MID-YEAR SPECIAL ENROLLMENT
FEBRUARY 14, 2020 to FEBRUARY 28, 2020 Medical Plan
for AFSCME Local 199, AFSCME Local 1542, AFSCME Local 3292

Q1. **Will My Employee Medical Plan Premium Payroll Deductions Change Beginning April 2020?**

A. No. Employee and dependent medical plan premium payroll deductions will remain flat for this year due to the implementation of several cost containment initiatives.

Q2. **What Is a PHCS – Private Healthcare System Network?**

A. The PHCS is a rented network of additional providers (not included in the AvMed Network) previously available in the High HMO and POS plans

If you are enrolled in the AvMed HMO Advantage Option or the AvMed POS Advantage Option, you will be redirected to an AvMed provider. Providers used outside of the AvMed network will be considered out-of-network effective April 1, 2020. AvMed has a comparable network of physicians and specialists. The AvMed Elite Network will no longer include PHCS providers. POS Advantage members may take advantage of the out-of-network plan option and will be subject to any applicable cost-sharing.

Q3. **Will my dependent enrolled in the "Away From Home" program be impacted by the network changes?**

A. No, eligible dependents enrolled in the Away From Home program will still have access to the PHCS network providers for out of area services while enrolled in the program.

Q4. **Will My Co-Pays for Physician Services and/or Prescription Drugs Change Beginning April 2020?**

A. In order to direct employees and dependents to the appropriate level of care, there have been utilization driven changes to co-pay amounts. Please see the Plan's Summary of Benefits for details.

Q5. **What Additional Changes to My Prescription Drug Coverage Do I Need to Know?**

A. Effective April 1, 2020, POS Advantage plan employees and dependents will be subject to use generics first. All new prescriptions will use the standard formulary and brand name prescriptions will be subject to any cost differential between generic and brand name, plus applicable copays and brand additional charge as they are today in the HMO plans.

Your prescription drug plan is designed to save you money. Before you use a brand-name drugs, you should first try a similar, alternative medication. In most cases, this will be a generic drug. Generics are approved by the FDA as safe and effective but will cost you less.

Example: Before you can fill a new prescription for the brand-name drug Crestor, you will need to try f the generic alternatives first – atorvastatin, fluvastatin, lovastatin, pravastatin or simvastatin.

Q6. **What are the Changes to my Maintenance Medication (90-day) Prescription Drug Pharmacy Network?**

A. Maintenance medications will be subject to Maintenance Choice options; mail order pharmacy and/or can be obtained through a Limited Network Pharmacy (CVS, Target and Navarro). After 3 refills at a retail pharmacy you will no longer be approved to fill a maintenance medication prescription. Out-of-network pharmacy users do not receive any discounts from the plan and are no longer covered under the Plan for filling maintenance prescriptions unless using a Maintenance Choice option.

For a (90 day) supply from a /CVS Maintenance Choice pharmacy or CVS Pharmacy Mail Order, members pay only 2 copays instead of 3 copays saving members 1 copay. Maintenance drugs can be filled at retail pharmacy up to **3 times** (30-60 day supply) and subsequent refills will be filled using the Maintenance Choice options (minimum 90 day supply). If you have less than a 90 day supply, contact your physician prior to your visit to the pharmacy or the refill prescription will not be processed causing foreseeable delays.

Q7. **Will I Be Able to Use The Same Prescription Drugs Beginning April 2020?**

A. The list of prescription drugs, both generic and brand name, covered by the Plan has been updated with newly approved drugs that are more cost effective. Rarely used and/or outdated drugs have been removed.

POS Advantage members currently using brand name prescription drugs will be allowed to continue use at the applicable copay without interruption until no longer prescribed. All new prescriptions will use the standard formulary and brand name prescriptions will be subject to any cost differential between generic and brand name, plus applicable copays and brand additional charge as they are today in the HMO plans.

Did you know that the Food and Drug Administration (FDA) requires generic drugs to have the same strength and purity as brand-name drugs? Generic drugs can be just as effective as their brand-name counterparts at a fraction of the price, so why would you spend more than you have to on your prescription medications? Choose generics and save.

Q8. **What Will I Pay If I Need High-Tech Imaging Testing (Ex. MRIs, CT/PET scans)?**

A. Effective April 1, 2020, high-tech imaging for non-emergency services must be performed at an in-network freestanding facility. Non-emergency services performed in a hospital (outpatient) facility will not be covered by the Plan unless the member is in active treatment for a serious illness such as Cancer, Renal Kidney Failure or is a Transplant patient. Once the member is no longer in treatment, all follow-up care will need to be performed in a freestanding setting. Contact a Health Cost Adviser through AvMed SmartShopper (866-285-7453) to choose a cost-effective location for your medical procedure. You and your dependents can qualify for **$25 - $500 CASH BACK** when you shop with **SmartShopper**! You can also shop online at **AvMed.VitalsSmartShaopper.com**

Q9. **What Medical Plan Options Will Be Available to Me Beginning April 1, 2020?**

A. Benefits eligible employees hired before January 1, 2020 will have the choice of electing AvMed's First Choice Advantage, Select Advantage HMO, HMO Advantage and POS Advantage.

Benefits eligible employees hired on or after January 1, 2020 will have the choice of electing the First Choice Advantage HMO plan or the Select Advantage HMO options. Other plan options are not available.

Q10. **Why am I getting two bills for one visit to the provider's office?**

A. Be aware that some hospital-based provider offices are charging patients co-pays for the office visit and another co-pay for an (outpatient) minor surgical services that may be performed in their office. Several hospital-based provider practices bill you and the insurance company as if you had the procedure in a hospital setting and charge you both the office and outpatient visit co-pays. Please check with your provider's office about copays before you have an in-office procedure performed.