

 WINDSOR
Medicare*Extra*



Summary of Benefits

Silver Plan (HMO)

H5698 MSUM107 0909
CMS APPROVED 10/2009

Section I

Introduction to Summary of Benefits

Thank you for your interest in Windsor Medicare Extra Silver Plan (HMO). Our plan is offered by Windsor Health Plan, Inc./Windsor Medicare Extra, a Medicare Advantage Health Maintenance Organization (HMO). This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call Windsor Medicare Extra Silver Plan (HMO) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like Windsor Medicare Extra Silver Plan (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call Windsor Medicare Extra Silver Plan (HMO) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare Windsor Medicare Extra Silver Plan (HMO) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

WHERE IS WINDSOR MEDICARE SILVER PLAN (HMO) AVAILABLE?

The service area for this plan includes:

Alabama Counties:

Blount, Jefferson, Mobile, Shelby, St. Clair, Talladega, Walker.

Arkansas Counties:

Arkansas, Ashley, Baxter, Benton, Calhoun, Carroll, Clark, Clay, Cleburne, Cleveland, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Desha, Franklin, Fulton, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Johnson, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Prairie, Pulaski, Randolph, Saline, Searcy, Sebastian, Sharp, St. Francis, Stone, Union, Washington, White, Woodruff, Yell;

Mississippi Counties:

Adams, Attala, Benton, Carroll, Claiborne, Clarke, Coahoma, Copiah, DeSoto, Forrest, Hinds, Kemper, Lafayette, Lamar, Lauderdale, Lawrence, Leake, Lincoln, Lowndes, Madison, Marshall, Newton, Panola, Pike, Prentiss, Rankin, Scott, Simpson, Smith Sunflower, Tate, Tippah, Tunica, Union, Walthall, Warren, Washington, Winston, Yalobusha, Yazoo;

South Carolina Counties:

Fairfield, Greenville, Kershaw, Newberry, Saluda, Spartanburg;

Tennessee Counties:

Anderson, Bedford, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Cheatham, Chester, Claiborne, Cocke, Coffee, Crockett, Davidson, DeKalb, Decatur, Dyer, Fayette, Franklin, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Knox, Lake, Lauderdale, Lawrence, Lewis, Loudon, Macon, Madison, Marshall, Maury, McMinn, McNairy,

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Meigs, Montgomery, Moore, Obion, Overton, Pickett, Polk, Rhea, Roane, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Wayne, Weakley, Williamson;

You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN WINDSOR MEDICARE EXTRA SILVER PLAN (HMO)?

You can join Windsor Medicare Extra Silver Plan (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in Windsor Medicare Extra Silver Plan (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?

Windsor Medicare Extra Silver Plan (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory or for an up-to-date list visit us at www.windsorextra.com.

Our customer service number is listed at the end of this introduction.

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither Windsor Medicare Extra Silver Plan (HMO) nor the Original Medicare Plan will pay for these services.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a

full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of Windsor Medicare Extra Silver Plan (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Alabama: AQAF, 205-970-1600; Arkansas: Arkansas Foundation for Medical Care, 501-375-5700; Mississippi: Information & Quality Healthcare, 601-957-1575; South Carolina: The Carolinas Center for Medical Excellence, 803-251-2215; Tennessee: QSource, 800-528-2655.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

Windsor Medicare Extra Silver Plan (HMO) does cover Medicare Part B prescription drugs. Windsor Medicare Extra Silver Plan (HMO) does NOT cover Medicare Part D prescription drugs.

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WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact Windsor Medicare Extra Silver Plan (HMO) for more details.

Some Antigenes: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

Injectable Drugs: Most injectable drugs administered incident to a physician's service.

Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

Some Oral Cancer Drugs: If the same drug is available in injectable form.

Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

Inhalation and Infusion Drugs provided through DME.

PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select

“Compare Medicare Prescription Drug Plans” or “Compare Health Plans and Medigap Policies in Your Area” to compare the plan ratings for Medicare plans in your area. You can also call us directly at (800)-316-2273 to obtain a copy of the plan ratings for this plan. TTY users call (866)-460-7617.

Please call Windsor Medicare Extra for more information about Windsor Medicare Extra Silver Plan (HMO). Visit us at www.WindsorExtra.com, or call us:

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 7:00 a.m. - 8:00 p.m. Central Time

Current members should call toll-free (800)-316-2273. (TTY/TDD (866)-460-7617)

Prospective members should call toll-free (866)-448-8313. (TTY/TDD (866)-460-7617)

Current members should call locally (615)-782-7878. (TTY/TDD (866)-460-7617)

Prospective members should call locally (866)-448-8313. (TTY/TDD (866)-460-7617)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

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| Benefit | Original Medicare | Windsor Medicare Extra Silver Plan (HMO) |
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| IMPORTANT INFORMATION | | |
| <p>1. Premium and Other Important Information</p> | <p>In 2009 the monthly Part B Premium was \$96.40 and will change for 2010 and the yearly Part B deductible amount was \$135 and will change for 2010.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p> <p>Most people will pay the standard monthly Part B premium. However, starting January 1, 2010, some people will pay a higher premium because of their yearly income. (For 2009, this amount was \$85,000 for singles, \$170,000 for married couples. This amount may change for 2010.) For more information about Part B premiums based on income, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.</p> | <p>General \$0 monthly plan premium in addition to your monthly Medicare Part B premium.</p> <p>Windsor Medicare Extra will reduce your Medicare Part B premium by up to \$55.00.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>All plan services included.</p> |
| <p>2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p> | <p>You may go to any doctor, specialist or hospital that accepts Medicare.</p> | <p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>No referral required for network doctors, specialists, and hospitals.</p> |

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| INPATIENT CARE | | |
| <p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p> | <p>In 2009 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1068 deductible</p> <p>Days 61 - 90: \$267 per day</p> <p>Days 91 - 150: \$534 per lifetime reserve day</p> <p>These amounts will change for 2010.</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>In-Network For hospital stays:</p> <p>Days 1 - 5: \$100 copay per day</p> <p>Days 6 - 60: \$0 copay per day</p> <p>Days 61 - 90: \$100 copay per day</p> <p>\$100 copay for each additional hospital day.</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |
| <p>4. Inpatient Mental Health Care</p> | <p>Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care” above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p> | <p>In-Network In 2009 the amounts for each benefit period were:</p> <p>Days 1 - 60: \$1068 deductible</p> <p>Days 61 - 90: \$267 per day</p> <p>Days 91 - 150: \$534 per lifetime reserve day</p> <p>These amounts will change for 2010.</p> <p>You will not be charged additional cost sharing for professional services. You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> |

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| <p>5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p> | <p>In 2009 the amounts for each benefit period after at least a 3-day covered hospital stay were:</p> <p>Days 1 - 20: \$0 per day</p> <p>Days 21 - 100: \$133.50 per day</p> <p>These amounts will change for 2010.</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF.</p> <p>It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p> | <p>General Authorization rules may apply.</p> <p>In-Network For SNF stays:</p> <p>Days 1 - 20: \$0 copay per day</p> <p>Days 21 - 100: \$100 copay per day</p> <p>Plan covers up to 100 days each benefit period</p> <p>No prior hospital stay is required.</p> |
| <p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p> | <p>\$0 copay.</p> | <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits.</p> |
| <p>7. Hospice</p> | <p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare-certified hospice.</p> | <p>General You must get care from a Medicare-certified hospice.</p> |

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| OUTPATIENT CARE | | |
| 8. Doctor Office Visits | 20% coinsurance | <p>General See “Physical Exams,” for more information.</p> <p>In-Network \$20 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$20 copay for each in-area, network urgent care Medicare-covered visit.</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits.</p> |
| 9. Chiropractic Services | <p>Routine care not covered.</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> | <p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p> |
| 10. Podiatry Services | <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p> | <p>In-Network \$30 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p> |
| 11. Outpatient Mental Health Care | 45% coinsurance for most outpatient mental health services. | <p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for each Medicare-covered individual therapy visit.</p> <p>\$20 copay for each Medicare-covered group therapy visit.</p> |

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| 12. Outpatient Substance Abuse Care | 20% coinsurance | <p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered individual visits. \$20 copay for Medicare-covered group visits.</p> |
| 13. Outpatient Services/ Surgery | 20% coinsurance for the doctor 20% of outpatient facility charges | <p>General Authorization rules may apply.</p> <p>In-Network \$0 to \$300 copay [or 20% of the cost] for each Medicare-covered ambulatory surgical center visit. \$0 to \$300 copay [or 20% of the cost] for each Medicare-covered outpatient hospital facility visit.</p> |
| 14. Ambulance Services (medically necessary ambulance services) | 20% coinsurance | <p>General Authorization rules may apply.</p> <p>In-Network \$50 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p> |
| 15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.) | 20% coinsurance for the doctor 20% of facility charge, or a set copay per emergency room visit You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances. | <p>General \$35 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 24-hour(s) for the same condition, you pay \$0 for the emergency room visit</p> |

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| <p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p> | <p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p> | <p>General \$25 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hour(s) for the same condition, \$0 for the urgent-care visit.</p> |
| <p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p> | <p>20% coinsurance</p> | <p>General Authorization rules may apply.</p> <p>In-Network \$30 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$30 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.</p> |
| OUTPATIENT MEDICAL SERVICES AND SUPPLIES | | |
| <p>18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p> | <p>20% coinsurance</p> | <p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> |

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| <p>19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p> | <p>20% coinsurance</p> | <p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> |
| <p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p> | <p>20% coinsurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> | <p>In-Network \$20 copay for Diabetes self-monitoring training. \$20 copay for Nutrition Therapy for Diabetes . 20% of the cost for Diabetes supplies.</p> |
| <p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p> | <p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p> | <p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests <p>\$0 copay for Medicare-covered X-rays.</p> <p>\$0 to \$75 copay for Medicare-covered diagnostic radiology services.</p> <p>\$75 copay for Medicare-covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p> |

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| PREVENTIVE SERVICES | | |
| 22. Bone Mass Measurement (for people with Medicare who are at risk) | 20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions. | General Authorization rules may apply. In-Network \$0 to \$15 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of \$20 copay may apply. |
| 23. Colorectal Screening Exams (for people with Medicare age 50 and older) | 20% coinsurance Covered when you are high risk or when you are age 50 and older. | In-Network \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$20 copay may apply. |
| 24. Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine) | \$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. | In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and pneumonia vaccines. |
| 25. Mammograms (Annual Screening) (for women with Medicare age 40 and older) | 20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39. | In-Network \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$20 copay may apply. |
| 26. Pap Smears and Pelvic Exams (for women with Medicare) | \$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams | In-Network \$0 copay for Medicare-covered pap smears and pelvic exams. Separate Office Visit cost sharing of \$20 copay may apply. |

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| <p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p> | <p>20% coinsurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% coinsurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p> | <p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Separate Office Visit cost sharing of \$20 copay may apply.</p> |
| <p>28. End-Stage Renal Disease</p> | <p>20% coinsurance for renal dialysis</p> <p>20% coinsurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p> | <p>In-Network \$0 copay for renal dialysis</p> <p>\$20 copay for Nutrition Therapy for End-Stage Renal Disease.</p> |
| <p>29. Prescription Drugs</p> | <p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p> | <p>Drugs covered under Medicare Part B General Most drugs not covered.</p> <p>20% of the cost for Part B covered chemotherapy drugs and other Part B-covered drugs.</p> <p>Drugs covered under Medicare Part D General This plan does not offer prescription drug coverage.</p> |

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| 30. Dental Services | Preventive dental services (such as cleaning) not covered. | In-Network \$0 copay for Medicare-covered dental benefits In general, preventive dental benefits (such as cleaning) not covered. |
| 31. Hearing Services | Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams. | In-Network Hearing aids not covered. - \$20 copay for Medicare-covered diagnostic hearing exams - \$30 copay for up to 1 routine hearing test(s) every year. |
| 32. Vision Services | 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk. | In-Network \$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery - glasses - contacts - lenses - frames - \$20 copay for exams to diagnose and treat diseases and conditions of the eye. - \$30 copay for up to 1 routine eye exam(s) every year \$100 limit for eye wear every year. |
| 33. Physical Exams | 20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests. | In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year. Separate Office Visit cost sharing of \$20 copay may apply. |

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| Health/Wellness Education | <p>Smoking Cessation: Covered if ordered by your doctor.</p> <p>Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p> | <p>In-Network</p> <p>The plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Health Club Membership/Fitness Classes <p>\$0 copay for each Medicare-covered smoking cessation counseling session.</p> |
| Transportation (Routine) | <p>Not covered.</p> | <p>In-Network</p> <p>This plan does not cover routine transportation.</p> |
| Acupuncture | <p>Not covered.</p> | <p>In-Network</p> <p>This plan does not cover Acupuncture.</p> |

Section III

NOTE: Some of the benefits described in this section are not applicable to every plan in this booklet. When a benefit does not apply to all plans, the plans that do have the benefit are specifically noted. In addition to this booklet, you may also refer to your “Evidence of Coverage” for more details on the benefits covered under your plan or you can call Customer Service.

THE MANY EXTRAS FROM WINDSOR MEDICARE EXTRA

All Windsor Medicare Extra plans are developed with your health in mind. We work hard to include many benefits that make it easier and more affordable for you to be as healthy as possible. This section explains more about how to get the health care services available in your plan and it provides more information about some of the extra benefits available to you. Please refer to your “Evidence of Coverage” for more information about your plan benefits and services.

PHYSICIAN OF CHOICE (POC) FROM THE WINDSOR MEDICARE EXTRA NETWORK

As a member of Windsor Medicare Extra, you receive quality care from health care providers in your area. To help coordinate your health care needs, choose a network provider (see below for more information about network providers) to be your POC. With a few exceptions, your POC may be almost any provider from our provider directory who you feel is primarily responsible for your care and treatment. For example, your POC may be a primary care physician who provides your routine care, a specialist physician who treats a particular condition you have, any provider who is associated with a medical clinic in our network, or a nurse practitioner. Choosing a POC does not mean this is the only medical doctor or health care provider you are allowed to see. You may choose to see any of the other primary care or specialist providers in our plan network at any time without a referral from your POC.

If there is a particular doctor or other type of provider you want to list as your POC, first make sure the individual is listed in the

provider directory. Since we continually add physicians to our network, you may also want to access the provider information on our website. You may also call Customer Service to ask about your provider or to get help in selecting a POC that is accepting new patients. You should choose a POC when you enroll by placing his/her name on your enrollment application. You may change your POC at any time by completing a POC request form or by calling Customer Service.

REFERRALS

As a member of Windsor Medicare Extra, you are not required to get referrals for treatment by your POC or other network providers. You may choose to see any provider in our plan network at any time. To find out if a particular provider is in our plan network, consult your provider directory, search our website, or call Customer Service.

NETWORK PROVIDERS

To receive coverage for medically necessary services, you must (in most instances) receive those services from Windsor Medicare Extra network providers. Network providers contract with us to provide health care services to Windsor Medicare Extra members and follow our plan rules. Our network providers are trained to handle all of your health care needs. You do not need a referral to seek care from specialists in the plan network. If you can't get the care you need from a network provider, your POC will work with Windsor Medicare Extra to request a referral to a non-network provider.

If you go to a non-network provider without preauthorization, you are responsible for paying any charges. Neither Windsor Medicare

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Extra nor Original Medicare will pay for these services. The only exceptions are:

- Emergency services
- Urgently needed services
- Out-of-area, renal dialysis services

CARE MANAGEMENT

If you are living with a serious illness and/or a chronic medical condition such as Diabetes or a mental health condition, specially-trained nurses or other health care professionals may be assigned to help you manage your care. These individuals will partner with you to help with your health care needs. Assistance is typically provided through a care coordination program that includes telephone education and monitoring.

The Windsor Medicare Extra Care Management professionals are available by telephone at 1-800-316-2273 (TTY: 1-866-460-7617) and fax at 1-615-782-7822, Monday – Friday, 8 a.m. - 5 p.m. Central Time.

If you are a part of the Windsor Medicare Extra Care Management Program, you will receive periodic educational materials in the mail in addition to regular telephone calls. This communication between you and your Windsor Medicare Extra health care professional does not replace the care you receive from your doctor(s), but is in addition to that care.

EMERGENCY CARE

Windsor Medicare Extra will cover you for emergency care anywhere! A “medical emergency” is when you believe your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that quickly gets much worse.

If you are having a medical emergency, get medical help as soon as possible. Call 911 or go to the nearest hospital, physician’s office, or emergency facility. You do not need a referral or authorization. Windsor Medicare Extra will pay for all medically necessary emergency services. We do ask that you contact your POC as soon as possible so follow-up care can be provided.

Please make sure we know about your emergency because we need to be involved in following up on your care. You or someone you designate should tell us about your emergency care by calling Customer Service within 48 hours.

MEDICAL VISION BENEFITS

Windsor Medicare Extra covers all eye exams that diagnose and treat diseases and conditions of the eye, as covered by Medicare. For this type of medical care, you must see an eye care specialist physician (ophthalmologist) who is a network provider, but you do not need a referral. Do not see a provider listed in the Routine Vision section of the provider directory for these services.

Diabetic eye exams are considered medical eye exams, and you must see a network eye specialist (no referral necessary).

You are also covered for one pair of eyeglasses or contact lenses after each cataract surgery, as covered by Medicare. There is no copayment for Medicare-covered eye wear, but frame enhancements and lens enhancements are not covered.

ROUTINE VISION BENEFITS

The Windsor Medicare Extra Silver (HMO) plan offers routine vision benefits in addition to medical vision benefits. As a Windsor Medicare Extra member, you are covered for one routine eye exam (refraction) every year. You will pay a copayment for each routine eye exam. See Section 2 of this booklet for more details.

Section III

When you need a routine eye exam, you can go to any network ophthalmologist listed in the specialist section of the provider directory who performs these services OR any network optometrist listed in the Routine Vision section of the provider directory, both without a referral. If your routine eye exam shows that you need other medical treatment or tests, you must see a network eye specialist (ophthalmologist).

The Windsor Medicare Extra Silver Plan (HMO) also covers routine **eye wear up to one pair of glasses (frames and lenses) or one pair of contacts every year up to the plan's dollar limit.** The costs of routine eye wear exceeding the plan's annual dollar limit are your responsibility. You must get your eye wear from a network provider listed in the Routine Vision section of the provider directory. Please see Section 2 of this booklet for more details.

ROUTINE HEARING BENEFITS

As a member of the Windsor Medicare Extra Silver Plan (HMO), you are covered for one routine hearing exam every year. You will pay a copayment for each routine hearing exam. Please see Section 2 of this booklet for more details.

EXERCISE AND FITNESS PROGRAM

If you are a member of Windsor Medicare Extra, and wish to participate in a self-directed exercise or fitness program at gym, fitness center or health club in our network, you may join that fitness facility as part of your plan. You also have the option to obtain an exercise program to use at home, if a facility is not nearby or you choose to exercise at home. This benefit is offered through our partnership with Silver&Fit and participation will require registration through Silver&Fit.

Special rules do apply on changing fitness facilities and home exercise programs. To find a facility near you or to learn more about using this benefit, please call Customer Service.

OUR GOALS FOR YOUR HEALTH

Windsor Medicare Extra wants to help you be as healthy as possible. As a member of our plan, you have a wide range of medical benefits. You also have access to extra benefits that support your overall health and well-being. If you have any questions or concerns about your plan or your benefits, please call Customer Service for assistance.

Customer Service

1-800-316-2273, TTY:1-866-460-7617

7 a.m. to 8 p.m. Central Time, 7 days a week



Windsor Medicare Extra is a product of Windsor Health Plan, Inc., a Medicare Advantage organization with a Medicare contract.