a generic drug, the Plan will give you at least 60 days notice, or give you a 60-day refill of your brand-name drug at a network pharmacy.

However, if a drug has been recalled from the market, you will not be given 60 days notice nor will you be given a 60-day supply of the drug when you request a refill. The Plan will remove the drug from the formulary immediately and notify you about the change as soon as possible. Your physician will also know about this change and can work with you to find another drug for your condition.

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 (*see front cover*) 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 the Plan. 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 for a formulary exception to cover your drug. See Section 7 to learn more about how to request an exception.
- You can pay the full cost 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 the full cost 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 decision. See Section 7 for more information on how to request an exception or appeal.

In some cases, the Plan 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, 2010
- Enrolled in a new plan, effective January 1, 2010, during open enrollment held November 15 to December 31, 2009
- 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 unless you are in a long-term health care facility and need a supply of a non-formulary drug right away.

During **your first 90 days** in the Plan, you may receive up to a one-time 30-day transition supply of a non-formulary drug to give you time to talk to your doctor about alternative medications. You may receive less than a 30-day supply if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

If you are in a long-term health care facility, and

- You are **new to the Plan**, 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.
- You have been a **participant in the Plan for more than 90 days** and need a supply right away, you may receive one transition supply of up to 31 days (or less if, your prescription is written for fewer days). This is in addition to the transition supply when you are new to the Plan.

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.

To ask for a transition supply, call Customer Care (*see front cover*).

While you are getting a transition supply of the drug or 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 (See Section 7).

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 to promote fertility
- Drugs when used for the symptomatic relief of cough or colds
- 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
- Benzodiazepines
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
- 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 (*see front cover*) if you have any questions.

Your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

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.
- drugs purchased outside the United States and its territories.

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.

In general, our rules encourage you to get a drug that works for your medical condition and is safe. Whenever a safe, lower-cost drug will work for your medical condition just as well as a higher-cost drug, the plan's rules are designed to encourage you and your doctor or health care professional to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

Before you get your prescription filled, you should check to see if any utilization management is required. Please consult your copy of our formulary or the formulary on our web site. Examples of utilization management tools are:

- **Prior Authorization:** The Plan requires you to get prior approval from the Plan before we agree to cover certain drugs. This is called "prior authorization". This means that your prescribing physician will need to get approval from us before you can fill your prescription.

Sometimes prior authorization is required so that the Plan can be sure that your drug is covered by Medicare rules. In other cases, prior authorization helps guide appropriate use of certain drugs. If you do not get this approval, we may not cover the drug.

- **Quantity Limits:** For certain drugs, the Plan limits the amount of the drug that you can get per prescription. The plan might limit how many refills you can get or how much of a drug you can get each time you fill your prescription, or limit a drug to a defined period of time.

For example, if it normally is considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. For instance, the Plan will provide up to twelve units per 25 days of MAXALT.

- **Step Therapy:** In some cases, the Plan requires you to try safer or more effective drugs first 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. This requirement to try a different drug first is called “Step Therapy.”

- **Generic Substitution:** A “generic” drug works the same as a brand-name drug, but usually costs less. **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.

The Plan’s formulary includes information about these utilization management programs. 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 at <http://nreca.medicareplanrx.com> or by calling Customer Care (*see front cover*).

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

These programs are voluntary and free to participants.

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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

How much do you pay for drugs covered by the Basic 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 (Deductible, Initial Coverage Period, Coverage Gap and Catastrophic Coverage level)
- the type of drug
- whether you are filling your prescription at a network or out-of-network pharmacy.

Keep in mind that you are always responsible for the plan's monthly premium regardless of the coverage level.

Your drug costs for each coverage level are described on the next page. Refer to the plan formulary for your plan to see what drugs are covered.

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 LIS Rider. If you do not already qualify for Extra Help, see “Do you qualify for Extra Help?” in Section 1 for more information.

<u>Level 1</u>	<u>Level 2</u>	<u>Level 3</u>	<u>Level 4</u>
Annual Deductible	Initial Coverage Period	Coverage Gap	Catastrophic Coverage
<p>You begin this level when you fill your first prescription of the year.</p> <p>At this level, you pay the full cost of your drugs.</p> <p>Your annual deductible is \$310. That means you must pay \$310 for your drugs before you can move to the Initial Coverage Period.</p>	<p>The Plan pays its share of the cost of your drugs (75 percent) and you pay your share of the cost (25 percent).</p> <p>You stay at this level for the next \$2,520 in total drug costs.</p> <p>When total drug costs for your annual deductible and this Initial Coverage Period reach \$2,830, you reach the initial coverage limit.</p> <p>Once you reach the initial coverage limit, you move to the Coverage Gap.</p>	<p>You pay the full cost of your drugs.</p> <p>You stay at this level until your true out-of-pocket costs (TrOOP) reach \$4,550 in 2010.</p> <p>The maximum TrOOP amount and rules for costs that count toward TrOOP have been set by Medicare.</p>	<p>Once you have paid the maximum in true out-of-pocket costs, the Plan will pay most of the cost of your drugs for the rest of the year.</p> <p>Your share of the cost drops to 5 percent or a minimum copayment, whichever is higher.</p> <p>The minimum copayment for Catastrophic Coverage is \$2.50 for generic drugs and \$6.30 for brand-name or specialty drugs.</p>

As shown in the table above, when you can move to the next coverage level depends on how much you and/or the Plan spends for your drugs while you at each level.

Deductible

The deductible is the first coverage level. This level begins when you fill your first prescription during the year. At this level, you (or others on your behalf) **must pay the full cost of your drugs** until you reach the plan’s deductible amount, which is \$310 for 2010.

Your full cost is usually lower than the normal full price of the drug, since you are able to take advantage of the lower costs the Plan has negotiated for most drugs.

Your deductible is the amount that must be paid each year in covered drug costs before the Plan begins to pay its share of your drug costs. Once you have paid \$310 for your covered drugs – the deductible for 2010 – you leave the deductible level and move on to the next coverage level, called the Initial Coverage Period.

Initial Coverage Period

During the **Initial Coverage Period**, the Plan will pay its share of the costs for your covered drugs and you (or others on your behalf) will pay your share of the costs. Your share of the cost of a covered drug is 25 percent coinsurance.

Coinsurance means that you pay a **percentage of the total cost of the drug** each time you fill a covered prescription. 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:	25%	25%

You stay at the Initial Coverage Period level until the total costs for your covered drugs reaches \$2,830 – the **initial coverage limit** for 2010.

Your total drug cost is calculated by adding together what you have paid and what the Plan has paid:

- Everything you have paid for all covered drugs you have received since your first drug purchase of 2010. This includes

\$ 310 – your annual deductible

\$ 630 – your share of the cost for your drugs during the initial coverage period

\$ 940 total you paid

If other individuals, organizations, current or former employer/union, another insurance plan or policy and/or Extra Help from Medicare help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

- \$1,890 – the amount the Plan has paid for its share of the cost for your drugs during the initial coverage period.
- \$2,830 total paid by you and the Plan

The **Explanation of Benefits** (EOB) is a statement sent to you each month that you get a prescription or a refill. This statement helps you keep track of how much you have paid and the Plan has paid for your covered drugs during the year. Many people do not reach the \$2,830 initial coverage limit during the year.

We will let you know if you reach the \$2,830 initial coverage limit. If you do reach this amount, you will leave the initial coverage period and move into the Coverage Gap.

Coverage Gap

After your total costs for covered drugs reach \$2,830, you move into the **Coverage Gap**.

When you are at the Coverage Gap level, **you pay the full cost for your drugs**. Your full cost is usually lower than the normal full price of the drug, since you are able to take advantage of the lower costs the Plan has negotiated for most drugs.

You continue paying the full cost until your true out-of-pocket costs (TrOOP) reach the maximum amount that Medicare has set. In 2010, that amount is \$4,550.

Medicare has rules about what counts and what does not count as true out-of-pocket costs. When your true out-of-pocket costs for covered drugs total \$4,550—from your deductible, your coinsurance during the Initial Coverage Period and your payments during the Coverage Gap—you leave the Coverage Gap and move to Catastrophic Coverage.

Catastrophic Coverage

All Medicare Part D prescription drug plans include Catastrophic Coverage for people with high drug costs. You qualify for Catastrophic Coverage when the total amount you have paid toward your deductible, coinsurance and the cost for covered Part D drugs during the Coverage Gap reaches \$4,550, the true out-of-pocket maximum for 2010.

At the Catastrophic Coverage level, you pay the greater of 5% coinsurance or a copayment of \$2.50 for generics or drugs that are treated like generics and \$6.30 for brand-name and specialty drugs. The Plan pays the rest.

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.

Remember, you are responsible for all of the costs associated with vaccines during any deductible or Coverage Gap phases of your benefit. Save your receipt and submit a paper claim to see if you can be reimbursed.

The chart 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>

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 (*see front cover*) 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)?

The Plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one coverage level to the next.

In particular, there are two types of costs which the Plan tracks:

- **True out-of-pocket cost or TrOOP** – how much you have paid or qualified others paid on your behalf.
- **Total drug costs** – the amount you have paid (or qualified others paid on your behalf) plus the amount paid by the Plan.

The **Explanation of Benefits** (EOB) is a statement sent to you by the Plan each month that you get a prescription or a refill. This statement helps you keep track of how much you have paid and the Plan has paid for your covered drugs during the year.

The types of payments for prescription drugs that can count toward your true out-of-pocket cost and help you qualify for Catastrophic Coverage include:

- your annual deductible
- the coinsurance you pay for covered drugs during the Initial Coverage Period
- any payments you make for covered drugs during the Coverage Gap
- any payments you made during this calendar year under another Medicare prescription drug plan before you joined our Plan.

When you (or other qualified entities paying on your behalf) have spent a total of \$4,550 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 (*see front cover*) or call 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- 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 including employer 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 (other than NRECA) 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.

If you are in the Deductible or Coverage Gap level, and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you will be responsible for submitting a paper claim for these purchases to have them count towards your true out-of-pocket cost and help you qualify for Catastrophic Coverage (see Section 1).

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 statement 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, as well as 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 (*see front cover*).

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- **Totals for the year since January 1.** This section of the EOB is called the Summary of Your Medicare Prescription Drug Costs for This Year. It shows you the total drug costs and total payments for your drugs since the year began, as well as 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.
 - **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.
 - **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 deductible, coinsurance and payments made on covered Part D drugs during the Coverage Gap.
- **Information for that month.** This section of the EOB is called the Summary of Prescription Claims Processed and tells you the dates the statement covers. It lists the drugs you had filled during the previous month. It shows the total drug costs, including the amount paid by the Plan and what you or others on your behalf paid for each prescription.
- **Changes to the formulary.** This section of the EOB is called Updates to the NRECA Part D Plan's Drug List (Formulary). A description of changes to the formulary that will occur at least 60 days in the future.
- Information about how to request a formulary exception and appeal our coverage decisions.

The true out-of-pocket costs shown on your Explanation of Benefits does not include payments made by your current or former employer/union (other than NRECA), 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 the month after you have a prescription filled. For example, if you get a prescription filled in February, your Explanation of Benefits will be sent to you the end of March showing that prescription.

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 (*see front cover*).

Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your Plan ID card every time you get a prescription filled.** This way, we can keep track of the prescriptions you receive and the amount you paid for them.
- **Make sure we have the information we need.** There are times when you may pay for prescription drugs and we will not automatically get the information. To help us keep track of your out-of-pocket costs, send us copies of the receipts for drugs that you have purchased. Or, if you are billed for a covered drug, you can ask the Plan to pay our share of the cost (*see Section 1*).

Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- when you purchase a covered drug at a network pharmacy at a special price or use a discount card that is not part of our plan's benefit
- when you pay a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- any time you buy covered drugs at out-of-network pharmacies or you have paid the full price for a covered drug under special circumstances.
- **Check the written report we send you.** When you receive an Explanation of Benefits in the mail, please check it to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Customer Care (*see front cover*). Be sure to keep these reports. They are an important record of your drug expenses.

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 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

Medicare requires us to collect information from you about any other medical or drug insurance coverage you have. The Plan must coordinate your benefits under our Plan with any other coverage you have.

Once a year, the Plan will send you a letter that lists any other medical or drug insurance coverage that the Plan knows about. This letter is called the COB Survey or coordination of benefits survey.

Please read this information carefully. If it is correct, you do not need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please fill it out and send it back to us or call Customer Care (*see front cover*).

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 (*see front cover*) 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, deductibles 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 (other than NRECA), please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan.

In general, if you currently are 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 because you may need them later. If you didn't get this creditable coverage disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

If you enroll in a Medicare plan that includes Part D coverage, you may need these notices to show that you have maintained creditable prescription drug coverage.

SECTION 7—Appeals and Grievances

What to do if you have complaints

Your health and satisfaction are important to us. Please let Customer Care (*see front cover*) know right away if you have questions, concerns or problems related to your prescription drug coverage. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a participant of our Plan and as someone who is getting Medicare. We will honor your rights, take your problems and concerns seriously, and treat you with respect.

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.

Process for dealing with problems

The Plan will handle a complaint as a grievance, coverage determination or an appeal, depending on the subject of the complaint. Each process has been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this section. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this section explains the legal rules and procedures and sometimes uses more common words in place of certain legal terms. For example, this section may say “making a complaint” rather than “filing a grievance”... “coverage decision” rather than “coverage determination”... and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for your situation. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

You can get help from government organizations that are not connected with the Plan

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected to us.

You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. Their services are free.

The program's counselors can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit Medicare's web site at www.medicare.gov.

Which process do you use? That depends on the type of problem you are having.

If you have a problem or concern and you want to do something about it, you just need to find and read the parts of this section that apply to your situation.

Process	Type of Problems
Grievance	You are not happy about the quality of care, waiting times, customer service or other concerns , such as <ul style="list-style-type: none">• You were not happy with the customer service you received.• A pharmacy was not clean or the staff was not courteous.• You did not receive the required notices from the Plan or did not receive them quickly enough.
Coverage Determination	<ul style="list-style-type: none">• You do not agree with any decision made by the Plan regarding a payment or benefits you feel entitled.• You want the Plan to make an exception to its benefits or payment policies, such as<ul style="list-style-type: none">○ You believe you need a drug that is not on the plan's formulary.○ You want the Plan to waive any limits on your drug.○ You want the Plan to make a drug available at a lower cost.
Appeal	You want the Plan to reconsider its decision regarding <ul style="list-style-type: none">• a payment• your benefits• if you are eligible for Extra Help• a late enrollment penalty.

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 (*see front cover*) **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 1-866-884-9478.
2. You may submit a grievance via fax at 1-866-788-5143.
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”, an “initial determination” or a “coverage decision”.

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 CVS Caremark Part D Services, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

You can call Customer Care (*see front cover*) 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 (*see front cover*) Monday through Saturday from 6:30 a.m. to 11:00 p.m. Central Time, or
- send a written request by fax to 1-866-884-9475 or
- mail a written request to:

NRECA's Part D Plan
c/o CVS Caremark Part D Services, 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 (*see front cover*) 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 CVS Caremark Part D Services, 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 (*see front cover*) 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 1-866-884-9475 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 CVS Caremark Part D Services, LLC
Appeals Department, MC109
P.O. Box 52000
Phoenix, AZ 85072-2000

By fax: 1-866-884-9475

If it is a fast appeal, by telephone: 1-866-586-7322

In person: NRECA's Part D Plan
c/o CVS Caremark Part D Services, 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, all costs incurred after your costs exceed the initial coverage limit (Coverage Gap) 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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- 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 (*see front cover*).

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)

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. The only exceptions are a Private Fee For Service (PFFS) Plan, Medicare Medical Savings Account (MSA) and a Cost Plan. If your Medicare Advantage Plan does not offer prescription drug coverage, you will not be covered for prescription drugs.

For more information on joining a Medicare Advantage Plan in your area, please contact 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048 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.

HIPAA Certificate of Creditable Coverage

The Plan will provide you and/or your dependents with a HIPAA Certificate of Creditable Coverage when you and/or your dependents cease to be covered under NRECA’s Medical Plan, including when you are eligible for COBRA continuation coverage.

In addition, you may request a HIPAA Certificate of Creditable Coverage from the Plan by contacting NRECA's Employee Benefits Services:

Employee Benefits Services
P.O. Box 6338
Lincoln, NE 68506
Phone: 1-866-673-2299
FAX: 1-402-483-9362

Employee Benefits Services will mail, fax, or email the requested certificates according to your instructions.

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, a Medicare Medical Savings Account (MSA) Plan or a Cost 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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. to request disenrollment from our plan. TTY users call 1-877-486-2048.

- **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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048 to request disenrollment from our plan. 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, 2010, the annual coordinated enrollment period began on November 15, 2009, and ends on December 31, 2009.

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 (*see front cover*) 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 (*see front cover*) and we will assist you.

Your termination from the Plan will be effective on the first day of the month after we receive your request to change your Plan.

How do you disenroll?

In most cases, you simply enroll in another Medicare plan during one of the enrollment periods to end your enrollment in our Plan. 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
- Medicare Part D Plan ID 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 CVS Caremark Part D Services, LLC, 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 (*see front cover*) or go to <http://nreca.medicareplanrx.com>.

You may also disenroll by calling 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. 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”).

There is an exception if you enroll in

- a Private Fee-For-Service (PFFS) plan without prescription drug coverage
- a Medicare Medical Savings Account (MSA) without prescription drug coverage
- a Medicare Cost Plan without prescription drug coverage.

In this case, you can enroll in that plan and keep the NRECA Medicare Part D Plan for your drug coverage. If you do not want to keep our Plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.

If you leave the NRECA Medicare Part D Plan, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you are still a participant of our Plan and must continue to get your prescription drugs, as usual, through our Plan until the date your membership ends.

You should continue to use network pharmacies to get your prescriptions filled until your membership in our Plan ends. Usually, your prescription drugs are covered only if they are filled at a network pharmacy, including through our mail-order pharmacy services.

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.
- Our Plan is no longer contracting with Medicare.
- You materially misrepresent third-party reimbursement.
- You fail to pay your Plan premium. We must notify you in writing that you have a grace period to pay the plan premium before we end your membership.
- You continuously engage in disruptive behavior that makes it difficult for us to provide care for you or other participants in our Plan. We cannot make you leave our Plan for this reason unless we get permission from Medicare first.
- You provided fraudulent information when you enrolled.
- You let someone else use your membership card to get prescription drugs. If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- You lied about or withheld information about other insurance you have that provides prescription drug coverage.
- You move out of the United States or its territories for more than six months. If you move or take a long trip, you need to call Customer Care (*see front cover*) to find out if the place you are moving is in our Plan's service area.
- You become incarcerated.

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/EOC 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 the national Medicare help line at 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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 Plan.

If you and/or your eligible dependents reject COBRA continuation coverage before the 60-day due date, you may change your mind as long as you furnish a completed election form before the 60-day due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed election form. Please note that your COBRA coverage will end 18 months or 36 months, whichever is applicable, from the date of the Qualifying Event.

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 reject COBRA continuation coverage before the 60-day due date, you may change your mind as long as you furnish a completed election form before the 60-day due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed election form. Please note that your COBRA coverage will end 18 months or 36 months, whichever is applicable, from the date of the Qualifying Event.

Michelle's Law

Under Publication Law No. 110-381, coverage may be extended for Dependents in Student Status who take a Medically Necessary leave (upon written certification by a treating Doctor or Physician of the Dependent which states that Dependent is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is Medically Necessary), subject to the terms of the Plan. Coverage, pursuant to this section, shall continue under the Plan until the earlier of:

- (a) the date that is 1 year after the first day of the medically necessary leave of absence; or
- (b) the date on which such coverage would otherwise terminate under the terms of the Plan.

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, the maximum COBRA coverage period for the surviving spouse and dependent children is 36 months. However, for the surviving spouse who had not remarried, coverage may continue beyond the 36-month period until the earlier of the surviving spouse's remarriage or the surviving spouse's death.

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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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 (*see front cover*) 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 1-800-368-1019. TTY users call 1-800-537-7697, 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 (*see front cover*), or NRECA's Member Contact Center at 1-866-673-2299. TTY users call 1-402-484-9555. 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 Customer Care or NRECA's Member Contact Center based on a language or disability, call 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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 (*see front cover*).

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

As explained in this SPD/EOC, you should get all of your prescriptions filled and refilled at network pharmacies, 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 (*see front cover*).

Your right to get information about your drug coverage and costs

This SPD/EOC 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 (*see front cover*).

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 the NRECA Medicare Part D Prescription Drug Plan and the Basic Plan. This includes information about the Plan's financial condition and network pharmacies. To get this information, call Customer Care (*see front cover*).

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Customer Care (*see front cover*). 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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. 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 1-800-368.1019. TTY users call 1-800-537-7697, 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 (*see front cover*). 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/EOC 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 (*see front cover*) 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.
- Use 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. We are required to follow Medicare’s rules to coordinate benefits and we will help you with it.
- Tell the Plan if you have additional drug coverage by calling Customer Care (*see front cover*). You are required to do this or your coverage could be terminated.
- Notify 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.
- Notify 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 (*see front cover*) 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/EOC. 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/EOC 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 disclose your Protected Health Information to its business partners for the purpose of conducting disease management services, including:

- (1) population-based activities to improve health and reduce health care costs (e.g., to identify the relative prevalence among Plan participants of major chronic conditions like diabetes;
- (2) case management and case coordination (e.g., to identify you as someone who may benefit from the services of a health coach because you potentially are facing a significant medical decision or experiencing gaps in effective clinical care); and
- (3) contacting Plan participants with information about treatment alternatives or other health related benefits and services that may be of interest to them (e.g., to identify you as someone who may benefit from information provided via mail, e-mail or telephone by a disease management program regarding a particular health condition like asthma).

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/EOC. 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/EOC 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, CVS Caremark Part D Services, LLC, 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 and your employer reserve 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 1-800-MEDICARE (1-800-633-4227), available 24 hours a day, 7 days a week. TTY users call 1-877-486-2048 or www.medicare.gov.

CVS Caremark Part D Services, LLC 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 NRECA Medicare Part D Customer Care Team located in San Antonio, TX, toll free at:

By Phone: 1-866-586-7322 (Monday-Saturday, 6:30 a.m. - 11:00 p.m., CT)

By Fax: 1-210-403-8201

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 CVS Caremark Part D Services, LLC 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: 1-866-586-7322

By Fax: 1-210-403-8201

Where to file a Grievance:

By Phone: 1-866-884-9478

By Fax: 1-866-788-5143

By Mail: CVS Caremark Part D Services, LLC Prescription Drug Plan
Grievance Department
P.O. Box 280500
Nashville, TN 37228

Where to File a Coverage Determination or Appeal:

By Phone: 1-866-586-7322 (Fast Appeal)

By Fax: 1-866-884-9475

By Mail: CVS Caremark Part D Services, LLC
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

1-888-FRAUD89 (1-888-372-8389) NRECA Fraud Hotline

1-800-Medicare (1-800-633-4227) Centers for Medicare and Medicaid Services
Available 24 hours a day, 7 days a week
TTY 1-877-486-2048

1-877-7SafeRx (1-877-772-3379) 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 1-888-382-1222 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/EOC by reference, specify individual responsibilities and actions regarding fraud and dishonest acts.

Call the Hotline at 1-888-FRAUD89

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/EOC 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 level where you will pay a low coinsurance or copayment for your covered drugs after you or other qualified parties on your behalf have spent \$4,550 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 you pay when you receive your covered drugs.

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

Cost Sharing—Cost sharing refers to amounts that a participant has to pay when drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a Plan may impose before drugs are covered; (2) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a drug, or (3) any fixed “copayment” amounts you may pay if you receive Extra Help from Medicare.

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 benefit level 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 costs (TrOOP) for the year total \$4,550.

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 cover of this booklet or the Introduction for information about how to contact Customer Care.

Deductible—The amount of money you must first pay each year before the Plan pays any part of the cost for covered drugs.

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.

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—A Medicare program to help people with limited income and resources pay Medicare prescription drug costs, such as premiums, deductibles, and coinsurance.

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 benefit level after you meet the annual deductible (if you have one) and before your total drug expenses have reached the initial coverage limit (\$2,830 in 2010 for the Basic 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 2010 initial coverage limit for the Basic Plan is \$2,830.

Late Enrollment Penalty—An amount added to your monthly premium for Medicare prescription drug coverage if you go without credible prescription drug coverage (coverage that

expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more from 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 a Medicare drug plan.

List of Covered Drugs (Formulary or “Drug List”)—A list of covered drugs provided by the Plan. The drugs on this list are selected by the Plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy—A Medicare program to help people with limited income and resources pay Medicare prescription drug costs, such as premiums, deductibles, and coinsurance. Also called Extra Help.

Medically Necessary—Drugs that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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—Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plans in the same service area. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan—Cost Plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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” (Medicare Supplement Insurance) 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. (A Medicare Advantage plan is not a Medigap policy.)

Membership in our Plan or Member of our Plan—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).

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 offered by the government and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the Part A and/or Part B 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/EOC, 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 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 Improvement Organization (QIO)—Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare providers. See the Introduction for information about how to contact the QIO in your state and Section 7 for information about making complaints to the QIO.

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 the United States and its territories and is 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.

Summary Plan Description and Evidence of Coverage (SPD/EOC) 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.

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 2010 is \$4,550. 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.

For more information, please visit our web site at
<http://nreca.medicareplanrx.com>

Call 1-866-586-7322,
Monday-Saturday, 6:30 a.m. to 11:00 p.m. Central Time,
TTY users call 1-866-236-1069.

NRECA Medicare Part D Plan
c/o CVS Caremark Part D Services, LLC
PO Box 280200
Nashville, TN 37228