

Retirement/ Disability Retirement

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Benefits for Retirees

This chapter provides useful information for eligible participants in the state insurance program who are considering retirement or who have retired. For detailed information on specific programs, refer to the previous chapters in this guide.

If you or a family member you cover is eligible for Medicare, you will find helpful information in the Medicare chapter, as well as in this one. **Please read both chapters.**

If you have questions or need additional information about your insurance, contact the Employee Insurance Program (EIP) through our Web site at www.eip.sc.gov or call 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).



A checklist that will help you find information about retiree insurance benefits is on page 32.

Are You Eligible for Retiree Insurance?

You may be eligible for health, vision and dental coverage in retirement through an employer that participates in the state insurance program when you retire:

- Due to years of service
- Due to age
- On approved disability:
 - Through the S.C. Retirement Systems (SCRS)
 - Through approval by The Standard for Basic Long Term Disability and/or Supplemental Long Term Disability if you participate in the Optional Retirement Program (ORP) or work for an employer that does not participate in the SCRS.



For more information about state retirement eligibility, call 803-737-6800 (Greater Columbia area) or 800-868-9002 (toll-free outside the Columbia area but in South Carolina) or visit the S.C. Retirement Systems Web site at www.retirement.sc.gov.

Regardless of how or when you qualify for retirement, to qualify for the retiree group insurance program, your last five years of employment must be served consecutively and in a full-time, permanent position with an employer that participates in the state insurance program.

Some retirees, who are referred to as “non-funded retirees,” are eligible for insurance but must pay the full premium, which includes the retiree share plus the employer contribution. These retirees worked in an insurance-eligible position before May 2, 2008, with an employer participating in the state insurance program, and include:

- Employees who retire at age 55 with at least 25 years of retirement service credit (including at least 10 years of earned service credit with an employer that participates in the state insurance program). This is commonly referred to as the “55/25 rule.” These retirees must pay the full insurance premium until they reach age 60 or the date they would have had 28 years of service credit, whichever occurs first. At the end of this period, they will be eligible for funded retiree rates. This rule applies only to SCRS participants. If you are retiring from a local subdivision, contact your benefits administrator for premium information.
- Employees who are eligible to retire and have at least five years, but fewer than 10 years, of earned SCRS service credit with an employer participating in the state insurance program
- General Assembly members who leave office or retire with at least eight years of General Assembly Retirement System service credit



If you are eligible for retiree insurance, you must enroll within 31 days of your eligibility date. See page 182 for more information.

- Former municipal and county council members who served on council for at least 12 years and were covered under the state's plan when they left the council. It is up to the county or municipal council to decide whether to allow former members to have this coverage.

State Optional Retirement Program participants must meet the same retiree insurance eligibility guidelines as SCRS participants, with the exception of the 55/25 year rule.

Whether you are a funded or a non-funded retiree, the following types of service do not count toward your earned service credit requirement for insurance eligibility: non-qualified, federal, military, out-of-state employment, educational service, leave of absence, unused sick leave or service with employers that do not participate in the state insurance program.

If you are not eligible for insurance as a retiree, you may still be eligible to continue coverage under COBRA (see page 26).

TERI Program Participants:

If you are a Teacher and Employee Retention Incentive (TERI) program participant in a permanent, full-time position, your insurance benefits as an active employee continue. When your TERI employment ends, you must apply for continuation of your insurance benefits as a retiree (if eligible) within 31 days of your date of termination. Your service as a TERI participant in a full-time, permanent position with a participating employer may be applied toward retiree insurance eligibility.

Who Pays For Your Insurance?

State Agency, Higher Education and School District Retirees:

You may be eligible for a state contribution to your retiree insurance premiums based on **when you began employment** and on your **number of years of earned service credit** with an employer that participates in the state insurance program.

Local Subdivision Retirees:

Local subdivisions may or may not pay a portion of the cost of their retirees' insurance premiums. Each local subdivision develops its own policy for funding retiree insurance premiums for its eligible retirees. **If you are a local subdivision employee, contact your benefits office for information about retiree insurance premiums.**

A local subdivision is a South Carolina public employer that falls within one of the categories established by Section 1-11-720 of the S.C. Code of Laws, as amended, (such as a city or county) and participates in the state insurance program.

Employees Hired Before May 2, 2008

If you worked in an insurance-eligible position before May 2, 2008, with an employer participating in the state insurance program, your health insurance benefits in retirement are eligible for funding if you fall into one of these categories:

- Employees who leave employment when they are eligible to retire and have at least 10 years of earned SCRS service credit with an employer that participates in the state insurance program
- Employees who leave employment before they are eligible to retire and who have at least 20 years of earned SCRS service credit with an employer that participates in the state insurance program. These employees are not eligible for insurance coverage until age 60 when they are eligible to receive a retirement check. (This also applies to local subdivision or ORP retirees who are covered under EIP but not under SCRS.) Employees who qualify under the Police Officers Retirement System (PORS) become eligible at age 55.

- Employees who left employment before 1990 and who were not eligible to retire, but who had 18 years of earned SCRS service credit and returned to work with a participating group, enrolled in a state health and dental plan, and worked for at least two consecutive years in a full-time, permanent position.

Employees Hired on or After May 2, 2008

New retiree insurance provisions, which were created by Act 195 of 2008, apply to new employees hired **on or after May 2, 2008**. At retirement, you must meet established insurance eligibility rules, and funding for your health insurance will be determined by calculating the number of years of earned service with an employer participating in the state insurance program.

These new funding provisions apply to SCRS, ORP, PORS, General Assembly Retirement System and Judges-Solicitors Retirement System participants.

Funded Retirees:

If an employee retires with **25 or more years** of earned service credit, the state pays 100 percent of the employer's share of the premium. The retiree pays the retiree's share.

Partially Funded Retirees:

If an employee retires with **15 years, but fewer than 25 years**, of earned service credit, the state pays 50 percent of the employer's share of the premium. The retiree pays the retiree's share plus the remaining 50 percent of the employer's contribution.

Non-Funded Retirees:

If an employee retires with **5 years, but fewer than 15 years**, of earned service credit, the retiree pays the full premium. There is no state contribution.



If you have questions about your insurance benefits at retirement, contact your benefits administrator.

Retiree Premiums and Premium Payment

State Agency, Higher Education and School District Retirees

Your health, vision, State Dental Plan and Dental Plus premiums are deducted from your monthly SCRS pension check.

When you retire, your insurance premiums may be due before your retirement paperwork has been finalized by SCRS or EIP. If this happens, you will receive a monthly bill for the premiums until you receive your first retirement check. If you do not pay the bill, the total premiums due will be deducted from your first retirement check.



Tables showing retiree insurance premiums begin on page 221.

Your pension is paid at the end of the month, and your insurance premiums are paid at the beginning of the month. For example: your insurance premiums for April are deducted from your March retirement check. Depending on when your retirement paperwork is processed, more than one month's premium may be deducted from your first retirement check.

If, at any time, the total premiums due are greater than the amount of your pension check, EIP will bill you directly for the full amount.

Local Subdivision Retirees

You pay your health, vision, State Dental Plan and Dental Plus premiums directly to your former employer. Your employer sends them to EIP. Contact your benefits office for information about your insurance premiums in retirement.

Enroll Within 31 Days Of Your Retirement

Your insurance will **NOT** be automatically continued when you retire. In addition to completing your paperwork with the S.C. Retirement Systems (SCRS), **you must contact EIP within 31 days of the date you retire to arrange for your retiree insurance and to complete the paperwork.** Please visit our office in Suite 300, 1201 Main St., Columbia, if you would like to see an EIP representative. We do not schedule appointments.

You may also request a retiree insurance enrollment packet by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area) or print forms from the EIP Web site, www.eip.sc.gov.

You must complete the Retiree Notice of Election form and the Employment Verification Record. You may also need the Notice of Continuation of Coverage (Basic Life, Optional Life and Dependent Life) and the Group Life Insurance Portability Enrollment form.

How to Enroll

If you are an eligible retiree, you must enroll by completing a Retiree Notice of Election (NOE) form and an Employment Verification Record within 31 days of:

- Your retirement date or
- The end of your TERI period or
- The date on the letter approving your SCRS disability retirement if you participate in the SCRS or
- The date on the letter approving your BLTD/SLTD retirement if you are retiring under ORP or from an employer that is not covered under the SCRS or
- *A special eligibility situation.*

You may enroll yourself and any eligible family members. (However, you are not required to cover the same eligible family members as a retiree that you covered as an active employee.)

If you and/or your eligible family members are **not covered by a state health plan** at the time of your retirement, you may enroll within 31 days of:

- Your retirement date or
- The date of the letter approving your disability retirement or
- The end of your TERI period or
- *A special eligibility situation.*

Special Eligibility Situations

A special eligibility situation is created by a qualifying event. It allows eligible employees and retirees to enroll in an insurance plan, or to make enrollment changes if requested within 31 days of the *qualifying event*. For more information, see pages 21-25.

Examples of a *qualifying event* include: marriage, birth, adoption or placement for adoption. Loss of other coverage is a qualifying event only for those who lost coverage.

You will be subject to *pre-existing condition* exclusions for 12 months. Proof of *creditable coverage* may be used to reduce a pre-existing condition exclusion period, if any break in coverage did not exceed 62 days. Those enrolling who have had a break in health coverage of more than 62 days will be subject to pre-existing condition exclusions for up to 12 months.

Your BENEFITS ADMINISTRATOR, or “BA,” helps you enroll in or change your insurance coverage.

If you worked for a state agency, higher education institution or school district, your BA, in retirement, is the Employee Insurance Program.

If you worked for a local subdivision, your BA remains the same after retirement.

Late Entrants

If you and/or your spouse and children do not enroll within 31 days of retirement, disability approval or a special eligibility situation, you may enroll as a late entrant during open enrollment, which is in October of every odd-numbered year (e.g., October 2011). Your coverage will take effect on the following January 1 (January 1, 2012), but, as a late entrant, your coverage will be subject to pre-existing condition exclusions for 18 months. Proof of creditable coverage may be used to reduce a pre-existing condition exclusion period, if any break in coverage did not exceed 62 days.

For more information about the pre-existing condition exclusion, see page 12.

Your Health Plan Choices as a Retiree

If You Are Not Eligible for Medicare

If you, your covered spouse and your covered children **are not** eligible for Medicare, you may be covered under one of these plans:

- The SHP Savings Plan (You may contribute to a Health Savings Account (HSA), but not through MoneyPlu\$.*)
- The SHP Standard Plan
- An HMO offered in the county where you live. (See page 75 for counties where each HMO is available.)

***Please note:** If the retiree is not eligible for Medicare but the spouse is, the retiree can enroll in the Savings Plan and contribute to an HSA. For more information about HSAs, see page 169.

Your health benefits, which are described in a previous chapter, will be the same as if you were an active employee. However, your premiums may change depending on whether you are a funded or a non-funded retiree. Refer to pages 221-222 for premiums.



A chart describing your health plan benefits, if you are not eligible for Medicare, begins on page 192.

If You Are Eligible for Medicare

If you, your covered spouse or your covered children **are** eligible for Medicare, you may be covered under one of these plans:

- The SHP Standard Plan
- The SHP Medicare Supplemental Plan
- An HMO offered in the county where you live. (See page 75 for counties where each HMO is available.)

Please note: If you are retired and eligible for Medicare, you may not enroll in the Savings Plan, and you cannot contribute to a Health Savings Account associated with the Savings Plan.



To learn how Medicare affects your health insurance benefits, see the Medicare chapter, which begins on page 199.

When Your Coverage as a Retiree Begins

Even if you go directly from active employment to retirement, you still have to enroll as a retiree. Your retiree coverage will begin the day after your active coverage ends. If you are enrolling due to a special eligibility situation, your effective date will be either the date of the qualifying event or the first of the month after the qualifying event, depending on the event. If you enroll during open enrollment your coverage will be effective the following January 1.

Information You Will Receive

After you enroll, you will receive a letter from the Employee Insurance Program that confirms you have retiree group coverage. Because your coverage as an active employee is ending, federal law requires that you also be sent:

- A Certificate of Creditable Coverage, which gives the dates of your active coverage, the names of the individuals covered and the types of coverage
- A Qualifying Event Notice, which tells you that you may continue your coverage under COBRA.

Typically, these letters require no action on your part.

Your Insurance Identification Card in Retirement

Keep your identification card if you do not change plans when you retire. You and your covered family members may not receive new cards at retirement if you remain covered under any State Health Plan option or the State Dental Plan and Dental Plus. You will receive a new health identification card if you are changing from an HMO to any State Health Plan option or vice versa and/or if you enroll in the State Dental Plan, Dental Plus or the State Vision Plan for the first time. If your card is lost, stolen or damaged, you may request a new card from EIP or from these third-party administrators:

- State Health Plan — BlueCross BlueShield of South Carolina
- HMOs — CIGNA HealthCare or BlueChoice HealthPlan
- Dental Plus — BlueCross BlueShield of South Carolina
- State Vision Plan — EyeMed Vision Care.

Contact information for the third-party administrators is on the inside cover of this guide.

Changing Coverage

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment*, which occurs in even-numbered years, eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to the Medicare Supplemental Plan, if you are retired.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents.
- During every enrollment period, eligible subscribers may add or drop State Vision Plan coverage.

For more information, see page 21 in the General Information chapter.



MyBenefits, EIP's online enrollment system, is available to retirees. To learn more, see page 30.

Dropping a Covered Spouse or Child

If a covered spouse or child becomes ineligible, you must drop him from your health, dental and vision coverage. This may occur because of divorce or separation, a spouse or a child gains coverage as an employee of an EIP participating group, a child turns 26, or a child becomes eligible for a group health plan sponsored by his employer (or by his spouse's employer). If you drop a spouse or child from your coverage, you must complete an NOE within 31 days of the date he becomes ineligible.

When your child becomes ineligible for coverage because of age, he will be dropped automatically. If he is your last covered child, your level of coverage will be changed.

Failure to Pay Premiums

Premiums are due by the 10th of each month billed. If a subscriber fails to pay the full bill for all of the plans in which he is enrolled, including the tobacco-use surcharge, if it applies, **all** of his coverage will be canceled effective the last day of the month in which he paid his premiums in full. This includes coverage for which he may not pay a premium, such as retiree-only State Dental Plan coverage.

Returning to Employment After Retirement

If you, your spouse or your children are covered under the retiree group insurance program and you become eligible for insurance benefits because you have returned to work for an employer participating in the state insurance program, you will need to make decisions regarding your coverage.

As long as you or any of your covered family members are not eligible for Medicare, you can decide whether to return to coverage under active group employee benefits or to continue your retiree group benefits. You cannot be covered under both. **If you or any of your covered family members are eligible for Medicare, you cannot remain on retiree group coverage while employed**, as explained below.

If you refuse to enroll as an active employee, you are also refusing benefits that are available only to active employees:

- MoneyPlu\$ benefits (You must have completed one year of continuous state-covered service by January 1 after October enrollment to qualify for a Medical Spending Account.)
- Basic and Supplemental Long Term Disability coverage
- \$3,000 Basic Life benefit
- Optional Life Insurance
- Dependent Life Insurance.

If you prefer to continue your retiree group insurance benefits, you must complete and sign an **Active Group Benefits Refusal** form.

When you leave work and return to retiree group coverage before age 65, be sure to contact the Social Security Administration within 60 days of turning 65. You should enroll in Medicare Part A and Part B.

Retirees who Continued or Converted Life Insurance

Retirees Hired in a Benefits-Eligible Position

If you continued (ported) your Optional Life coverage, you must decide whether to keep your continued coverage or cancel in order to enroll in Optional Life as an active employee. You cannot have both.

If you converted your Optional Life coverage and are rehired within two years of the date the coverage was converted, you must cancel your converted policy in order to enroll in Optional Life as an active employee. **If you return to work more than two years after your policy was converted, you can enroll in active coverage and keep your converted policy.**

If You or Your Covered Family Members are Enrolled in Medicare

Medicare cannot be the primary insurance for you, or for any of your covered family members, while you are employed, according to federal law. To comply with this regulation, you are required to suspend your retiree group coverage and enroll as an active employee with Medicare as the secondary payer, or refuse all EIP-sponsored health coverage for yourself and your eligible family members and have Medicare coverage only.

If you enroll in active group coverage, you must notify the Social Security Administration (SSA), since

Medicare will pay after your active group coverage. You may remain enrolled in Medicare Part B and continue paying the premium, and Medicare will be the secondary payer. You may also delay or drop Medicare Part B without a penalty while you have active group coverage. Contact the SSA for additional information.

When you stop working and your active group coverage ends, you must re-enroll in retiree group coverage within 31 days of your active termination date. In addition, you must notify the SSA that you are no longer covered under an active group so that you can re-enroll in Medicare Part B, if you dropped it earlier.

If your new position does not make you eligible for benefits, your retiree group coverage continues, and Medicare remains the primary payer.



Please check the Medicare chapter, which begins on page 199, for more information about how your coverage through EIP works with Medicare.

WHEN YOU OR ONE OF YOUR COVERED FAMILY MEMBERS BECOMES ELIGIBLE FOR MEDICARE due to age or disability, your health insurance options and the way your health insurance is handled changes. You **MUST** notify EIP within 31 days of eligibility. If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- Begin paying benefits as if you were enrolled in Medicare
- Seek reimbursement for overpaid claims back to the date you or your covered family member(s) became eligible for Medicare.

Medicare Before Age 65: Disability Retirees

If you or your spouse becomes eligible for Medicare before age 65 due to disability, including end-stage renal disease (ESRD), you must notify EIP within 31 days of Medicare eligibility. When you notify EIP, please submit a copy of your Medicare card.

Because Medicare is primary (pays first) over your retiree health insurance (except during the 30-month ESRD coordination of benefits period), when you become eligible for Medicare, you must enroll in Medicare Part A, and it is strongly advised that you enroll in Part B. **If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.**

If you turn down Medicare Part B when you are first eligible, you must wait until Medicare's General Enrollment Period. This period is from January 1 to March 31 of each year, and coverage begins on July 1. Your Medicare premium will be 10 percent higher for each year you were not covered by Part B after you were first eligible. Contact Medicare for enrollment details and for premium information that applies specifically to you.

If you are covered under the Savings or Standard Plan, you will automatically be switched to the Medicare Supplemental Plan the first of the month after EIP is notified that you are enrolled in Medicare.

When you enroll in Medicare, you should notify EIP and send in a copy of your Medicare card.

End-stage Renal Disease

If you have end-stage renal disease you will become eligible for Medicare three months after beginning dialysis. At this point, a 30-month "coordination period" begins. During this period, your health coverage through EIP is primary, which means it pays your medical claims first. After 30 months, Medicare becomes your primary coverage. Please notify EIP within 31 days of the end of the coordination period. You will then have the option of changing to the Medicare Supplemental Plan. (The Medicare Supplemental Plan is not available to active employees or their covered family members.)

The coordination period applies whether you are an active employee, a retiree, a survivor or a covered spouse or child and whether you were already eligible for Medicare for another reason, such as age. If you were covered by the Medicare Supplemental Plan, your claims will be processed under the Standard Plan for the 30-month coordination period.

Dental Benefits

If you retire from a participating employer, you can continue your State Dental Plan and Dental Plus coverage if you meet the eligibility requirements (see page 179). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election (NOE) form and an Employment Verification Record with EIP within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you are not eligible for retiree insurance, you may request COBRA continuation coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next open enrollment period (October 2011). Coverage will be effective the following January 1. You also may enroll within 31 days of a special eligibility situation. For information on the State Dental Plan and Dental Plus, see pages 95-102.

If you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2011, or until you become eligible to change your coverage due to a special eligibility situation.

Vision Care

State Vision Plan

If you retire from a participating employer, you can continue your State Vision Plan coverage if you meet the eligibility requirements (see page 179). Coverage is not automatic. To maintain continuous coverage, you must file a Retiree Notice of Election (NOE) form and an Employment Verification Record with EIP within 31 days of your retirement date, the date your TERI plan ends or the date of disability approval.

If you are not eligible for retiree insurance, you may request COBRA coverage within 60 days of loss of coverage or notification of the right to continue coverage, whichever is later.

If you do not enroll within 31 days of your date of retirement, you may enroll during the next enrollment period (October 2011). Coverage will be effective the following January 1. For information on vision care benefits, see pages 105-110.

Vision Care Discount Program

This discount program is available at no cost to retirees, as well as to full-time and part-time employees, covered family members, survivors and COBRA subscribers. Refer to page 110 for more information.

MoneyPlu\$

MoneyPlu\$ is not available in retirement. However, when you retire, you may be able to continue your **Medical Spending Account (MSA)** through the end of the plan year, including the grace period. If you know your retirement date during the October enrollment period, you can divide your MSA contributions by the number of paychecks you will receive before retirement. For example, if you are retiring in June, you could divide your contributions among half of the paychecks you receive annually. Another option is to deduct the amount remaining in your yearly contribution from your last few paychecks. You may also be able

to continue your account on an after-tax basis through COBRA. See page 169 for more information. If you wish to continue your account, contact your benefits administrator within 31 days of your last day at work and fill out the appropriate forms.

If you do not wish to continue your MSA, you have 90 days from your last day at work to submit claims for eligible expenses incurred before you left employment.

You cannot continue contributing to your **Dependent Care Spending Account** after you retire. However, you can request reimbursement for eligible expenses incurred while you were employed until you exhaust your account or the plan year ends.

The Pretax Group Insurance Premium Feature, which allows you to pay health, vision, dental and some life insurance premiums before taxes, is not available in retirement.

Prudential is EIP's LTC insurer. If you have questions, contact customer service at 877-214-6588 or go to the EIP Web site, www.eip.sc.gov, click on the "Links" tab and then select "Prudential" under "Long Term Care."

Long Term Care

Long Term Care (LTC) refers to a wide range of services for people of all ages who suffer from chronic conditions. These individuals need assistance with day-to-day activities, such as bathing, eating, continence, toileting, transferring and/or dressing or supervision due to cognitive impairment, such as Alzheimer's disease. Care can be provided in a nursing home, in an assisted living facility, at home or in the community, such as in an adult day care center.

Long Term Care Services Already Covered

Medicare covers some home healthcare and skilled nursing facility services. However, there are limits on the dollar amounts paid and the number of visits allowed. Neither the SHP nor Medicare covers custodial care services. To qualify for Medicaid, you must exhaust most of your assets and income.

Continuing Coverage Into Retirement

You and your family members may keep this coverage when you retire. Your coverage will remain in effect as long as you continue to pay your premiums on a timely basis and do not exhaust your benefits.

Enrolling in Coverage at Retirement

You and/or your spouse/surviving spouse may apply to enroll in LTC at any time by providing medical evidence of good health. Applicants age 72 and older will receive an in-person assessment to supplement the information provided on the enrollment form. See "How Do I Enroll?" on page 148 for more information.

Premiums

You pay the entire cost of LTC coverage for yourself and your spouse, if he or she is enrolled. Premiums are based on your age when you enroll. Premiums are on pages 228-229.

LTC insurance premiums may not be deducted from your payroll or pension check. Retirees and qualified family members can select a direct billing method, which provides a 2.83 percent discount for semi-annual payments and a 5.58 percent discount for annual payments. Quarterly direct billing is available upon request. You may also select the monthly Electronic Funds Transfer (EFT) option and have the premium withdrawn automatically from your checking or savings account.

Life Insurance

You may want to think about your life insurance needs in retirement. If you continue or convert your policy,

your premiums may increase. If you would like to continue or convert your life insurance, contact your benefits administrator.

Retiree life insurance coverage does not include accidental death and dismemberment benefits.

Please note: You must pay your life insurance premium by the due date. An easy way to ensure that your premiums will be on time is to authorize payment through a bank draft. Contact MetLife to set one up.

If you have questions about life insurance coverage, billing, claims, etc., call MetLife's retiree customer service, officially "Life Recordkeeping Customer Service," at 866-492-6983. For information about converting a group life policy to an individual policy, call 877-275-6387, prompt 1.

\$3,000 Basic Life Insurance

This term life insurance is given to you as an active employee and *ends* with retirement or when you leave your job for another reason. You may convert the \$3,000 Basic Life to an individual policy within 31 days of the date coverage ends. Contact your benefits office or EIP for additional information.

Optional Life Insurance

You can carry your Optional Life Insurance into retirement through MetLife. Here are your options:

If you retired on or after January 1, 2001, you can continue or you can convert your life insurance coverage. Your coverage can be continued in \$10,000 increments up to the final face value of coverage.

1. Continuation (Portability)

As a retiree, you may continue your Optional Life coverage at the same rates you paid while you were an employee. The minimum amount that can be continued is \$10,000. You cannot increase your coverage, but you can decrease it. Your coverage will reduce by 35 percent at age 70 and then end at age 75. When your amount either reduces or ends, you can convert the amount of reduced or lost coverage **within 31 days**, as described in Section 2 below. **Continued coverage is term life insurance.**

To continue your coverage, you and your BA (or an EIP staff member) must complete the Continuation of Group Optional Life Coverage Form. You must also complete the Beneficiary Designation Form. Both documents must be mailed to MetLife within 31 days of your loss of coverage.

2. Conversion

You may convert your Optional Life coverage **within 31 days** to an individual whole life policy.

Whole life is a permanent form of life insurance.

You may also split your coverage between individual whole life insurance (Conversion) and term life insurance (Continuation).

To convert your coverage, your BA (or an EIP staff member) must fax the Notice of Group Life Conversion Privilege form to MetLife within 31 days of your date of retirement. A MetLife representative will contact you to discuss your options, premiums and designation of beneficiaries. If you are interested in converting your coverage as a retiree, contact your benefits office or EIP.

If you participate in the TERI program, you can continue your benefits as an active employee, if you are eligible. When the TERI period ends, you must file for retiree benefits within 31 days as indicated above.

If you return to work as a full-time, active employee with a participating employer, you must choose whether to enroll in Optional Life insurance coverage as an active employee or to continue your retiree coverage.

If you refuse to enroll as an active employee, you also refuse the \$3,000 Basic Life benefit, and Optional and/or Dependent Life coverage. Your active group coverage will become effective only if you discontinue the retiree continuation coverage.

If you converted your Optional Life coverage and are rehired within two years of the date the coverage was converted, you must cancel your converted coverage in order to enroll in Optional Life as an active employee. **If you return to work more than two years after your policy was converted, you can enroll in active coverage and keep your converted policy.**

Dependent Life Insurance

Any Dependent Life Insurance coverage you have will end when you leave active employment. Your covered spouse or child may convert the insurance coverage to an individual whole life policy. The spouse or child must apply to MetLife, in writing, within 31 days of the date of coverage ends and pay the required premiums.

Long Term Disability

Disability insurance protects an employee and his family from loss of income due to an injury or an extended illness that prevents the employee from working. When you leave active employment and retire, your Basic and Supplemental Long Term Disability end.

Basic Long Term Disability

This benefit may not be continued or converted to an individual policy.

Supplemental Long Term Disability

Generally, you may not continue Supplemental Long Term Disability coverage in retirement. However, if you are retiring or leaving employment, but plan to be self employed or work for an employer that does not have a supplemental long term disability program, see page 142 for information about continuing coverage.

When Coverage Ends

Your coverage will end:

- The day after your death
- The date it ends for all employees and retirees
- If you do not pay the required premium when it is due.

Coverage of your family members will end:

- The date your coverage ends
- The date spouse or children coverage is no longer offered
- The last day of the month your spouse or child is no longer eligible for coverage. If your spouse or child's coverage ends, he may be eligible for continuation of coverage under COBRA (see page 26).

If you are dropping a spouse or child from your coverage, you must complete a Notice of Election (NOE) form within 31 days of the date the spouse or child is no longer eligible for coverage.

Death of a Retiree

If a retiree dies, a surviving family member should contact EIP to report the death and end the retiree's health coverage. If the deceased was a retiree of a local subdivision, contact his benefits administrator.

Survivors of a Retiree

Spouses or children who are covered as dependents under the State Health Plan, an HMO, a dental plan or the State Vision Plan are classified as “survivors” when a covered employee or retiree dies. Survivors of funded retirees of a state agency, a higher education institution or a school district may be eligible for a one-year waiver of health insurance premiums. Survivors of non-funded retirees may continue their coverage. However, they must pay the full premium.

Participating local subdivisions may, but are not required to, waive the premiums of survivors of retirees, but a survivor may continue coverage, at the full rate, for as long as he is eligible. If you are a retiree of a participating local subdivision, check with your benefits administrator to see whether the waiver applies.

After the first year, a survivor who qualifies for the waiver must pay the coverage. At the end of the waiver, coverage can be canceled or continued for all covered family members. If coverage is continued, no covered family members can be dropped until open enrollment or within 31 days of a special eligibility situation.



full premium to continue

For a checklist of information that may be helpful when a loved one dies, see page 33.

If you and your spouse are both covered employees or funded retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

State Dental Plan, Dental Plus and State Vision Plan premiums are not waived. However, survivors can continue coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a child, you can continue coverage until you are no longer eligible. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. If your spouse retired from a state agency, a higher education institution or a school district, contact EIP for more information. If your spouse retired from a local subdivision, contact his benefits administrator.

As long as a survivor remains covered by health, vision or dental insurance, he can add the others at open enrollment. If he has health, vision and dental, and drops all three, he is no longer eligible as a survivor and cannot re-enroll in coverage, even at open enrollment.

If a surviving spouse becomes an active employee of a participating employer, he can switch to active coverage. When he leaves active employment, he can go back to survivor coverage within 31 days of termination, if he has not remarried.



Until you become eligible for Medicare, your health insurance, whether it is the State Health Plan, BlueChoice HealthPlan HMO or CIGNA HMO, is handled the same way it was when you were an active employee. For more information, see the Health Insurance chapter and the chart on the following pages.

Comparison of Health Plans for Retirees &

Retirement/Disability Retirement

Type	High Deductible Health Plan		Preferred Provider Organization	
	After the deductible is met, other benefits are paid at the same level as the SHP Standard Plan.		To receive the higher level of benefits, subscribers should use a network provider.	
Plan	SHP Savings Plan		SHP Standard Plan	
Availability	Coverage worldwide		Coverage worldwide	
Annual Deductible <i>Single Family</i>	\$3,000 \$6,000¹		\$350 \$700	
Coinsurance	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%	In-network Plan pays 80% You pay 20%	Out-of-network Plan pays 60% You pay 40%
Coinsurance Maximum <i>Single Family</i>	\$2,000 \$4,000 (excludes deductibles)	\$4,000 \$8,000 (excludes deductibles)	\$2,000 \$4,000 (excludes deductibles)	\$4,000 \$8,000 (excludes deductibles)
Physicians Office Visits	Chiropractic benefits limited to \$500 a year, per person, after deductible		Chiropractic benefits limited to \$2,000 a year, per person	
	No per-occurrence deductibles		\$10 per-occurrence deductible, then	
	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%	Plan pays 80% You pay 20%	Plan pays 60% You pay 40%
Hospitalization/ Emergency Care	No per-occurrence deductibles or copays		Outpatient facility services: \$75 per-occurrence deductible Emergency care: \$125 per-occurrence deductible	
Prescription Drugs	Participating pharmacies and mail order only: You pay 100% of the plan's allowable charge until the annual deductible is met. Afterward, the plan will reimburse 80% of the allowable charge. The remaining 20% will be credited to your coinsurance maximum. (Pay-the-difference applies, see p. 65)		Participating pharmacies only (up to 31-day supply): \$9 Tier 1 (generic—lowest cost), \$30 Tier 2 (brand—higher cost), \$50 Tier 3 (brand—highest cost) Mail order (up to 90-day supply): \$22 Tier 1, \$75 Tier 2, \$125 Tier 3 Copay maximum: \$2,500 (Pay-the-difference applies, see p. 65)	
Mental Health/ Substance Abuse	Preauthorization required for some services. Call 800-221-8699. Subject to above deductibles and coinsurance.		Preauthorization required for some services. Call 800-221-8699. Subject to above deductibles and coinsurance.	
Lifetime Maximum	None		None	

¹ If more than one family member is covered, no family members will receive benefits, other than preventive, until the \$6,000

Please Note: This chart is just a summary of your benefits. More information is available earlier in the Retirement/Disability

Family Members NOT Eligible for Medicare

HMOs	
All care must be directed by a primary care physician (PCP) and approved by the HMO.	
BlueChoice HealthPlan HMO	CIGNA HMO
Available in all counties in South Carolina	Available in all S.C. counties, except : Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda
\$250 \$500 (Does not apply to some services. See p. 77)	None
HMO pays 85% after deductible and copays You pay 15%	HMO pays 80% after copays You pay 20%
\$2,000 \$4,000 (excludes deductibles)	\$2,000 \$4,000 (includes inpatient and outpatient copays and 20% coinsurance)
\$15 PCP copay \$15 OB/GYN well woman exam \$40 specialist copay	\$15 PCP copay \$15 OB/GYN exam \$30 specialist copay
Inpatient: \$200 copay Outpatient: \$100 copay/first 3 visits Emergency care: \$125 copay HMO pays 85% after copays and deductible. You pay 15% \$35 Urgent care copay, then HMO pays 100%	Inpatient: \$500 copay Outpatient: \$250 copay HMO pays 80% after copay Emergency care: \$100 copay. Urgent care: \$50 copay HMO pays 100% after copay
Participating pharmacies only (up to 31-day supply): \$8/\$15 generic, \$35 preferred brand, \$55 non-preferred brand. \$125/\$80 specialty pharmaceuticals Mail order (up to 90-day supply): \$20/\$37.50 generic, \$87.50 preferred brand, \$137.50 non-preferred brand	Participating pharmacies only (up to 30-day supply): \$7 generic, \$25 preferred brand, \$50 non-preferred brand Mail order (up to 90-day supply): \$14 generic, \$50 preferred brand, \$100 non-preferred brand
Participating providers only. Call 800-868-1032 Inpatient: \$200 copay, then HMO pays 90% Outpatient: \$40 specialist copay	Participating providers only. Inpatient: \$500 copay, then 80% covered Outpatient: \$30 specialist copay
None	None

Retirement/Disability Retirement

annual family deductible is met.

Retirement chapter and in the Health Insurance chapter.

Comparison of Health Plans for Retirees &

Plan	SHP Savings Plan	SHP Standard Plan	
Inpatient Hospital Days ¹	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call or APS preauthorization required)	Plan pays 80% You pay 20% with coinsurance maxi- mum (Medi-Call or APS preauthorization required)	
Skilled Nursing Care	Plan pays 80% up to 60 days (Medi-Call required)	Plan pays 80% up to 60 days (Medi-Call required)	
Private Duty Nursing	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Home Healthcare	100 visits, if Medi-Call approved	100 visits, if Medi-Call approved	
Hospice Care	\$6,000 maximum, including \$200 bereave- ment counseling	\$6,000 maximum, including \$200 be- reavement counseling	
Durable Medical Equipment	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	Plan pays 80% You pay 20% with coinsurance maximum (Medi-Call required)	
Routine Mammography Screening	Ages 35-74 in participating facilities only; guidelines apply	Ages 35-74 in participating facilities only; guidelines apply	
Pap Test	Ages 18-65 Routine or diagnostic	Ages 18-65 Routine or diagnostic	
Ambulance	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	Plan pays 80% You pay 20% with coinsurance maximum for emergency transport	
Eyeglasses	None, except for prosthetic lenses from cataract surgery	None, except for prosthetic lenses from cataract surgery	

¹Semi-private room and board, physician/surgeon charges, operating/delivery room and recovery room, general nursing and

WHEN YOU OR YOUR ELIGIBLE FAMILY MEMBERS BECOME ELIGIBLE FOR MEDICARE due to age or disability, notify EIP within 31 days of eligibility. If you do not notify EIP and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP will:

- Begin paying benefits as if you were enrolled in Medicare
- Seek reimbursement for overpaid claims back to the date you or your covered family members became eligible for Medicare.

When you become eligible for Medicare, it is strongly advised you **ENROLL IN MEDICARE PART A AND PART B** if you are covered as a retiree or as a spouse or child of a retiree. Medicare becomes your primary insurance. If you are not enrolled in Part B, you will be required to pay the portion of your healthcare costs that Part B would have paid.

Family Members NOT Eligible for Medicare

	BlueChoice HealthPlan HMO	CIGNA HMO
	Plan pays 85% You pay 15% with a \$200 copay and coinsurance	Plan pays 80% You pay 20% with \$500 copay and coinsurance maximum
	Plan pays 85% You pay 15% up to 120 days	Plan pays 80% You pay 20% up to 180 days
	Plan pays 85% You pay 15% up to 60 days	Plan pays 100%
	Plan pays 85% You pay 15%	Plan pays 100% up to 60 visits
	Plan pays 85% You pay 15%	Inpatient: Plan pays 80%, you pay 20% Outpatient: Plan pays 100%
	Plan pays 85% You pay 15%	Plan pays 100%
	Plan pays 100%; guidelines apply	Plan pays 100%
	Routine: any age; 2 per year; \$15 copay Diagnostic: copay/coinsurance	Plan pays 100% You pay \$15 copay
	Plan pays 85% You pay 15%	Plan pays 80% You pay 20%
	None	None

miscellaneous hospital services and supplies.

Retirement/Disability Retirement

