



Dear Member,

Here are three documents with important information for you.

1. Please start by reading the **Annual Notice of Changes for 2012**. It gives you a summary of changes to your benefits and costs for next year. These changes will take effect at the start of your plan year.
 - Please take a moment *very soon* to look through this summary and see how the changes might affect you.
 - If you decide to stay with Humana Medicare Employer PPO for 2012 - you do not have to tell us or fill out any paperwork. You will automatically remain enrolled as a member of Humana Medicare Employer PPO.
2. We're including a copy of next year's **Evidence of Coverage**. It's the legal, detailed description of your benefits costs for the plan's contract year if you stay enrolled as a member of Humana Medicare Employer PPO. It also explains your rights and rules you need to follow when using your coverage for medical care. Please look through this document so you know what's in it, then keep it handy for reference.
3. We're also including a copy of the Humana Medicare Employer PPO plan's Drug Guide (Formulary), effective January 2012.

If you have questions, we're here to help. Please call our Customer Care Team at 1-800-733-6592 (TTY only, call 711). You can call seven days a week from 8 a.m. to 8 p.m. Calls to these numbers are free. You may also go to our Plan Website at **Humana.com**.

We value your membership and hope to continue to serve you next year.

Humana Medicare Employer PPO Annual Notice of Changes for 2012

This booklet tells you how your benefits and costs as a member of Humana Medicare Employer PPO will change next year from your current benefits. The changes take effect on the first day of your coverage year.

To decide what's best for you, compare this information we're sending with the benefits and costs of other Medicare Advantage plans in your area, as well as the benefits and costs of Original Medicare.

Humana Medicare Employer PPO Customer Care Team:

For help or information, please call the Customer Care Team (phone numbers can be found on the back of your membership card) or go to our plan website at Humana.com. Calls to these numbers are free.

Hours of Operation: 8 a.m. to 8 p.m., seven days a week. A Customer Care Team representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 a.m. until 8 p.m.

However, after February 14, 2012, your call may be handled by our automated phone system on Saturdays, Sundays, and some Public Holidays. When leaving a message, simply select the reason for your call from the automated list and a knowledgeable representative will return your call by the end of the next working day.

This Plan is offered by Humana Insurance Company / Humana Health Insurance Company of Florida, Inc. / Humana Insurance Company of New York / Humana Insurance of Puerto Rico, Inc. / Humana Medicare Employer PPO, referred throughout the Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) as "we", "us" or "our." Humana is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government

Our plan is a health plan with a Medicare contract.

This information is available in a different format, including Spanish, large print, and audio tapes. Please call the Customer Care Team (phone numbers can be found on the back of your membership card) if you need plan information in another format or language.

Esta informacion puede estar disponible en otro formato, incluyendo en ingles, en letra grande o en cintas de audio. Si necesita informacion del plan en otro idioma o en otro formato, llame al Servicio al Cliente al numero que aparece anteriormente.

If you remain enrolled in Humana Medicare Employer PPO for 2012, there will be some changes to your benefits and what you pay.

You are currently enrolled as a member of Humana Medicare Employer PPO. This plan is a Medicare Advantage PPO. (PPO stands for Preferred Provider Organization.) Like all Medicare Advantage plans, this Medicare PPO is approved by Medicare and run by a private company. We are pleased to be providing your Medicare health care coverage including your prescription drug coverage. This notice describes changes in benefits from Humana Medicare Employer PPO to Humana Medicare Employer PPO next year.

We're sending you this *Annual Notice of Changes* to tell you how your benefits and costs as a member of Humana Medicare Employer PPO will change next year from your current benefits. The changes take effect on the first day of your coverage year. Medicare has approved these changes.

What should you do?

We want you to know what's ahead for next year, so **please read this document very soon to see how the changes in benefits and costs will affect you if you stay enrolled in Humana Medicare Employer PPO for 2012.**

We hope to keep you as a member of Humana Medicare Employer PPO. But if you want to make a change for 2012, see "*When can you change*" in Section 6 for time periods when you can make a change.

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Section 1. Important things to know

This *Annual Notice of Changes* is only a summary (see your *Evidence of Coverage* for the details)

This *Annual Notice of Changes* gives you a summary of the changes in your benefits and what you will pay for these services the plan's contract year.

- To get the details, you can look in the plan's contract year *Evidence of Coverage* for Humana Medicare Employer PPO. The *Evidence of Coverage* is the legal, detailed description of your benefits and costs for the plan's contract year. It explains your rights and the rules you need to follow to get your covered services and prescription drugs. (We have included a copy of the *Evidence of Coverage* in the same booklet with this *Annual Notice of Changes*. If you do not have this copy, call the Customer Care Team.)
- If you have questions or need more information, you can always call the Customer Care Team (phone numbers can be found on the back of your membership card) Hours are 8 a.m. to 8 p.m., seven days a week and calls to these numbers are free.

There are programs to help people with limited resources pay for their prescription drugs

You might qualify to get help in paying for your drugs. There is one basic kind of help:

- **"Extra Help" from Medicare.** This program is also called the "low-income subsidy" or LIS. People whose yearly income and resources are below certain limits can qualify for this help. See Section III of the new *Medicare & You 2012 Handbook* or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

What if you are currently getting help to pay for your drugs?

If you already get help paying for your drugs, **some of the information in this *Annual Notice of Changes* is not correct for you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), that tells you about your drug coverage. If you don't have this insert, please call the Customer Care Team and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for the Customer Care Team are on the back of your membership card.

Section 2. Changes to your monthly premium

This is a simulation or baseline lineup. For the actual products the system will place the appropriate language in this space: Employer-billed and split-billed groups will have explanatory text. Individually-billed groups will have a premium comparison line with a dummy amount. The exact amount will be determined by member at print time.

Exception: If you are required to pay a late enrollment penalty (because you did not join a Medicare drug plan when you first became eligible), your monthly premium for 2012 will be *2012 premium amount plus* the amount of your late enrollment penalty. For more information about this penalty, see Chapter 6 of your *Evidence of Coverage*.

Section 3. Medical services: Changes to your benefits and what you pay

Changes to your benefits

As shown below, Humana Medicare Employer PPO is adding a new benefit or ending a benefit or changing our covered benefits for next year. For details, see Chapters 3 and 4 in your *Evidence of Coverage*.

| | 2011 (last year) | 2012 (this year) |
|------------------------|--|---|
| Fitness Program | | |
| Silver & Fit | Covered in Arizona, Nevada, and Pennsylvania | Covered in Nevada and Pennsylvania |
| SilverSneakers | Covered in all states except Arizona, Nevada, and Pennsylvania | Covered in all states except Nevada, and Pennsylvania |

Changes to what you pay

The chart below summarizes changes to what you will pay as your share of the cost of covered medical services. For details, see Chapter 4, *Medical benefits chart (what is covered and what you pay)*, in your *Evidence of Coverage*.

| | 2011 (last year) | 2012 (this year) |
|--|------------------|------------------|
| Kidney Disease Education Services | | |
| Primary Care Physician's Office - IN | 20% coinsurance | You pay nothing |
| Specialist's Office - IN | 20% coinsurance | You pay nothing |
| Outpatient Hospital - IN | 20% coinsurance | You pay nothing |
| Primary Care Physician's Office - OON | 20% coinsurance | You pay nothing |
| Specialist's Office - OON | 20% coinsurance | You pay nothing |
| Outpatient Hospital - OON | 20% coinsurance | You pay nothing |

Section 4. Part D prescription drugs: Changes to your benefits and what you pay

Changes to your benefits

Humana Medicare Employer PPO has a "*Prescription Drug Guide (Formulary)*" - or "Drug Guide" for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1 of your *Evidence of Coverage* explains about Part D drugs.)

We may make changes to the plan's Drug Guide from time to time throughout the year. In addition, there are a number of changes to the Drug Guide that will take effect on the plan's contract year. Changes to the plan's Drug Guide have been approved by Medicare.

- **We have added some new drugs to the list and removed others.** We have added some new drugs that became available. We have replaced some brand-name drugs with new generic drugs. We have replaced some expensive drugs with less costly drugs that have been shown to work just as well or better. We have removed a few drugs due to safety concerns or because medical research has shown they are not effective.

- **We have added some new restrictions to certain drugs, and reduced the restrictions on others.** Restrictions can include a requirement to get plan approval in advance or to try a different drug first to see how well it works. Restrictions can also include limits on quantity of the drug.
- **Some of your drug cost-sharing tier names may have changed.** Tier 1 is now referred to as Preferred Generic and Generic. Tier 2 is now referred to as Preferred Brand. Tier 3 is now referred to as Non-Preferred Brand. Tier 4 is now referred to as Specialty.

Please check to see if any of these changes to drug coverage affect the drugs you use.

- You can look for your drugs on the Drug Guide we sent with this *Annual Notice of Changes*.
- The Drug Guide we sent includes many of the drugs that we cover, but it does not include all of our covered drugs. If you can't find some of your drugs on this Drug Guide, you may find them on a complete Drug Guide, which includes all the drugs we cover. You can get the complete Drug Guide by calling the Customer Care Team or visiting our website Humana.com.

Changes to what you pay

The chart below summarizes changes to what you will pay as your share of the cost of covered prescription drugs. These changes affect Part D prescription drugs only.

- Every drug on the plan's Drug Guide is in one of 4 cost-sharing tiers. Medicare allows us to **change what you pay for a drug in each cost-sharing tier** only once a year. The changes shown below will take effect on the first day of your plan year, and stay the same for the entire plan year.
- Besides the changes to cost share you see below, there is another change that could affect what you pay for your drugs next year. **We have moved some of the drugs on the Drug Guide to a different cost-sharing tier.** Some drugs may be in a lower cost-sharing tier, others may be in a higher cost-sharing tier. To see if any of your drugs have been moved to a different cost-sharing tier, look them up on the Drug Guide.

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Your number of cost-sharing tiers has changed for 2012. The Preferred Generic Tier 1 and Generic Tier 2 is now a Preferred Generic or Generic Tier 1. The Non-Preferred Generic/Preferred Brand Tier 3 is now Preferred Brand Tier 2. The Non-Preferred Brand Tier 4 is now Non-Preferred Brand Tier 3. The Specialty Tier 5 is now Specialty Tier 4. For cost-sharing tiers, please refer to "What you pay for your Part D prescription drugs" of the EOC

| Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
|---|---|--|
| For a one-month (30 day) supply of a drug in the preferred generic or generic cost-sharing tier that is filled at a network retail pharmacy | \$5 copayment | \$5 copayment |
| Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
| For a one-month (30 day) supply of a drug in the preferred brand cost-sharing tier that is filled at a network retail pharmacy | 30% coinsurance with a \$50 maximum member out of pocket per prescription | 30% coinsurance (\$50 maximum member out of pocket per prescription) |
| Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a one-month (30 day) supply of a drug in the non-preferred brand cost-sharing tier that is filled at a network retail pharmacy | 50% coinsurance with a \$75 maximum member out of pocket per prescription | 50% coinsurance (\$75 maximum member out of pocket per prescription) |

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| Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
|---|--|---|
| For a one-month (30 day) supply of a drug in the specialty cost-sharing tier that is filled at a network retail pharmacy | 25% coinsurance with a \$100 maximum member out of pocket per prescription | 25% coinsurance (\$100 maximum member out of pocket per prescription) |
| Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
| For a one-month (30 day) supply of a drug in the preferred generic or generic cost-sharing tier that is filled at a network mail order pharmacy | \$5 copayment | \$5 copayment |
| Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
| For a one-month (30 day) supply of a drug in the preferred brand cost-sharing tier that is filled at a network mail order pharmacy | 30% coinsurance with a \$50 maximum member out of pocket per prescription | 30% coinsurance (\$50 maximum member out of pocket per prescription) |
| Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a one-month (30 day) supply of a drug in the non-preferred brand cost-sharing tier that is filled at a network mail order pharmacy | 50% coinsurance with a \$75 maximum member out of pocket per prescription | 50% coinsurance (\$75 maximum member out of pocket per prescription) |

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| Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
|---|--|---|
| For a one-month (30 day) supply of a drug in the specialty cost-sharing tier that is filled at a network mail order pharmacy | 25% coinsurance with a \$100 maximum member out of pocket per prescription | 25% coinsurance (\$100 maximum member out of pocket per prescription) |
| Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
| For a three-month (90 day) supply of a drug in the preferred generic or generic cost-sharing tier that is filled at a network retail pharmacy | \$15 copayment | \$15 copayment |
| Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
| For a three-month (90 day) supply of a drug in the preferred brand cost-sharing tier that is filled at a network retail pharmacy | 30% coinsurance with a \$150 maximum member out of pocket per prescription | 30% coinsurance (\$150 maximum member out of pocket per prescription) |
| Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a three-month (90 day) supply of a drug in the non-preferred brand cost-sharing tier that is filled at a network retail pharmacy | 50% coinsurance with a \$225 maximum member out of pocket per prescription | 50% coinsurance (\$225 maximum member out of pocket per prescription) |
| Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
| For a three-month (90 day) supply of a drug in the specialty cost-sharing tier that is filled at a network retail pharmacy | Not Available | Not Available |

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| Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
|---|--|---|
| For a three-month (90 day) supply of a drug in the preferred generic or generic cost-sharing tier that is filled at a network mail order pharmacy | \$10 copayment | \$10 copayment |
| Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
| For a three-month (90 day) supply of a drug in the preferred brand cost-sharing tier that is filled at a network mail order pharmacy | 25% coinsurance with a \$100 maximum member out of pocket per prescription | 25% coinsurance (\$100 maximum member out of pocket per prescription) |
| Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a three-month (90 day) supply of a drug in the non-preferred brand cost-sharing tier that is filled at a network mail order pharmacy | 45% coinsurance with a \$190 maximum member out of pocket per prescription | 45% coinsurance (\$190 maximum member out of pocket per prescription) |
| Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
| For a three-month (90 day) supply of a drug in the specialty cost-sharing tier that is filled at a network mail order pharmacy | Not Available | Not Available |
| Home Infusion Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
| For a one-month (30 day) supply of a home infusion drug in the preferred generic or generic cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | \$5 copayment |

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| Home Infusion Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
|---|---|--|
| For a one-month (30 day) supply of a home infusion drug in the preferred brand cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | 30% coinsurance (\$50 maximum member out of pocket per prescription) |
| Home Infusion Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a one-month (30 day) supply of a home infusion drug in the non-preferred brand cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | 50% coinsurance (\$75 maximum member out of pocket per prescription) |
| Home Infusion Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
| For a one-month (30 day) supply of a home infusion drug in the specialty cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | 25% coinsurance (\$100 maximum member out of pocket per prescription) |
| Home Infusion Drugs in Preferred Generic or Generic Cost-Sharing Tier | 2011 (this year) Tier 1 and Tier 2 | 2012 (next year) Tier 1 |
| For a one-month (90 day) supply of a home infusion drug in the preferred generic or generic cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | \$15 copayment |

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| Home Infusion Drugs in Preferred Brand Cost-Sharing Tier | 2011 (this year) Tier 3 | 2012 (next year) Tier 2 |
|--|--------------------------------|--|
| For a one-month (90 day) supply of a home infusion drug in the preferred brand cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | 30% coinsurance (\$150 maximum member out of pocket per prescription) |
| Home Infusion Drugs in Non-Preferred Brand Tier | 2011 (this year) Tier 4 | 2012 (next year) Tier 3 |
| For a one-month (90 day) supply of a home infusion drug in the non-preferred brand cost-sharing tier that is filled at a network retail pharmacy | Not Applicable | 50% coinsurance (\$225 maximum member out of pocket per prescription) |
| Home Infusion Drugs in Specialty Tier | 2011 (this year) Tier 5 | 2012 (next year) Tier 4 |
| For a one-month (90 day) supply of a home infusion drug in the specialty cost-sharing tier that is filled at a network retail pharmacy | Not Available | Not Available |
| Description | 2011 (this year) | 2012 (next year) |
| Prescription Drug Amount (Initial Coverage Limit) | \$0 - \$4,550 | \$0 - \$2930 |
| Prescription Drug Amount (Coverage Gap Stage) | Not Applicable | \$2930.01 - \$4700 |

What if changes for 2012 affect drugs you are taking now?

What if a drug you are taking now is not on the Drug Guide for 2012? What if it has been moved to a higher cost-sharing tier? What if a new restriction has been added to the coverage for this drug? If you are in any of these situations, here's what you can do:

- In some situations, the plan will cover a **one-time, temporary supply** of your drug when your current supply runs out. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. Chapter 5, Section 6 explains when you can get a temporary supply and how to ask for one.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find a different drug** covered by the plan that might work just as well for you. You can call the Customer Care Team to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. To learn what you must do to ask for an exception, see the *Evidence of Coverage* that was included in the mailing with this *Annual Notice of Changes*. Look for Chapter 9 (*What to do if you have a problem or complaint*).

Section 5. What about changes to the plan's network of providers?

Will your doctors and other providers still be in the plan's network next year?

There are a few changes to the network of providers for 2012. In addition, it's possible for the network of plan providers to change at any time during the year.

- **Please check with your doctors and other providers you currently use** to make sure they will continue to be part of the provider network for Humana Medicare Employer PPO in 2012.
- For the most up-to-date information on the network of providers, check our website **Humana.com** or call the Customer Care Team (see phone numbers on the back of your membership card).

Section 6. Do you want to stay in the plan or make a change?

Do you want to stay with Humana Medicare Employer PPO?

If you want to keep your membership in Humana Medicare Employer PPO for 2012, it's easy. You don't need to tell us or fill out any paperwork. **You will automatically remain enrolled as a member.**

Do you want to make a change?

If you decide to leave Humana Medicare Employer PPO, please contact your Benefits Administrator for other plan options that may be available to you. Of course, you can always switch to an Individual Medicare Advantage plan or to Original Medicare (either with or without a separate Medicare prescription drug plan).

When can you change?

Because you are currently on an Employer or Retiree Group Plan, you may choose to leave the plan at any time during the plan year. Please contact your Benefits Administrator to understand the consequences of leaving your Employer or Retiree Group Plan.

How do you make a change?

See Chapter 10 of the enclosed Evidence of Coverage document. It outlines what you need to do to make a change from Humana Medicare Employer PPO to another plan.

Something to remember before you make a change

Because you are a member of an Employer or Retiree Group, please contact your Benefits Administrator to understand the consequences of leaving your plan.

Section 7. Do you need some help? Would you like more information?

We have information and answers for you

To learn more, read the information we sent in the same package with this *Annual Notice of Changes*. This includes a copy of the *Evidence of Coverage* and of the *List of Covered Drugs (Formulary)*.

If you have any questions, we are here to help. Please call the Humana Medicare Employer PPO Customer Care Team (phone numbers can be found on the back of your membership card). We are available for phone calls 8 a.m. to 8 p.m., seven days a week. Calls to these numbers are free:

You can get help and information from your State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

Your state's SHIP is independent (not connected with any insurance company or health plan). Your state's SHIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You may find contact information for the SHIP in your state in the state specific data sheets at the end of this Evidence of Coverage.

You can get help and information from Medicare

Here are three ways to get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)** 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Visit the Medicare website** (<http://www.medicare.gov>).

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- **Read *Medicare & You 2012*.** Every year in October, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227).