

Silver Rx (HMO)
Annual Notice of Changes for 2012

This booklet tells you how your benefits and costs will change next year if you stay in Silver Rx. These changes will take effect on January 1, 2012 if you stay in this plan.

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

This plan, Silver Rx, is offered by Welborn Health Plans. (When this *Annual Notice of Changes* says "we," "us," or "our," it means Welborn Health Plans. When it says "plan" or "our plan," it means Silver Rx.)

A Coordinated Care plan with a Medicare Advantage contract.

This information is available in a different format, including large print. Please contact our Customer Services number at 1-800-521-0265 for additional information. (TTY users should call 1-800-743-3333). Hours are 7 days a week, 8 a.m. - 8 p.m. Customer Services has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

Annual Notice of Changes for 2012

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Section 1. Important things to know

The Annual Enrollment Period ends on December 7th

Starting this year, you have from **October 15 until December 7 to make a change** to your Medicare coverage.

You are currently enrolled in *Silver Rx*, which is a Medicare HMO

You are currently enrolled as a member of Silver Rx. This plan is a Medicare Advantage HMO (HMO stands for Health Maintenance Organization). Like all Medicare Advantage Plans, this Medicare HMO 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.

If you stay enrolled in *Silver Rx* for 2012, there will be some changes to your benefits and to what you pay

Each year, Medicare health plans may decide to change the premiums, cost-sharing amounts, and benefits they offer. These changes may include increasing or decreasing premiums, increasing or decreasing cost-sharing amounts, and adding or subtracting benefits.

We're sending you this *Annual Notice of Changes* to tell you how your benefits and costs as a member of Silver Rx will change next year from your current benefits. The changes will take effect on January 1, 2012. Medicare has approved these changes.

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 in 2012. This notice is a brief summary, not a comprehensive description of benefits. For more information, contact the plan or look in your *Evidence of Coverage*.

- To get the details, you can look in the 2012 *Evidence of Coverage* for Silver Rx. The *Evidence of Coverage* is the legal, detailed description of your benefits and costs for 2012. 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 have questions or need more information, *you can always call* Customer Services at 1-800-521-0265 (TTY only, call 1-800-743-3333). Hours are 7 days a week, 8 a.m. - 8 p.m. CST and calls to these numbers are free.

What should you do?

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

Silver Rx for 2012. Starting this year, **you have only until December 7 to make a change** to your Medicare coverage. If you make a change, your new coverage will start on January 1, 2012.

To decide what's best for you, compare this information about the 2012 benefits and costs for Silver Rx to what your benefits and costs would be if you switched to a different Medicare health plan or to Original Medicare.

If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website at <http://www.medicare.gov>. The Plan Finder helps you compare your choices by giving you information about plans' benefits and costs and showing you how Medicare rates the plans. For example, these ratings let you compare how well plans are doing in different categories that include detecting and preventing illness, member satisfaction, and customer service. (To view the information about plans, go to <http://www.medicare.gov>. Click on the "Health & Drug Plans" button on the left and then choose "Compare Drug and Health Plans.") If you want us to mail you a copy of the ratings for Silver Rx that are shown on the Medicare website, please call us at 7 days a week, 8 a.m. - 8 p.m. CST. TTY users call 1-800-743-3333.

To get information about Original Medicare and about Medicare plans available in your area, you can also call Medicare or your State Health Insurance Assistance Program. For numbers to call, see Section 7 of this *Annual Notice of Changes*.

We value your membership in Silver Rx and hope to keep you as a member. But if you want to make a change for 2012, see "*When can you change to a different plan?*" in Section 6 for time periods when you can make a change.

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 two basic kinds of help:

- **"Extra Help" from Medicare.** This program is also called the "low-income subsidy" or LIS. If your yearly income and resources are below certain limits, you may qualify for this help. To learn more about the Extra Help program, 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. You can also look in Section III of the *Medicare & You 2012 Handbook* or call your State Health Insurance Assistance Program (the name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).
- **Help from Hoosier Rx your state's pharmaceutical assistance program.** Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age, or medical condition. In Indiana, the program is called Hoosier Rx. Each state has different rules. To learn more about the program in your state, check with your State Health Insurance Assistance Program (the

name and phone numbers for this organization are in Chapter 2, Section 3 of your *Evidence of Coverage*).

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 about premiums and Part D drug costs 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), which tells you about your drug coverage. If you don’t have this insert, please call Customer Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Services are on the back cover of this booklet.

Section 2. Changes to your monthly premium

	2011 (this year)	2012 (next year)
Monthly premium	\$61	\$62
	(You must continue to pay your Medicare Part B premium.)	(You must continue to pay your Medicare Part B premium.)

Exceptions:

- If you are required to pay a late enrollment penalty (because you went at least 63 days without Part D or other “creditable” prescription drug coverage anytime after the end of your Part D initial enrollment period), your monthly premium for 2012 will be \$62 *plus* the amount of your late enrollment penalty. For more information about this penalty, see Chapter 6 of your *Evidence of Coverage*.
- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 6, Section 11 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.

Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs)

Changes to your benefits

As shown below, Silver Rx is changing our covered benefits for next year. For details, see Chapters 3 and 4 in your *Evidence of Coverage*.

	2011 (this year)	2012 (next year)
Silver & Fit	Covered	Not Covered
Healthy Life	Not Covered	Covered

Changes to your cost sharing (“out-of-pocket” costs)

Cost sharing is your share of the cost of covered medical services. It is the amount you pay “out-of-pocket” for coinsurance and copayments. You usually pay these amounts at the time services are received. The chart below summarizes changes from 2011 to 2012 to your “out-of-pocket” costs. For details, see Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*, in your *Evidence of Coverage*.

	2011 (this year)	2012 (next year)
<p>Maximum out-of-pocket amount for in-network medical services</p> <p>The maximum out-of-pocket amount is the most that you pay for copayments and coinsurance during the calendar year for in-network covered Part A and Part B services.</p> <p>Amounts you pay for your <i>copayments</i> and coinsurance count toward your maximum out-of-pocket amount. Amounts you pay for your plan premium and your prescription drugs do <u>not</u> count toward your maximum out-of-pocket amount.</p>	<p>\$3,400</p> <p>This is the most you pay out-of-pocket for in-network covered Part A and Part B services.</p> <p>Once you have paid \$3,400 out-of-pocket for in-network covered Part A and Part B services, you pay nothing for your in-network Part A and Part B services for the rest of the calendar year.</p>	<p>\$3,400</p> <p>This is the most you pay out-of-pocket for in-network covered Part A and Part B services.</p> <p>Once you have paid \$3,400 out-of-pocket for in-network covered Part A and Part B services, you pay nothing for your in-network Part A and Part B services for the rest of the calendar year.</p>
Inpatient Hospital Care	<p>Days 1 -10 \$150 copay per day</p> <p>Days 11 - 90 \$0 copay per day</p>	<p>Days 1 -9 \$160 copay per day</p> <p>Days 10 - 29 \$50 copay per day</p> <p>Days 30 - 90 \$0 copay per day</p>
Inpatient Mental Health	<p>Days 1 -10 \$150 copay per day</p> <p>Days 11 - 90 \$0 copay per day</p>	<p>Days 1 -9 \$160 copay per day</p> <p>Days 10 - 29 \$50 copay per day</p> <p>Days 30 - 90 \$0 copay per day</p>
Skilled Nursing Facility (SNF)	<p>Days 1 -10 \$0 copay per day</p> <p>Days 11 – 50 \$90 copay per day</p> <p>Days 51- 100 \$0 copay per day</p>	<p>Days 1 -10 \$0 copay per day</p> <p>Days 11 – 50 \$85 copay per day</p> <p>Days 51- 100 \$0 copay per day</p>

Doctor Office Visits	\$15 copay for each Primary Care Provider visit	\$20 copay for each Primary Care Provider visit
Outpatient Substance Abuse Care	Visit(s) 1 – 8: \$55 copay per visit Visit(s) 9 and beyond: \$65 copay per visit	\$60 copay for Medicare-covered individual or group visits
Outpatient Services and Surgery	\$125 copay for each ambulatory surgical and outpatient hospital facility visit	\$35 to \$135 copay for each ambulatory surgical and outpatient hospital facility visit
Emergency Care	\$50 copay for each emergency room visit Copay waived if admitted within 12 hours Worldwide coverage - you can access Emergency care anywhere in the world. \$300 per year limit for Physician Coverage out of the United States. See Chapter 3 Section 3.1 of this document for details	\$65 copay for each emergency room visit Copay not waived if admitted Worldwide coverage - you can access Emergency care anywhere in the world. Your plan will pay up to \$300 US currency amount towards physician visits out of the US, or what is considered foreign travel, per year. This benefit is ONLY for situations which would be considered EMERGENCY or URGENT CARE had they been done in the US. See Chapter 3 Section 3.1 of this document for details.

Outpatient Cardiac Rehabilitation	\$35 to \$125 copay for each covered visit	\$35 to \$135 copay for each covered visit
Outpatient Pulmonary Rehabilitation	\$35 to \$125 copay for each covered visit	\$35 to \$135 copay for each covered visit
Diabetes Supplies	\$15 copay for Diabetes Supplies	\$8 copay for Diabetes Supplies
	\$15 copay for Therapeutic shoes or inserts	\$8 copay for Therapeutic shoes or inserts
Outpatient Blood	\$35 to \$125 copay per unit	20% coinsurance
Diagnostic Tests, X-Rays, and Radiology Services	\$35 copay for Medicare-covered Diagnostic procedures and tests	\$0 to \$40 copay for Medicare-covered Diagnostic procedures and tests
	20% coinsurance for Medicare-covered X-Rays	\$45 copay for Medicare-covered X-Rays
	20% coinsurance for Medicare-covered Diagnostic Radiology services	\$75 copay for Medicare-covered Diagnostic Radiology service
Partial Hospitalization	\$50 copay for Medicare-covered benefits	\$160 copay for Medicare-covered benefits
End-Stage Renal Disease	\$0 copay for Renal Dialysis	You pay 20% of the total cost

Kidney Disease Education Services

\$0 copay for Medicare covered Kidney Disease Education Services

\$0 copay for Medicare covered Kidney Disease Education Services

When Kidney Disease Screenings and other health reasons are combined in one visit, Office Visit copay will apply. The office visit copay will be \$0 for Primary Care Physician or \$10 for a Specialist.

Section 4. Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

Changes to the *List of Covered Drugs (Formulary)*

Silver Rx has a “*List of Covered Drugs (Formulary)*” – or “Drug List” for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your *Evidence of Coverage* explains about Part D drugs.)

We may make changes to the plan’s Drug List from time to time throughout the year. In addition, there are a number of changes to the Drug List that will take effect on January 1, 2012. Changes to the plan’s Drug List 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 the quantity of the drug that the plan will cover for you.
 - If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Services to learn what you or your provider would need to do to get coverage for the drug.

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 Formulary we sent with this *Annual Notice of Changes*. If you can't find some of your drugs on this Drug List, you can call Customer Services for help finding your drugs.
- <http://www.welbornhealthplans.com/medicare>

Changes to your "out-of-pocket" costs

Every drug on the plan's Drug List is in one of 5 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 January 1, 2012, and stay the same for the entire plan year.

Besides the changes to copayments and coinsurance 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 List to a different cost-sharing tier.** Some drugs will be in a lower cost-sharing tier, others will 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 List.

Changes to what you pay for your drugs during the Initial Coverage Stage

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount).

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

The costs in the chart are for prescriptions filled at network, retail pharmacies. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. There may be restrictions for prescriptions filled at out-of-network pharmacies, such as a limit on the amount of the drug you can receive. See Chapter 5, Section 3.5 of the *Evidence of Coverage* for more information.

	2011 (this year)	2012 (next year)
<p>Drugs in Cost-Sharing Tier 1 (Generic Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 1 that is filled at a network pharmacy</p>	For copayments: You pay \$8 per prescription.	For copayments: You pay \$4 per prescription.
<p>Drugs in Cost-Sharing Tier 2 (Non-Preferred Generic Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 2 that is filled at a network pharmacy</p>	For copayments: You pay \$10 per prescription.	For copayments: You pay \$12 per prescription.
<p>Drugs in Cost-Sharing Tier 3 (Preferred Brand Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 3 that is filled at a network pharmacy</p>	<i>For copayments:</i> You pay \$40 per prescription.	<i>For copayments:</i> You pay \$45 per prescription.
<p>Drugs in Cost-Sharing Tier 4 (Non-Preferred Brand Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 4 that is filled at a network pharmacy</p>	You pay \$80 per prescription.	You pay \$85 per prescription.
<p>Drugs in Cost-Sharing Tier 5 (Specialty Drugs)</p> <p>For a one-month (30-day) supply of a drug in cost-sharing tier 5 that is filled at a network pharmacy</p>	You pay 32% of the total cost.	You pay 33% of the total cost.

Changes to the plan's Drug Payment Stages

There are no changes to the plan's Drug Payment Stages for 2012. The table below explains each of the stages.

	2011 (this year)	2012 (next year)
Yearly Deductible Stage	\$0	\$0
Because there is no deductible for the plan, this payment stage does not apply to you.	Not applicable.	Not applicable.
Initial Coverage Stage	\$2,840	\$2,930
During the Initial Coverage Stage, the plan pays its share of the cost of your covered drugs, and you pay your share. (Changes to your share of the costs are described in the previous chart.)	When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage	When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage
You stay in this stage until your year-to-date "total drug costs" total \$2,930 of your Part D drugs reaches the limit for the Initial Coverage Stage. Once you reach this limit, you move on to the Coverage Gap Stage.		

Coverage Gap Stage	During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 93% of the price for generic drugs.	During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs.
You stay in the Coverage Gap Stage until your out-of-pocket costs for your Part D drugs reaches the amount that qualifies you for Catastrophic Coverage.	You stay in this stage until your out-of-pocket costs reach:	You stay in this stage until your out-of-pocket costs reach:
	\$4,550	\$4,700
	This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.	This is the amount you must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.
Catastrophic Coverage Stage	\$2.50 or \$6.30	\$2.60 or \$6.50
During the Catastrophic Coverage Stage, the plan will pay most of the cost for your Part D drugs.		
You will stay in this stage until the end of the calendar year.		

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

What if a drug you are taking now is not on the Drug List 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 6.2 of the *Evidence of Coverage* 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 Customer Services 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. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. 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 of the *Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*.

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 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 Silver Rx in 2012.
- For the most up-to-date information on the network of providers, check our website (<http://www.welbornhealthplans.com/medicare>) or call Customer Services (see phone numbers on the back cover of this booklet).

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

Do you want to stay with Silver Rx?

If you want to keep your membership in Silver Rx 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 if you do not sign up for a different plan or Original Medicare.**

Do you want to make a change?

If you decide to leave Silver Rx, you can switch to a different Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan).

If you want to change to a different plan, there are many choices. If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on the "Health & Drug Plans" button on the left. Then choose

“Compare Drug and Health Plans.”) You can also get information about plans from Medicare or from your State Health Insurance Assistance Program. (For numbers to call, see Section 7 of this *Annual Notice of Changes*.) As a reminder, Welborn Health Plans offers other Medicare health plans and Medicare prescription drug plans in addition to the plan you are now enrolled in. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

When can you change to a different plan?

- During the **yearly enrollment period (called the “annual coordinated election period”) from October 15 through December 7, 2011**, you can change to another Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan). Your new coverage will begin on January 1, 2012.
- You also have **another, more limited enrollment period from January 1 through February 14, 2012**. During this period (called the annual “Medicare Advantage Disenrollment Period”), you could switch from Silver Rx to Original Medicare. Your coverage will begin the first day of the month after we get your request to switch to Original Medicare.
 - If you choose to switch to Original Medicare during this annual disenrollment period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage. Your drug coverage will begin the first day of the month after the drug plan gets your enrollment form.
 - For more information about your choices during the January 1 through February 14 annual disenrollment period, please see Chapter 10, Section 2.2 of the *Evidence of Coverage*.

Are these the only times of the year to choose a different plan?

For most people, yes. Certain individuals, such as those with Medicaid, those who get Extra Help paying for their drugs, or those who move out of the service area, can make changes at other times. There may be other situations in which you are allowed to change plans. For more information, see Chapter 10, Section 2.3 of the *Evidence of Coverage*.

How do you make a change?

See Chapter 10 of the *Evidence of Coverage*. It tells what you need to do to make a change from Silver Rx to another plan.

Check on these things before you make a change

1. **Are you a member of an employer or retiree group plan?** If you are, please check with the benefits administrator of your employer or retiree group *before you change your plan*. This is important because you may lose benefits you currently receive under your employer or retiree group coverage if you switch plans.

2. **Are you getting help with paying for your drugs from a State Pharmaceutical Assistance Program (SPAP)?** If you are, please check with this program before switching to another plan. The phone number for your State Pharmaceutical Assistance Program is listed in Chapter 2, Section 7 of the *Evidence of Coverage*.

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 a copy of the *List of Covered Drugs (Formulary)*.

If you have any questions, we are here to help. Please call our Customer Services at 1-800-521-0265 (TTY only, call 1-800-743-3333). We are available for phone calls *7 days a week, 8 a.m. - 8 p.m. CST*. Calls to these numbers are free.

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

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

SHIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. 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 can call SHIP at 1-800-452-4800, TDD 1-866-846-0139. You can learn more about SHIP by visiting their website (<http://www.in.gov/idoi/>).

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>).
- **Read *Medicare & You 2012 Handbook***. Every year in the fall, 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), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

