

# State Retiree, Annuitant and Survivor Benefits Handbook Amendment

## (Amendment V)

This document is an amendment to the State Retiree, Annuitant and Survivor Benefits Handbook released in October 2011. An amendment adds, modifies, deletes or otherwise changes a benefit listed in the Benefits Handbook. As changes occur, the online handbook will be modified to reflect the changes. Those updates and changes will be included in this amendment document as they occur. If you have a printed copy of the online handbook, you should refer to this amendment to ensure you have the most up-to-date information.

### STATE RETIREE, ANNUITANT AND SURVIVOR AMENDMENT – 07/01/2013

#### The following amends the Benefits Handbook:

1. The term 'usual and customary (U&C)' was replaced with 'allowable charges' throughout the handbook.
2. A new section (Quality Care Health Plan (QCHP) Summary of Benefits and Exclusions) was added behind the 'Health Plan Options' section of the handbook. The addition of these pages have caused the remaining pages to be renumbered beginning with page 34. The index has been updated to reflect the page number changes.
3. On pages 13 and 14, under the 'Qualifying Change in Status' charts, in the definition for 'O' (i.e., Opt Out), the portion of the sentence that read "when the State is responsible for 100% of the contribution" was removed.  
  
This change was made since effective July 1, 2013, all retirees, annuitants and survivors are responsible for a monthly contribution to their health insurance coverage.
4. On page 17, in the 'Opt Out with Financial Incentive' section, references to the opt out with financial incentive applying only to SERS annuitants were removed since, effective July 1, 2013, the financial incentive is now an option for annuitants in any of the five state retirement systems.  
  
Public Act 98-0019, effective July 1, 2013, included a financial incentive of \$150 per month for annuitants with less than 20 years of state service and a \$500 per month incentive for annuitants with 20 years or more of state service, less applicable withholding.
5. On page 18, under the 'Retiree, Annuitant and Survivor Contributions' section, the 'Member Coverage Contributions' language was replaced with the following:  
  
"Contribution amounts for retirees, annuitants and survivors are based on years of service and Medicare status. Effective July 1, 2013, all members are responsible for a member-paid contribution for their health coverage."
6. On pages 18 through 20, the language in the 'State Contribution' section was changed to reflect the new contribution amounts for which annuitants, retirees and survivors are responsible, effective July 1, 2013.
7. On page 29, under 'Health Plan Options', the 'Open Access Plan (OAP)' section was expanded to give more information regarding how an OAP works.
8. After page 33, a section that lists the benefits covered under the QCHP, as well as the plan's exclusions, was added.
9. On page 34 (new page 44), in the 'Prescription Coverage' section, the following changes were made to the headings and to the text throughout those sections:  
  
'Managed Care Plans (Fully-Insured)' was changed to a more accurate description of 'Health Maintenance Organizations (HMOs)'  
  
'Self-Insured Managed Care Plans and the Quality Care Health Plan (QCHP)' was changed to 'Open Access Managed Care Plans and the Quality Care Health Plan (QCHP)'

10. On page 36 (new page 46), in the 'Prescription Coverage' section, under "Maintenance Medication", the references to 'two copayments' for a 90-day supply were changed to 'two and a half copayments' in accordance with the AFSCME bargaining contract that went into effect July 1, 2013.
11. On pages 48 through 51 (new pages 58-60), the 'Medicare' section was updated to indicate that beginning July 1, 2013, members who are enrolled in the Quality Care Health Plan (QCHP) and who have Medicare as their primary insurance must satisfy the annual plan year deductible before the QCHP will pay the standard benefits.  
  
The 'Medicare' section was also updated to clarify that members enrolled in QCHP who have Medicare as their primary insurance must utilize QCHP network providers in order to receive the in-network benefit level after Medicare pays its portion. Members who use providers who are not in the QCHP network will have benefits paid at the out-of-network benefit level after Medicare pays their portion.
12. On pages 55 and 56 (new pages 64-65), in the 'Claims Appeal Process' section, the option for a second level of internal appeals was removed in order to bring the appeal process in line with industry standards and mirror PPACA, NCQA and URAC guidelines.
13. On page 59 (new page 68), the term 'allowable charges' was added to the glossary with the following definition:  
  
"The maximum amount the plan will pay an out-of-network healthcare professional for billed services."
14. On pages 63 and 64 (new pages 72-73), the page numbers associated with the terms listed in the index were updated since additional pages were added to the 'Health Plan Options' section.