

Appeals and Grievances

What to do if you have a complaint

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage.

Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this plan or be penalized in any way if you make a complaint.

A complaint will be handled as a grievance or an appeal, depending on the subject of the complaint.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. If we issue an unfavorable coverage determination, you may file an appeal called a “redetermination” if you want us to reconsider and change our decision.

Examples of coverage determinations you may wish to appeal:

- Plan’s decision not to cover a Part D drug, vaccine, or other Part D benefit.
- Plan’s decision not to reimburse you for a Part D drug that you paid for, if you think we should have reimbursed you 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.
- Plan’s decision to deny your exceptions request.

There are five levels to the appeals process. The first level is a redetermination by the plan. If our redetermination decision is unfavorable, you have additional appeal rights.

How to file an appeal (Also known as “redetermination”)

If you wish to file an appeal with the plan, you must do so within 60 calendar days from the date included on the notice of our coverage determination.

You cannot request an appeal if we have not issued a coverage determination.

For a standard request, you or your appointed representative may file the request in writing. We will respond to your standard appeal no later than 7 calendar days after we receive your appeal.

You may fax, mail, or deliver your written appeal to us at:

Call: 1-800-264-1587, TTY/TDD: 1-800-595-8856, 8 a.m. - 8 p.m., Seven Days A Week. FAX: 1-615-782-7971. WRITE: Windsor Rx, 7100 Commerce Way, Suite 285, Brentwood, TN 37027.

1-800-264-1587, TTY: 711, 8 a.m. - 8 p.m., Seven Days A Week; www.windsorhealthplan.com

Windsor RX® PDP is a product of Windsor Health Plan, Inc., a Medicare Advantage Organization with a Medicare contract and a Medicare-approved Part D sponsor. Individuals must have both Part A and Part B to enroll. You must continue to pay your Medicare Part B premium.

For your convenience, you may use the “Appeals and Grievance” form to file an appeal with us. Print the [Appeals and Grievances Form](#). Simply complete, sign, and date the form. You may fax, mail, or deliver the form to us as listed above. Please include any supporting documents you wish for us to consider when we process your appeal.

What if you want a fast appeal?

A fast appeal (also known as an expedited appeal) may be filed by you, your appointed representative, or your prescribing doctor by calling Member Services 7 days a week, from 7 am to 8 pm Central Time at the numbers below. Remember, appeals must be filed within 60 calendar days.

Calls to these numbers are free: Call: 1-800-264-1587 TTY/TDD: 711.

Or, you can file a written request for a fast appeal as listed above. We will respond to your fast appeal no later than 72 hours after we receive your fast appeal.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast appeal, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “fast grievance” if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast appeal, we will give you our decision within the 7 calendar day standard timeframe.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug.

Examples of concerns that might lead you to filing a grievance:

- 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.
- Problems with the Member service you receive.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination. (This is known as a “fast” grievance)

What to do if you have a grievance

If you have a grievance, we encourage you to first call Member Services for assistance. You may call Member Services 8 days a week, from 7 am to 8 pm Central Time at the numbers below.

Calls to these numbers are free: Call: 1-800-264-1587, TTY/TDD: 711.

We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this a “formal grievance.”

How to file a formal grievance

If you wish to file a formal grievance with the plan, you must do so within 60 calendar days of the event that led to your complaint.

You or your appointed representative may file a grievance either orally or in writing.

In general, we will respond to your grievance no later than 30 calendar days after we receive your grievance. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

You may fax, mail, or deliver your written grievance to us at:

Call: 1-800-264-1587, TTY/TDD: 1-800-595-8856, 8 a.m. - 8 p.m., Seven Days A Week. FAX: 1-615-782-7971. WRITE: Windsor Rx, 7100 Commerce Way, Suite 285, Brentwood, TN 37027.

For your convenience, you may use the “Appeals and Grievance” form to file a formal grievance with us. Print the [Appeals and Grievances Form](#). Simply complete, sign, and date the form. You may fax, mail, or deliver the form as listed above. Please include any supporting documents you wish for us to consider when we process your formal grievance.

What if I want a fast grievance?

If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination, you or your appointed representative may file a request for a fast grievance (also known as an expedited grievance) by calling Member Services 7 days a week, from 8 a.m. to 8 p.m. at the numbers below. Remember, grievances must be filed within 60 calendar days.

Calls to these numbers are free: Call: 1-800-264-1587 TTY/TDD: 711.

Or, you can file a written request for a fast grievance at the contact information listed above. We will respond to your fast grievance no later than 24 hours after we receive your fast grievance.

How to appoint a representative

You can file an appeal or grievance by yourself or you may name someone to 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. Please note that your prescribing physician does not need to be appointed by you to request a fast appeal.

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.

For your convenience, you may use the “Appointment of Representative” form to appoint a representative. Print the [Appointment of Representation Form](#).

You may also obtain a copy of the "Appointment of Representative" form by visiting Medicare's web site at: <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>.

Simply, complete, sign, and date the form and include it with your appeal and/or grievance request.

You also have the right to have an attorney ask for an appeal 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.

Questions about the appeal and grievance processes or case status

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 Member Services 7 days a week, from 8 a.m. to 8 p.m. at the numbers below for assistance.

Calls to these numbers are free: Call: 1-800-264-1587 TTY/TDD: 711.

Detailed information about appeals and grievances

The information described above is a summary of the appeals and grievance process.

For a more detailed description of these processes, please refer to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter located in your Evidence of Coverage (EOC).

You may access a copy of your Evidence of Coverage at http://windsorhealthplan.com/Providers/Evidence_of_Coverage/2012.

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>.

A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. We have network providers (that is, providers who have signed contracts with our plan) for all services covered under Original Medicare. These providers have already agreed to see members of our plan. If your provider is not one of our network providers, then the provider is not required to agree to accept the plan's terms and conditions, of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment.

Providers can find the plan's terms and conditions of payment on our website at: www.windsorhealthplan.com.

If you choose to utilize services from a provider outside of the network, except for emergency or urgent situations, you are more likely to pay more for your care.

Members must use network pharmacies to access their prescription drug benefit, except in non-routine circumstances. Benefits, formulary, pharmacy network, premium and/or copayments/co-insurance 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.