

## **Frequently Asked Questions**

### **What are the BIN and PCN numbers for 2012?**

Our BIN number for processing pharmacy claims is 012320. The PCN is MEDDADV.

### **Will I need a referral to go to a specialist?**

Windsor Medicare Extra network does not require a referral to see a network specialist however, some specialists may require you to get a referral form from your PCP before you make an appointment.

### **Will I be able to use more than one Medicare Advantage or Medicare Prescription Drug Plan?**

Generally, no. You are only able to join, and get coverage under, one Medicare Advantage (MA) or Medicare Prescription Drug Plan (PDP) at a time.

Individuals enrolled in an MA plan may not, at the same time, enroll in a PDP, except for individuals enrolled in a Medicare Medical Savings Account plan or individuals enrolled in a Private Fee-for-Service (PFFS) plan that does not offer Medicare prescription drug coverage.

### **When and how often can I switch my Medicare Advantage or Medicare Prescription Drug Plan?**

Generally if you join a Medicare Advantage or Medicare Prescription Drug Plan, you can only change plans under certain circumstances. You can choose to switch your current plan from October 15 through December 7 each year during the Medicare Advantage plan annual enrollment period. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Enrollment is generally for the calendar year. In certain cases, if you move or enter a nursing home, for example, you can switch your plan at other times. You may also have one enrollment election if you qualify medically for a Chronic Special Needs Plan.

If you have both Medicare and Medicaid, you can change plans at any time.

### **How do I pay for my coverage? Can it be deducted from my Social Security or my retirement check?**

In general, there are four ways to pay Medicare prescription drug plan premiums:

- Give us permission to deduct the premium automatically from a bank account or charge your credit card
- Have the premium deducted every month from Social Security Benefits, similar to premiums for Medicare Part B
- Pay us directly by mailing a check or money order each month
- If you are a Railroad Retirement Board retiree, you can choose to pay your plan premium by automatic deduction from your benefit check each month.

### **What does the term “extra help” mean when you are talking about Medicare prescription drug coverage?**

If you have Medicare and have limited income and resources, you may qualify for special financial assistance to help you pay for your Medicare prescription drug plan, or Medicare Advantage plan with prescription drug, costs. Medicare prescription drug coverage and Medicare Advantage plans with prescription drug coverage are available to everyone with Medicare, regardless of your income and resources, health status, or current prescription expenses. There is “extra help” (also called a “low-income subsidy”) available to assist Medicare enrollees who have limited income and resources pay for prescription drug coverage. The amount of extra help will be based on your income and resources.

If you qualify, Medicare could pay for 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and co-insurance. Persons eligible for Medicaid, Supplemental Security Income (SSI), or a Medicare Saving Program qualify for the extra help automatically and do not need to apply. For more information about this extra help, contact your local Social Security office, or call Social Security at [1-800-772-1213. TTY users should call 1-800-325-0778]. You can also apply for extra help online at <http://www.socialsecurity.gov/prescriptionhelp>.

### **If I am not certain whether or not I qualify, should I apply for extra help paying for my prescription drug coverage?**

Yes, because there is no risk or cost to apply. And, if you qualify, you will receive extra help paying for the annual deductible, premiums, and co-payments for Medicare prescription drug coverage.

### **What information do I need to apply for the extra help?**

If you are not getting the extra help automatically, it is easy to apply. Here’s how: Get an application or apply over the phone by calling Social Security at 1-800-772-1213 (TTY 1-800-

325-0778), or apply online at <http://www.socialsecurity.gov/prescriptionhelp>. In order to complete the application, you will need your Social Security number and financial information for you and your spouse (if married and living together). That financial information includes information about deposits in bank accounts, income from pensions, investments or annuities, and face value of life insurance policies. However, you should apply even if you think you don't have all of this information. After you apply, Social Security will review your application and send you a letter to let you know if you qualify for the extra help. You will need to enroll in a Medicare-approved prescription drug plan to get this extra help.

### **What is the difference between PDP and MAPD?**

**MAPD:** Medicare Advantage Prescription Drug Plans are health plan options that are part of the Medicare program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage can include prescription drug coverage. Medicare Advantage Plans include:

- Medicare Health Maintenance Organization (HMO)
- Preferred Provider Organizations (PPO)
- Private Fee-for-Service Plans (PFFS)
- Medicare Special Needs Plans (SNP)

When you join a Medicare Advantage Plan, you use the health insurance card that you get from the plan for your health care. In most of these plans, generally there are extra benefits and lower co-payments than in the Original Medicare Plan. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services. To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay your monthly Medicare Part B premium to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer. If you join a Medicare Advantage Plan, your Medigap policy won't work. This means it won't pay any deductibles, co-payments, or other cost-sharing under your Medicare Health Plan. Therefore, you may want to drop your Medigap policy if you join a Medicare Advantage Plan. However, you have a legal right to keep the Medigap policy.

**PDP:** These stand-alone plans add prescription drug coverage to the Original Medicare Plan. If you wish to receive the Medicare prescription drug benefit but do not want to enroll in a Medicare Advantage plan, you may want to consider a stand-alone Part D Prescription Drug Plan. The plan is called "stand-alone" because it is not attached to a Medicare Advantage plan. It

simply provides name brand and generic prescription drug coverage, with none of the extra healthcare benefits of Medicare Advantage plans.

### **What do I do if I have a medical emergency?**

Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do not need to get permission first from your Primary Provider or other plan provider. Make sure your Primary Provider knows about your emergency, because he or she will need to be involved in following up on your emergency care. You or someone else should call to tell your Primary Provider about your emergency care as soon as possible, preferably within 48 hours.

### **Do I get an EOB (Explanation of Benefits) for pharmacy claims?**

Yes! Windsor Medicare Extra is required to provide a monthly Explanation of Benefits (EOB) notice to each member that obtains Part D prescription drugs. The notice is to be sent at the beginning of the month following the month in which prescription drugs are obtained.

### **What is an EOB (Explanation of Benefits) for pharmacy claims?**

The EOB gives you details about each drug you purchase, helps you track your monthly prescriptions expenses and manage your budget. Every EOB statement has helpful definitions, formulary updates and phone numbers to call for help. You will also see the following helpful information, such as summaries of your prescription drug usage and coverage stages.

- Your prescriptions during the past month. Contains details about each drug you've purchased through Windsor Medicare Extra during the previous month. The monthly drug summary shows what you paid for your prescription drugs during the month, what Windsor Medicare Extra paid for your prescription drugs during the month and what others paid on your behalf for your prescription drugs.
- Your “out-of-pocket costs” and “total drug costs” (amounts and definitions). Lets you track your monthly and year-to-date prescription drug costs, including your True Out-of-Pocket (TrOOP) amount.
- Your drug payment stage. This allows you to track easily which payment stage you're in. You'll also be able to track the total drug costs (TrOOP costs) that remain before you move to the next payment stage. Every plan starts over at Stage 1 on January 1 of each year.

The EOB notice may also include information about any changes to the formulary that will occur at least 60 days in the future. It is very important to review your EOB statements for accuracy to confirm you received all drugs listed.

## **Who qualifies for the Part D benefit?**

Anyone currently enrolled in Medicare is eligible for Medicare Part D.

## **What are Medicare Parts A, B, C, and D?**

Medicare Part A typically pays for your inpatient hospital expenses.

Medicare Part B typically covers your outpatient healthcare expenses, including doctor fees.

Medicare Part C, also known as Medicare Advantage (formerly Medicare+Choice), offers a choice of options including Medicare-managed care plans (like Medicare HMOs and PPOs) and Medicare private fee-for-service plans.

Medicare Part D is the outpatient prescription drug benefit resulting from the Medicare Modernization Act of 2003 that went into effect on January 1, 2006.

## **How much will Medicare prescription drug coverage cost?**

Medicare prescription drug coverage premiums will vary based on your geographic region and the plan that you choose.

## **What is creditable coverage?**

Beneficiaries who have other sources of current drug coverage – through a current or former employer or union, for example – may stay in that plan and choose not to enroll in the Medicare prescription drug plan. If their other coverage is at least as good as the new Medicare drug benefit (and therefore considered “creditable coverage”), then the beneficiary can continue to get the high quality care they have now as well as avoid higher payments later if they later sign up for the Medicare drug benefit. Coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the entity’s prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

## **Will I be able to enroll in more than one Medicare prescription drug plan?**

No, you will only be able to join, and get coverage under, one Medicare prescription drug plan at a time.

## **What if I turn age 65? Can I choose to enroll in a Medicare Advantage with prescription drug plan?**

Absolutely! When you turn age 65, you are eligible to enroll in a Medicare Advantage with prescription drug plan.

## **When is my premium due?**

If you have chosen direct bill as your payment method, we will bill you at the end of each month for the next month. Premiums are due and payable by the date listed on your invoice. If you have chosen to have your premium deducted from your bank account or charged to your credit card, the deduction will occur within the first week of each month.

## **What are the four stages of Medicare Part D drug coverage?**

**Stage 1: Deductible** - You must pay this amount first. Most Windsor Extra Plans do not have a deductible, so you will go directly to Stage 2.

**Stage 2: Initial Coverage Stage** - You will pay standard costs (called copays) for your prescription drugs and Windsor Medicare Extra pays the rest of the costs for your drugs. Please reference your Evidence of Coverage to determine what these costs are. You will pay these costs until your total drug costs reach \$2,930. Once your drug costs reach this amount, you will move on to the Coverage Gap Stage.

**Stage 3: Coverage Gap Stage** - You will receive discounts on brand and generic drugs in the coverage gap through the Medicare Coverage Gap Discount Program. These discounts are for plan members who are in the coverage gap and who are not receiving “Extra Help” from Medicare to pay for their prescription drug costs. You will receive a 50 percent discount on your costs for brand name drugs from drug manufacturers that have agreed to pay the discount at any Windsor Medicare Extra network pharmacy. These drugs include preferred or non-preferred brand name and specialty drugs. Additionally, for generic drugs that are not covered through the coverage gap by Windsor Medicare Extra, you will pay 86 percent and Windsor Medicare Extra will pay 14 percent of the cost of the drug. The coverage gap ends when your total out-of-pocket costs reach \$4,700. Once drug costs reach this amount, you move to the last stage.

**Stage 4: Catastrophic Coverage Stage** - You pay reduced copays for your prescription drugs. You will pay whichever is greater 5 percent of the total cost of your drugs, OR \$2.60 for generic drugs and \$6.50 for brand-name drugs. Windsor Medicare Extra pays the rest of your drug costs. The prescription drug cycle starts over again on January 1 of every year.

## **How do I know if I am in the coverage gap?**

You receive an EOB every month and the EOB will show how much money you have spent and how much the plan has spent with the combined total and balance left before the coverage gap.

## **What is a “coverage determination”?**

The following are the utilization management tools requiring coverage determination to be requested that are currently utilized by Windsor Pharmacy Department:

- Prior Authorization
- Quantity Limits Exceptions
- Step Therapy Exceptions
- Non-formulary Exceptions
- Tiering Exceptions

## **What is a Prior Authorization?**

Prior authorization is required for coverage of the medication before the beneficiary goes to the pharmacy. This applies to certain drugs which the Windsor Pharmacy & Therapeutics Committee decides can be used only in specific circumstances.

What is an Exception? There are four different types of Exceptions: Quantity Limit Exceptions, Step Therapy Exceptions, Non-formulary Exceptions and Tiering Exceptions.

- Quantity Limit Exceptions are established to promote safe, appropriate, and cost-effective use of specific classes of medications. All Quantity Limits will be listed on the formulary as an established number of units per 30 days. The system will count all units received within the therapeutic class and will only allow payment of the quantity established. The process used to establish the limit of the identified drug is the current approved U.S. Food and Drug Administration (FDA) dosing. Prescribers may request an exception to our Quantity Limits by completing a Part D Coverage Determination Form.
- Step Therapy is established through utilization review or the Windsor Pharmacy & Therapeutics Committee recommendations. When step therapies are established, they are coded in the pharmacy claims processing system. The code mandates a certain drug within a therapeutic class be tried before obtaining a different drug within the same class.
- A Non-formulary Exception should be requested to obtain a Part D drug that is not included on a plan sponsor’s formulary. For formulary exceptions, the physician’s supporting statement must indicate that the non-formulary drug is necessary for treating an enrollee’s condition because all covered Part D drugs on any tier would not be as

effective or would have adverse effects, the number of doses under a dose restriction has been or is likely to be ineffective, or the alternative listed on the formulary or required to be used in accordance with step therapy has been or is likely to be ineffective.

- A Tiering Exception should be requested to obtain a non-preferred drug at the cost-sharing terms applicable to drugs in the preferred tier. For tiering exceptions, the physician's supporting statement must indicate that the preferred drug would not be as effective as the requested drug for treating the enrollee's condition; the preferred drug would have adverse effects for the enrollee, or both.

### **How do I request an Exception?**

You should contact us to ask us for an initial coverage decision for a formulary, tiering or utilization restriction exception. When you are requesting a formulary, tiering or utilization restriction exception you should submit a statement from your physician supporting your request. Generally, we must make our decision within 72 hours of getting your prescribing physician's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

### **What is an Expedited Request?**

An expedited request means that you or your physician feels that waiting for a standard decision could seriously harm your health or your ability to function.

### **How will I be notified of the decision when requesting a Prior Authorization?**

You will receive the determination in the mail. We will also fax a copy to your physician.

### **What if the drug I need requires "prior authorization"?**

If the pharmacist tells you that the drug requires prior authorization (PA), you should contact Windsor Medicare Extra to find out about the PA requirement. Then ask your doctor if you meet this requirement.

Windsor Medicare Extra has a PA form that your doctor can complete and submit to the plan. Since a request for PA is a coverage determination request, when you or your doctor submit evidence to Windsor Medicare Extra to show that you meet the PA requirement, we must notify you of our decision no later than 72 hours from the time it is received or 24 hours from the time we received your request if your case is "expedited." If Windsor Medicare Extra decides you don't meet the PA requirement, you can appeal.

In some cases, your doctor may think you wouldn't meet the PA requirement but still need the drug. In those cases, you can ask Windsor Medicare Extra for an "exception" not to apply the PA requirement. Again, you would have the right to appeal if we deny this request.

Whenever you ask for any type of exception, your doctor will need to provide a statement to Windsor Medicare Extra to support this request. You should contact Windsor to find out what information we need. If Windsor approves your exception request, it's good for at least the remainder of the plan year, with the condition that you remain enrolled in the plan, that your doctor continues prescribing the drug, and that the drug continues to be safe and effective for treating your illness or condition.

### **The pharmacy could not fill my prescription; what do I need to do?**

First, try to find out from your pharmacist why the prescription couldn't be filled. The pharmacist may be able to give you this information and may be able to give you or recommend another drug you can use, such as a generic version. If you disagree with the information provided by the pharmacist, the pharmacist will provide you with a notice about your right to contact your plan to find out why the drug isn't covered, and your right to request an "exception". You can also review your plan materials or visit the plan's website for information about how to request an exception. Once you know why your prescription can't be filled, you should contact your doctor and give her/him this information. Then, you will need to work with your doctor to either:

- Find another drug that is covered by the plan
- Provide additional information to the plan so that you can get your prescription filled
- Request an exception

### **When can I refill a prescription?**

Network pharmacies cannot dispense refill medications to beneficiaries until the beneficiary has used at least 75percent of the original supply (70% for Ophthalmics). This edit is in place to eliminate stock-piling, sharing medications and to alert pharmacists to a potential compliance issue.

### **What if my doctor has changed the dosage on my medication?**

If the dose has increased, the pharmacist can obtain an early refill override from the pharmacy claims processor.

### **What if my medication was lost/stolen?**

If the medication was lost or stolen, you will be responsible for 100percent of the drug cost.

### **What is a formulary?**

A formulary is a list of specific drugs a Medicare prescription drug plan will cover. Medicare plans must cover all types of drugs required by Medicare, but within each type it can limit which specific drugs it will cover. It may also charge different cost-sharing amounts for different drugs within a type of drug.

### **Can the formulary change throughout the year? Will I be notified? What if the medication I am taking is removed?**

Generally, if you are taking a drug on our formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the coverage year except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost-sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or improve the safety of your drugs.

If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the U.S. Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

### **My drug plan covers generic drugs. Are they as good as brand-name drugs?**

Yes. Today, almost half of all prescriptions in the United States are filled with generic drugs. The U.S. Food and Drug Administration ensures that a generic drug is the same as a brand-name drug in dosage, safety, strength, quality, the way it works, the way it is taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs and work the same way. This means they have the same risks and benefits as the brand-name drugs. Creating a drug costs a lot of money. Since generic drug makers don't develop a drug from scratch, the costs to bring the drug to market are less. But they must show that their product performs in the same way as the brand-name drug.

## **What do I do before I can talk to my doctor about changing my drugs or requesting an exception?**

As a new or continuing member in our plan you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take.

While you talk to your doctor to determine the right course of action for you, we will cover your eligible Part D drug in certain cases during the first 90 days you are a member of our plan. For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover through our transition process up to a 30day supply (unless you have a prescription written for fewer days) during your first 90 days of coverage when you go to a retail network pharmacy. For Long Term Care, we will cover up to a 98-day supply during the first 90 days. After each transition fill, we will send you a letter within three business days outlining the steps you need to take in order to keep receiving the prescription. Your physician will also receive a copy of the notice.

## **Are there certain pharmacies I can go to?**

Yes, you must go to a “network pharmacy.” A network pharmacy is a pharmacy where beneficiaries obtain prescription drug benefits provided by Windsor. There are more than 64,000 pharmacies across the country that are part of the Windsor network. In most cases, your prescriptions are covered under Windsor only if they are filled at a network pharmacy or through our mail order pharmacy service. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription, you can go to any of our network pharmacies. We will fill prescriptions at non-network pharmacies under certain circumstances.

## **How do I find a network pharmacy in my area?**

To find a pharmacy near you in the pharmacy directory, you should first locate the type of pharmacy you need. The three types of pharmacies include retail, mail order and long term care. The directory is then arranged in alphabetical order by county, then by city, and finally then by zip code. We have also indicated if the pharmacy is open 24 hours a day and if the pharmacy will accept 90-day supply maintenance prescriptions. Or, you can call our Customer Service department.

### **How do I fill a prescription at a network pharmacy?**

To fill your prescription at a network pharmacy, you must show your Windsor Medicare Extra Member ID card. 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 co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To find out how to submit a claim, look in your Evidence of Coverage or call our Customer Service department.

### **How do I fill a prescription through a mail-order pharmacy?**

To get order forms and information about filling your prescriptions by mail, call CVS/Caremark at 1-800-262-9129. Please note that you must use the Windsor Medicare Extra mail-order service. Prescription drugs that you get through any other mail-order service are not covered. You can use the mail-order service to fill prescriptions for what we call “maintenance drugs”. These are drugs that you take on a regular basis, for a chronic or long-term medical condition. The formulary list tells you which drugs we consider to be maintenance drugs. These are the only drugs available through our mail-order service. When you order prescription drugs by mail, you must order at least a 60-day supply, and no more than a 90-day supply of the drug. You are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Instead, you have the option of using a retail pharmacy in our network to obtain a supply of maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medications for up to 90 days per dispensing, which may result in no out-of-pocket payment difference to you. Please look in the Evidence of Coverage or call our Customer Service department for more information. Mail-order maintenance prescriptions will be shipped within three business days after receipt of the prescription by the mail-order pharmacy, unless there is additional information or requirements needed to fill your prescriptions. Generally, if there is a delay filling your prescription it should be resolved and shipped to you within five business days. If a mail-order prescription is delayed due to a stock issue, the mail-order pharmacy will immediately advise you of the shortage and contact a local pharmacy to fill the prescription.

### **What if I cannot fill my prescription at a network pharmacy?**

Generally, we only cover 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 we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call our Customer Service department to see if there is a network pharmacy in your 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 co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. However, even after we reimburse you for our share of the cost, you may pay more for a drug purchased at an out-of-network pharmacy because the out-of-network pharmacy's price is higher than what a network pharmacy would have charged. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay, consistent with the circumstances listed above, will help you qualify for catastrophic coverage.

Getting coverage when you travel or are outside of your Windsor's Service Area: In the United States, Windsor Health Plan has over 64,000 pharmacies in the network. All major chains (Walmart, Walgreens, Kroger, CVS, etc.) and most independent pharmacies are in our network. Please remember that if you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. If needed, we may issue a vacation supply override as long as the drug is a maintenance medication. Regardless of where you are traveling, you may always call our Customer Service department (number is on the back of your Windsor ID Card) to locate a network pharmacy in the area you are traveling.

- Other times you can get your prescription covered if you go to an out-of-network Pharmacy: We will cover your prescriptions at an out-of-network pharmacy if at least one of the following applies: If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. If you are trying to fill a prescription drug that is not regularly stocked at accessible network retail or mail-order pharmacies (including high cost and unique drugs). If you are getting a Medicare Part D vaccine that is medically necessary.

### **What diabetic meters and testing supplies are covered under my plan?**

We cover the ACCU-CHEK products (ACCU-CHEK Aviva, ACCU-CHEK Compact Plus) at no charge to you. All other brands will require a prior authorization and if approved, will be covered at your Part B diabetic supply coinsurance.

Not only is the ACCU-CHEK meter covered at no cost, it is supported by the ACCU-CHEK Customer Care Service Center, which is available 24 hours a day to serve your needs. That includes a toll-free number, Web site and customized e-mails on topics of interest to you, if you choose. You also have access to important diabetes information, news, troubleshooting tips and answers to questions, as well as complete instructions on using your new meter at [www.accu-chek.com](http://www.accu-chek.com) or through calling 1-888-355-4242.

## **What if I am out of the country? Will you cover my prescription if filled outside the US?**

No, we cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

## **How do I submit a paper claim?**

When you go to a network pharmacy, your claim is automatically 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. When you return home, simply submit your claim and your receipt to the following address:

Windsor Medicare Extra  
Attention: Pharmacy Claims  
7100 Commerce Way, Ste. 285  
Brentwood, TN 37027

Upon receipt, we will make an initial coverage determination on the claim. Please refer to your Evidence of Coverage or call Customer Service.

Toll Free: 1-800-316-2273  
TTY/TDD (for hearing impaired): 711  
24 hours a day, seven days a week

## **What is a coinsurance?**

The sharing of charges by Windsor and you for covered services received by you, usually stated as a percentage of the allowed amount.

## **What is a co-payment?**

The fixed-dollar amount that is due and payable by you at the time a covered service is provided.

## **What is a deductible?**

The specific dollar amount that you must pay before benefits are payable for the remaining covered services. The deductible does not include co-payments, coinsurance, charges in excess of the allowed amount, amounts exceeding any maximum and expenses for non-covered services.

## **Does Windsor Medicare Extra provide coverage for HIV screenings?**

All Windsor Medicare Extra members are eligible to receive, at no cost, HIV rapid screening tests.

Windsor Medicare Extra covers:

1. Annual voluntary HIV screening for members at increased risk for HIV infection, including:

- Men and women having unprotected sex with multiple partners
- Persons being treated for sexually transmitted diseases
- Past or present injection drug users
- Men who have had sex with men after 1975
- Men and women who exchange sex for money or drugs, or have sex partners who do
- Individuals whose past or present sex partners were HIV-infected, bisexual or injection drug users
- Persons with a history of blood transfusion between 1978 and 1985
- Persons who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.

2. Voluntary HIV screening of pregnant Windsor members when the diagnosis of pregnancy is known, during the third trimester, and at labor.

If you fall into either category, please contact your physician immediately and start your HIV prevention dialog.



## **About Enrollment**

*Members may enroll in the plan only during specific times of the year. Contact Windsor Medicare Extra for more information.*

*Medicare beneficiaries may enroll in Windsor Medicare Extra plans through the CMS Medicare Online Enrollment Center located at <http://www.medicare.gov>.*

*Members must use network pharmacies to access their prescription drug benefit, except in non-routine circumstances. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2013. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call: 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/ 7 days a week; the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778; or your Medicaid Office.*