Annual Notice of Changes for 2017

You are currently enrolled as a member of AvMed Medicare Choice. Next year, there will be some changes to the plan’s costs and benefits. This booklet tells about the changes.

- You have from October 15 until December 7 to make changes to your Medicare coverage for next year.

Additional Resources

- This information is available for free in other languages.
- Please contact our Member Engagement number at 1-800-782-8633 for additional information. (TTY users should call 711.) Hours are October 1-February 14, 8 am-8pm., 7 days a week; February 15-September 30, 8 am-8pm, Monday-Friday, 9 am-1 pm, Saturday.
- Member Engagement also has free language interpreter services available for non-English speakers.
- Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-782-8633. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.
- This document may be available in other formats such as Braille, large print or other alternate formats.

Minimum essential coverage (MEC): Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual requirement for MEC.

About AvMed Medicare Choice

- AvMed Medicare is an HMO plan with a Medicare contract. Enrollment in AvMed Medicare depends on contract renewal.
- When this booklet says “we,” “us,” or “our,” it means AvMed, Inc. When it says “plan” or “our plan,” it means AvMed Medicare Choice.

AvMed Medicare is an HMO plan with a Medicare contract. Enrollment in AvMed Medicare depends on contract renewal with CMS.
Think about Your Medicare Coverage for Next Year

Each fall, Medicare allows you to change your Medicare health and drug coverage during the Annual Enrollment Period. It’s important to review your coverage now to make sure it will meet your needs next year.

Important things to do:

☐ Check the changes to our benefits and costs to see if they affect you. Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 2 for information about benefit and cost changes for our plan.

☐ Check the changes to our prescription drug coverage to see if they affect you. Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 2.6 for information about changes to our drug coverage.

☐ Check to see if your doctors and other providers will be in our network next year. Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 2.3 for information about our Provider Directory.

☐ Think about your overall health care costs. How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?

☐ Think about whether you are happy with our plan.

If you decide to stay with AvMed Medicare Choice:

If you want to stay with us next year, it’s easy - you don’t need to do anything.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans between October 15 and December 7. If you enroll in a new plan, your new coverage will begin on January 1, 2017. Look in Section 3.2 to learn more about your choices.
# Summary of Important Costs for 2017

The table below compares the 2016 costs and 2017 costs for AvMed Medicare Choice in several important areas. **Please note this is only a summary of changes. It is important to read the rest of this Annual Notice of Changes and review the attached Evidence of Coverage to see if other benefit or cost changes affect you.**

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monthly plan premium</strong>*</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><em>Your premium may be higher or lower than this amount. See Section 2.1 for details.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maximum out-of-pocket amount</strong></td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 2.2 for details.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor office visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visits: $0 per visit</td>
<td></td>
<td>Primary care visits: $0 per visit</td>
</tr>
<tr>
<td>Specialist visits: $10- $30 per visit</td>
<td>Specialist visits: $10- $40 per visit</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital stays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1 - 5: $0 copay per day</td>
<td>Days 1 - 5: $0 copay per day</td>
<td></td>
</tr>
<tr>
<td>Days 6 - 20: $80 copay per day</td>
<td>Days 6 - 20: $80 copay per day</td>
<td></td>
</tr>
<tr>
<td>Days 21 - 90: $0 copay per day</td>
<td>Days 21 - 90: $0 copay per day</td>
<td></td>
</tr>
<tr>
<td>$0 copay for each additional hospital day.</td>
<td>$0 copay for each additional hospital day.</td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>2016 (this year)</td>
<td>2017 (next year)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------</td>
<td>------------------</td>
</tr>
<tr>
<td><strong>Part D prescription drug coverage</strong></td>
<td>Deductible: $0</td>
<td>Deductible: $0</td>
</tr>
<tr>
<td>(See Section 2.6 for details.)</td>
<td>Copayment during the Initial Coverage Stage:</td>
<td>Copayment during the Initial Coverage Stage:</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 1: $0</td>
<td>• Drug Tier 1: $0</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 2: $7</td>
<td>• Drug Tier 2: $7</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 3: $35</td>
<td>• Drug Tier 3: $40</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 4: $70</td>
<td>• Drug Tier 4: $75</td>
</tr>
<tr>
<td></td>
<td>• Drug Tier 5: 33%</td>
<td>• Drug Tier 5: 33%</td>
</tr>
</tbody>
</table>
Annual Notice of Changes for 2017

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SECTION 1 Unless You Choose Another Plan, You Will Be Automatically Enrolled in AvMed Medicare Choice in 2017

If you do nothing to change your Medicare coverage by December 7, 2016, we will automatically enroll you in our AvMed Medicare Choice. This means starting January 1, 2017, you will be getting your medical and prescription drug coverage through AvMed Medicare Choice. If you want to, you can change to a different Medicare health plan. You can also switch to Original Medicare. If you want to change, you must do so between October 15 and December 7.

The information in this document tells you about the differences between your current benefits in AvMed Medicare Choice and the benefits you will have on January 1, 2017 as a member of AvMed Medicare Choice.

SECTION 2 Changes to Benefits and Costs for Next Year

Section 2.1 – Changes to the Monthly Premium

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly premium</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>(You must also continue to pay your Medicare Part B premium.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Your monthly plan premium will be more if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as “creditable coverage”) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be less if you are receiving “Extra Help” with your prescription drug costs.

Section 2.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay “out-of-pocket” during the year. This limit is called the “maximum out-of-pocket amount.” Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.
Cost

<table>
<thead>
<tr>
<th>Maximum out-of-pocket amount</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.</td>
<td>$5,000</td>
<td>Once you have paid $5,000 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year.</td>
</tr>
</tbody>
</table>

Section 2.3 – Changes to the Provider Network

There are changes to our network of providers for next year.

An updated Provider Directory is located on our website at http://www.avmed.org. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. Please review the 2017 Provider Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.
Section 2.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at http://www.avmed.org. You may also call Member Engagement for updated provider information or to ask us to mail you a Pharmacy Directory. Please review the 2017 Pharmacy Directory to see which pharmacies are in our network.

Section 2.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Medical Benefits Chart (what is covered and what you pay), in your 2017 Evidence of Coverage.

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Physician Office visit</td>
<td>You pay a $10 - $30 copay per office visit</td>
<td>You pay a $10 - $40 copay per office visit</td>
</tr>
<tr>
<td></td>
<td>You will pay a $10 copay per office visit for specialists with a proven track record for high quality, cost efficient care; these specialists are marked with a ▲ in the provider and pharmacy directory. You will pay a $30 copay per office visit for all other specialists.</td>
<td>You will pay a $10 copay per office visit for specialists with a proven track record for high quality, cost efficient care; these specialists are marked with a ▲ in the provider and pharmacy directory. You will pay a $40 copay per office visit for all other specialists.</td>
</tr>
</tbody>
</table>
### Cost

<table>
<thead>
<tr>
<th>Cost</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>You pay a $75 copay for non-hospital affiliated facility.</td>
<td>You pay a $75 copay for non-hospital affiliated facility.</td>
</tr>
<tr>
<td></td>
<td>You pay a $150 copay for hospital affiliated facility.</td>
<td>You pay a $200 copay for hospital affiliated facility.</td>
</tr>
<tr>
<td><strong>Outpatient Diagnostic Services</strong></td>
<td><strong>Complex testing</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>You pay a $75 copay for non-hospital affiliated facility.</td>
<td>You pay a $75 copay for non-hospital affiliated facility.</td>
</tr>
<tr>
<td></td>
<td>You pay a $175 copay for hospital affiliated facility.</td>
<td>You pay a $225 copay for hospital affiliated facility.</td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
<td>You Pay: $0 to $10 for oral exams</td>
<td>You Pay: $0 to $25 for oral exams</td>
</tr>
<tr>
<td></td>
<td>$0 to $28 for dental x-ray</td>
<td>$0 to $35 for dental x-ray</td>
</tr>
<tr>
<td></td>
<td>$20 for fluoride</td>
<td>Fluoride not covered</td>
</tr>
<tr>
<td></td>
<td>Provided by Solstice</td>
<td>Provided by Delta Dental</td>
</tr>
</tbody>
</table>

### Section 2.6 – Changes to Part D Prescription Drug Coverage

#### Changes to Our Drug List

Our list of covered drugs is called a Formulary or “Drug List.” A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.**

If you are affected by a change in drug coverage, you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception to cover the drug.** **We encourage current members** to ask for an exception before next year.
To learn what you must do to ask for an exception, see Chapter 9 of your Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) or call Member Engagement.

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Engagement to ask for a list of covered drugs that treat the same medical condition.

In some situations, we are required to cover a **one-time**, temporary supply of a non-formulary drug in the first 90 days of coverage of the plan year or coverage. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the Evidence of Coverage.) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

If you received an approval from AvMed for a formulary exception in 2016, please refer to the approval letter for its expiration date. A new request for a formulary exception will need to be submitted if continuation of the medication is required past the expiration date of your previous authorization. In some instances, AvMed may extend your current authorization through December 31, 2017. In these instances, we will notify you of our decision to extend the authorization in writing prior to the new effective year.

### Changes to Prescription Drug Costs

*Note: If you are in a program that helps pay for your drugs (“Extra Help”), the information about costs for Part D prescription drugs may not apply to you. We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also called the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug costs. If you get “Extra Help” and didn’t receive this insert with this packet, please call Member Engagement and ask for the “LIS Rider.” Phone numbers for Member Engagement are in Section 8.1 of this booklet.*

There are four “drug payment stages.” How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your Evidence of Coverage for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in the enclosed Evidence of Coverage.)
Changes to the Deductible Stage

<table>
<thead>
<tr>
<th>Stage</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1: Yearly Deductible Stage</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
<td>Because we have no deductible, this payment stage does not apply to you.</td>
</tr>
</tbody>
</table>

Changes to Your Cost-sharing in the Initial Coverage Stage

To learn how copayments and coinsurance work, look at Chapter 6, Section 1.2, *Types of out-of-pocket costs you may pay for covered drugs in your Evidence of Coverage.*

<table>
<thead>
<tr>
<th>Stage</th>
<th>2016 (this year)</th>
<th>2017 (next year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2: Initial Coverage Stage</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
<td>Your cost for a one-month supply filled at a network pharmacy with standard cost-sharing:</td>
</tr>
<tr>
<td></td>
<td>Tier 1: You pay $0 per prescription.</td>
<td>Tier 1: You pay $0 per prescription.</td>
</tr>
<tr>
<td></td>
<td>Tier 2: You pay $7 per prescription.</td>
<td>Tier 2: You pay $7 per prescription.</td>
</tr>
<tr>
<td></td>
<td>Tier 3: You pay $35 per prescription.</td>
<td>Tier 3: You pay $40 per prescription.</td>
</tr>
<tr>
<td></td>
<td>Tier 4: You pay $70 per prescription.</td>
<td>Tier 4: You pay $75 per prescription.</td>
</tr>
<tr>
<td></td>
<td>Specialty: You pay 33% of the total cost.</td>
<td>Specialty: You pay 33% of the total cost.</td>
</tr>
<tr>
<td></td>
<td>Once your total drug costs</td>
<td>Once your total drug costs</td>
</tr>
</tbody>
</table>

Once your total drug costs
Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage. For information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your Evidence of Coverage.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in AvMed Medicare Choice

To stay in our plan you don’t need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically stay enrolled as a member of our plan for 2017.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2017 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- OR-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read Medicare & You 2017, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click “Find health & drug plans.” Here, you can find information about costs, coverage, and quality ratings for Medicare plans.
**Step 2: Change your coverage**

- To change to a different Medicare health plan, enroll in the new plan. You will automatically be disenrolled from AvMed Medicare Choice.

- To change to Original Medicare with a prescription drug plan, enroll in the new drug plan. You will automatically be disenrolled from AvMed Medicare Choice.

- To change to Original Medicare without a prescription drug plan, you must either:
  - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 7.1 of this booklet).
  - or – Contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

**SECTION 4 Deadline for Changing Plans**

If you want to change to a different plan or to Original Medicare for next year, you can do it from October 15 until December 7. The change will take effect on January 1, 2017.

**Are there other times of the year to make a change?**

In certain situations, changes are also allowed at other times of the year. For example, people with Medicaid, those who get “Extra Help” paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area are allowed to make a change at other times of the year. For more information, see Chapter 10, Section 2.3 of the Evidence of Coverage.

If you enrolled in a Medicare Advantage plan for January 1, 2017, and don’t like your plan choice, you can switch to Original Medicare between January 1 and February 14, 2017. For more information, see Chapter 10, Section 2.2 of the Evidence of Coverage.

**SECTION 5 Programs That Offer Free Counseling about Medicare**

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Florida, the SHIP is called the Department of Elder Affairs “SHINE” program.

The SHINE program 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. SHINE 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 SHINE at 1-800-963-5337. You can learn more about the SHINE program by visiting their website (www.floridashine.org).
SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **“Extra Help” from Medicare.** People with limited incomes may qualify for “Extra Help” to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don’t even know it. To see if you qualify, call:
  - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
  - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778 (applications);
  - Your State Medicaid Office (applications);

- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Florida Department of Health AIDS Drugs Assistance Program. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call the Florida Department of Health ADAP at 1-850-245-4334 or visit the website at [http://www.floridahealth.gov/diseases-and-conditions/aids/adap](http://www.floridahealth.gov/diseases-and-conditions/aids/adap).

SECTION 7 Questions?

Section 7.1 – Getting Help from AvMed Medicare Choice

Questions? We’re here to help. Please call Member Engagement at 1-800-782-8633. (TTY only, call 711.) We are available for phone calls October 1-February 14, 8 am-8 pm., 7 days a week; February 15-September 30, 8 am-8 pm, Monday-Friday, 9 am-1 pm, Saturday. Calls to these numbers are free.

**Read your 2017 Evidence of Coverage (it has details about next year’s benefits and costs)**

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2017. For details, look in the 2017 Evidence of Coverage for AvMed Medicare Choice. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your
rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is included in this envelope.

**Visit our Website**

You can also visit our website at http://www.avmed.org. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

**Section 7.2 – Getting Help from Medicare**

To get information directly from Medicare:

**Call 1-800-MEDICARE (1-800-633-4227)**

You can 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**

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. 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 “Find health & drug plans”).

**Read Medicare & You 2017**

You can read the *Medicare & You 2017* 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.