

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.

What is the difference between PDP and MAPD?

PDP is a plan with stand-alone Part D prescription drug coverage. Windsor Rx is a PDP plan that adds prescription drug coverage to your existing medical coverage, like Original Medicare.

MAPD refers to Medicare Advantage health plans that include prescription drug coverage. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. Medicare Advantage plans include:

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

In most cases, Medicare Advantage plans include more benefits and lower co-payments than Original Medicare.

To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You must pay your Medicare Part B premium, in addition to the Medicare Advantage premium if one applies.

More information on [MAPD plans from Windsor Medicare Extra](http://www.windsorextra.com/pdf/cms1696%20Appointment%20of%20Representation%20Form.pdf) can be found online at: <http://www.windsorextra.com/pdf/cms1696%20Appointment%20of%20Representation%20Form.pdf>.

How much will Medicare prescription drug coverage cost?

Windsor Rx prescription drug plan premiums vary based on geographic regions. In addition to premiums, members need to take into consideration deductibles, copayments and coinsurances when determining costs of a prescription drug plan.

Deductible is a fixed amount that you must pay completely before plan benefits start.

Copayment is a fixed dollar amount paid by you at the time a prescription is filled.

Coinsurance is a fixed percentage of the cost for certain services paid by you at the time a prescription is filled.

How do I pay for my coverage?

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

- Give us permission to deduct the premium automatically from a bank account
- 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

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

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

What is creditable coverage?

Creditable coverage is defined as prescription drug coverage you've had in the past that is greater than or equal to standards set by Medicare. Having creditable coverage provides you certain rights when you apply for new coverage.

For example, this could be prescription drug coverage that was provided through a former employer, union, Veterans Administration (VA), or a state sponsored plan. Organizations providing prescription coverage are required to notify their Medicare eligible members of whether their coverage is creditable or not on an annual basis and at other times as specified by CMS.

What is the penalty for late enrollment into Part D?

You may owe a late enrollment penalty if:

- You didn't join a Part D prescription drug plan when you were first eligible for Medicare Part D (and you didn't have creditable coverage).
- You didn't have Part D prescription drug coverage or other creditable prescription drug coverage for more than 63 days in a row.

Note: Beneficiaries receiving Extra Help do not pay a late enrollment penalty.

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

Medicare prescription drug coverage is available to everyone with Medicare, regardless of your income and resources, health status, or current prescription expenses. There is also "extra help" (also called a “low-income subsidy”) to help people with Medicare who have limited income and resources pay for Medicare prescription drug coverage. If you qualify for extra help, you will get help paying for your Medicare drug plan's monthly premium, and for some of the costs you would normally pay for your prescriptions. The amount of extra help you get will be based on your income and resources.

For more information about Extra Help, contact your local Social Security office. 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?

Yes, because there is no risk or cost to apply. And, if you qualify, you will get 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?

You will need your Social Security number and financial information for you and your spouse (if married and living together), including information on deposits in bank accounts, income from pensions, investments or annuities, and face value of life insurance policies to complete the application. However, you should apply even if you think you don't have all of this information.

What is a formulary?

A formulary is a list of specific drugs a Medicare 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.

How do I use the formulary?

The formulary is initially arranged by Therapeutic Categories which include pharmacological class and drugs within the class. There is also an alphabetical drug index at the end of the formulary listing the generic and brand name with the page number location. There are two ways to find your drug within the formulary:

Medical Condition: The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular Agents”. If you know what your drug is used for, look for the category name in the list. Then look under the category name for your drug.

Alphabetical Listing: If you are not sure what category to look under, you should look for your drug in the Index. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

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.

How and when will I be notified of negative changes to the formulary?

You will be notified of all negative formulary changes 60 days prior to the change. You will receive a letter notifying you of any negative changes to the formulary.

Are there any drugs that are not covered?

Yes, there are certain medications that Medicare has determined will not be covered. They are as follows:

- Agents when used for anorexia, weight loss, or weight gain (i.e. Xenical)
- Agents when used to promote fertility (i.e. Clomid, Lupron)
- Agents when used for cosmetic purposes or hair growth (i.e. Retin-A, Avita)
- Agents when used for the symptomatic relief of cough and colds (i.e. Dimetapp)
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Nonprescription drugs - Over-the-Counter Drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.
- Barbiturates (i.e. Phenobarbital)

- Benzodiazepines (i.e. Valium, Xanax, Ativan)
- Erectile Dysfunction Drugs (i.e. Viagra, Cialis, Levitra)

What if I need a drug that isn't on the formulary or is covered at a higher cost?

You should ask your doctor if you can switch to a drug that is on the formulary. If your doctor thinks that you need the drug that is not on the formulary, you or your doctor will have to ask for an exception from the plan. Your doctor will have to send the plan information about why you need that particular drug and then the plan will decide to cover it for you or not. If the plan decides that it will not cover it, you can appeal the decision to try to get the plan to cover that drug for you.

My drug plan covers generic drugs. Are they as good as brandname 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 are the four stages of Medicare Part D drug coverage?

Stage 1: Deductible - You must pay this amount first. After you pay this amount, 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 Rx 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 Rx network pharmacy. These drugs include preferred or non-preferred brand name and specialty drugs. Additionally, for generic drugs that are not cover through the coverage gap by Windsor Rx, you will pay 86 percent and Windsor Rx 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 \$2.50 for generic drugs and \$6.50 for brand name drugs. Windsor Rx 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 an EOB (Explanation of Benefits) for pharmacy claims?

The EOB gives you details about your prescription history and each drug you purchase. It helps you track your monthly expenses and manage your budget. You will see summaries of your prescription drug usage, where you are in the coverage stages, with details like:

Your prescriptions filled

Contains details about each drug you've filled the previous month. The monthly summary shows:

- What you paid for your prescription drugs
- What Windsor Rx paid for your prescription drugs
- What others may have paid on your behalf for your prescription drugs

Your out-of-pocket costs and total drug costs

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 easily track which payment stage you are in. You'll also be able to track the total drug costs and TrOOP costs that remain before you move to the next payment stage. Your EOB 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.

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

Yes! Windsor Rx is required to provide a monthly EOB notice to each member that fills Part D prescription drugs. The notice is sent at the beginning of the month following the month in which prescription drugs are filled.

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 can not dispense refill medications to beneficiaries until the beneficiary has used at least 75% of the original supply (70% for Ophthalmics). This edit is in place to eliminate stock-piling, sharing medications and to alert pharmacist 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 100 percent of the drug cost.

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 Health Plans. 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 various types of pharmacies including retail, longterm care, Home Infusion, ITU and mail order. 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, if the pharmacy will accept 90day supply maintenance prescriptions or if the pharmacy accepts e-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 Rx 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.

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 Rx's Service Area: In the United States, Windsor Rx has over 64,000 pharmacies in the network. All major chains (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. Additionally you will be able to order your prescription drugs ahead of time through our mail order pharmacy service by calling 800-264-1587 (24/7). Regardless of where you are traveling, you may always call our Customer Service Department (number is on the back of your Windsor Rx 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 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 Rx
Attn: 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 “coverage determination”?

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

- Prior Authorization (3 types)
 - Prior Authorization (whether New Start or not)
 - Prior Authorization for New Starts
 - Prior Authorization Part B versus Part D
- Exception (5 types)
 - Quantity Limit Exception
 - Step Therapy Exception

- Non-formulary Exception
- Tiering Exception
- Prior Authorization Exception

What is a Prior Authorization?

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

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.

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 will send you a letter within three business days outlining the steps you need to take in order to keep receiving the prescription. We will also send a notice to your doctor.

How does my physician submit a coverage determination request?

You or your physician should submit a Coverage Determination Request Form. If a Coverage Determination Form is not available, all information may be given orally. This form is located on the website or you can request one having your physician call the Pharmacy Department.

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. We must give you a decision no later than 24 hours after we get your prescribing physician's supporting statement.

How long does a coverage determination take to complete?

There are two types of coverage determination requests: Standard and Expedited. There are specific time frames for each type of request.

For Standard Requests, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request/supporting statement.

For Expedited Requests, as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receipt of the request/supporting statement.

How will I be notified of the decision?

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

About Enrollment

Members may enroll in the plan only during specific times of the year. Contact Windsor Rx 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 co-payments/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.