



Important Information About Your Part D Appeal and Grievance Rights

What Is A Grievance?

Medicare defines a grievance as: any complaint or dispute, other than one that involves a coverage determination or an LIS or LEP determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Part D plan sponsor, regardless of whether remedial action is requested. A grievance may also include a complaint that a Part D plan sponsor refused to expedite a coverage determination or redetermination. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided item.

Filing A Grievance With Our Plan

If you have a complaint, you or your representative may call Customer Service at the phone number listed at the end of this document. You may also send us your complaint in writing. We call this our grievance procedure. As an enrollee of Windsor Medicare Extra, WindsorSterling or Windsor Rx (also referred to as "Plan") if your complaint is received by telephone, Windsor Health Plan, Inc., will address and resolve your complaint by telephone, especially if your complaint involves a possible misunderstanding or misinformation. If you request a written response to your phone complaint, or if your complaint is regarding a Quality of Care issue, we will respond in writing to you. If we receive your complaint in writing we will respond in writing. The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension or if we justify a need for additional information and the delay is in your best interest.

If you choose to submit your complaint in writing, send it to:

Windsor Health Plan, Inc.
Attn: Appeals & Grievance Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

Coverage Determinations and Part D Appeals

This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

7100 Commerce Way, Suite 285 • Brentwood, TN 37027
1-800-316-2273 • TTY 711 • www.windsorhealthplan.com

A Coverage Determination

A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan at the numbers below to ask for a formal decision about coverage if you disagree. Please note, it is very helpful to have your physician or other prescriber help you with this process. Medicare Prescription Drug Determination Request form for enrollees and providers, and other useful forms can be found on the Centers for Medicare & Medicaid Services' website here: http://www.cms.gov/medPrescriptDrugApplGriev/13_Forms.asp

Coverage Decisions for Part D Prescription Drugs

Call: **Windsor Medicare Extra**
1-800-316-2273, 24 hours a day, seven days a week (TTY: 711)

WindsorSterling
1-888-858-8551, 24 hours a day, seven days a week (TTY: 711)

Windsor Rx
1-800-264-1587, 24 hours a day, seven days a week (TTY: 711)

FAX: 1-615-782-7869

WRITE: Windsor Health Plan, Inc.
Attn: Pharmacy Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

What If I Don't Agree With A Decision?

If we make a coverage determination and you are not satisfied with the decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. When you make an appeal we review the coverage decision we have made to check to see if we were being fair and following all the rules properly. When we have completed the review we give you our decision.

How Do I File An Appeal?

You or your authorized representative should mail or deliver your written and signed appeal to:

Windsor Health Plan, Inc.
Attn: Appeals & Grievance Department
7100 Commerce Way, Suite 285
Brentwood TN 37037

FAX: 1-615-782-7971

We must give you a decision no later than 7 calendar days after we receive your appeal.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, signature, reasons for appealing, and details such as date(s) of service and provider names or claim/reference numbers, any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should pay for the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

Who May File An Appeal?

You or someone you name to act for you (your authorized representative) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you. You can visit: <http://www.cms.gov/cmsforms/downloads/cms1696.pdf> to learn how to name your authorized representative or call Customer Service at the phone number listed at the end of this document. If you want someone to act for you, you and your authorized representative must sign, date and send us a statement naming that person to act for you.

What Happens Next?

When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information. If your health requires a quick response, you may ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought. If we are using the fast appeal, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.

If we are using the standard appeal, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. After we review our decision, if payment for any of your claims is still denied, you will receive instructions on how to send a request to Medicare's Independent Review Entity to provide you with a new and impartial review of your case by a reviewer outside of the Plan. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

If you have any questions or concerns about the appeal and grievance processes, or wish to inquire on the status of your appeal or grievance, please call Customer Service at the number below for assistance. You may also contact Customer Service to obtain an aggregate (total) number of grievances, appeals, and exceptions filed with the plan.

Calls to these numbers are free:

Windsor Medicare Extra

1-800-316-2273, TTY: 711

24 hours a day, seven days a week

WindsorSterling

1-888-858-8551, TTY: 711

24 hours a day, seven days a week

Windsor Rx

1-800-264-1587, TTY: 711

24 hours a day, seven days a week

A Medicare Advantage organization with a Medicare contract
and a Medicare-approved Part D sponsor.