PEBA℠
SC Retirement Systems and State Health Plan

Insurance Summary

2023

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Welcome

There are certain times throughout the year when you may enroll in insurance coverage or make changes to your coverage. Review this summary to plan the 2023 health coverage and additional benefits that are best for you and your family.

Eligibility

Eligible employees generally are those who:

- Work full-time for and receive compensation from a state agency, a public higher education institution, a public school district, a participating public charter school or a participating optional employer, such as a participating county or municipal government; and
- Are hired into an insurance-eligible position.

Generally, an employee must work at least an average of 30 hours per week to be considered employed full time and eligible to participate in the insurance program.

New hires

Your employer will initiate the enrollment process. You will need to provide a valid email address to your employer, then make your elections online by following the instructions in the email you receive from PEBA. For more details about the enrollment process, view the ***Insurance Enrollment Guide for New Hires*** flyer.

From the date you become eligible, you have 31 days to enroll in your health insurance and other available insurance benefits.

EXPLORE YOUR BENEFITS
OPEN ENROLLMENT 2022

Open enrollment is October 1-31, 2022. During open enrollment, eligible employees may change their coverage for the upcoming year. Review your current coverage in MyBenefits (mybenefits.sc.gov). If you are satisfied with your current elections, the only thing you need to do is re-enroll in MoneyPlus flexible spending accounts. All open enrollment changes take effect January 1, 2023.

Follow these steps to learn about open enrollment and make changes:

Step 1 Visit the open enrollment webpage, peba.sc.gov/oe, to learn about the changes you can make.

Step 2 Download your open enrollment worksheet at peba.sc.gov/oe to plan your coverage for 2023.

Step 3 Log in to MyBenefits (mybenefits.sc.gov) to review your coverage and make changes during open enrollment if necessary.

Your health plan options

Your insurance needs are as unique as you are. You may meet your deductible each year, or maybe you can't remember the last time you saw a doctor. No matter your situation, the State Health Plan gives you two options to cover your expenses: the Standard Plan or the Savings Plan.

The Standard Plan has higher premiums and lower deductibles. The Savings Plan has lower premiums and higher deductibles. Compare the two plans on Page 5.

The TRICARE Supplement Plan provides secondary coverage to TRICARE members of the military community who are not eligible for Medicare. For eligible employees, it provides an alternative to the State Health Plan. Learn more about the plans at peba.sc.gov/health.

2023 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Standard Plan	Savings Plan	TRICARE Supplement
Employee	$97.68	$9.70	$62.50
Employee/spouse	$253.36	$77.40	$121.50
Employee/children	$143.86	$20.48	$121.50
Full family	$306.56	$113.00	$162.50

How much will you spend out of pocket on medical care?

Include this amount on the worksheet on Page 13 to determine how much you should contribute to your Medical Spending Account (MSA).

Amount: $_____

Tobacco-use premium

If you are a State Health Plan subscriber with single coverage and you use tobacco or e-cigarettes, you will pay an additional $40 monthly premium. If you have employee/spouse, employee/children or full family coverage, and you or anyone you cover uses tobacco or e-cigarettes, the additional monthly premium will be $60. The premium is automatic for all State Health Plan subscribers unless the subscriber certifies no one he covers uses tobacco or e-cigarettes or covered individuals who use tobacco or e-cigarettes have completed the Quit for Life® tobacco cessation program. The tobacco-use premium does not apply to TRICARE Supplement Plan subscribers.

Comparison of health plans

	Standard Plan	Savings Plan
Annual deductible	You pay up to **$515** per individual or **$1,030** per family.	You pay up to **$4,000** per individual or **$8,000** per family.[1]
Coinsurance[2] Maximum excludes copayments and deductible	In network, you pay **20%** up to **$3,000** per individual or **$6,000** per family.	In network, you pay **20%** up to **$3,000** per individual or **$6,000** per family.
Physician's office visit[3]	You pay a **$15** copayment plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Outpatient facility/ emergency care[4,5]	You pay a **$115** copayment (outpatient services) or **$193** copayment (emergency care) plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Inpatient hospitalization[6]	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.	You pay the **full allowed amount** until you meet your deductible. Then, you pay your coinsurance.
Prescription drugs[7,8] 30-day supply/90-day supply[9] at a network pharmacy	Tier 1 (generic): **$13/$32** Tier 2 (preferred brand): **$46/$115** Tier 3 (non-preferred brand): **$77/$192** You pay up to **$3,000** in prescription drug copayments. Then, you pay nothing.	You pay the **full allowed amount** until you meet your annual deductible. Then, you pay your coinsurance. Drug costs are applied to your coinsurance maximum. When you reach the maximum, you pay nothing.
Tax-favored accounts	Medical Spending Account	Health Savings Account Limited-use Medical Spending Account

[1]If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the $8,000 annual family deductible is met.
[2]Out of network, you will pay 40% coinsurance, and your coinsurance maximum is different. An out-of-network provider may bill you more than the State Health Plan's allowed amount. Learn more about out-of-network benefits at peba.sc.gov/health.
[3]The $15 copayment is waived for routine mammograms, adult well visits and well-child visits. Standard Plan members who receive in-person care at a BlueCross-affiliated patient-centered medical home (PCMH) provider will not be charged the $15 copayment for a physician's office visit. After Standard Plan and Savings Plan members meet their deductible, they will pay 10% coinsurance, rather than 20%, for care at a PCMH.
[4]The $115 copayment for outpatient facility services is waived for physical therapy, speech therapy, occupational therapy, dialysis services, partial hospitalizations, intensive outpatient services, electroconvulsive therapy and psychiatric medication management.
[5]The $193 copayment for emergency care is waived if admitted.
[6]Inpatient hospitalization requires prior authorization for the State Health Plan to provide coverage. Not calling for prior authorization may lead to a $515 penalty.
[7]Prescription drugs are not covered at out-of-network pharmacies.
[8]With Express Scripts' Patient Assurance Program, members in the Standard and Savings plans will pay no more than $25 for a 30-day supply of preferred and participating insulin products in 2023. This program is year to year and may not be available in the following year. It does not apply to Medicare members, who will continue to pay regular copays for insulin.
[9]You will pay a lower copayment for a 90-day supply of prescription drugs at your local network pharmacy that participates in the Smart90 Network than if you purchased the medication one month at a time.

Your dental plan options

New hires have two options for dental coverage. Dental Plus pays more and has higher premiums and lower out-of-pocket costs. Basic Dental pays less and has lower premiums and higher out-of-pocket costs. Changes to existing dental coverage can be made only during open enrollment in odd-numbered years. Learn more about the plans at peba.sc.gov/dental.

Dental Plus

Dental Plus has higher allowed amounts, which are the maximum amounts allowed by the plan for a covered service. Network providers cannot charge you for the difference in their cost and the allowed amount.

Basic Dental

Basic Dental has lower allowed amounts, which are the maximum amounts allowed by the plan for a covered service. There is no network for Basic Dental; therefore, providers can charge you for the difference in their cost and the allowed amount.

2023 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	Dental Plus	Basic Dental
Employee	$26.60	$0.00
Employee/spouse	$61.42	$7.64
Employee/children	$75.76	$13.72
Full family	$101.94	$21.34

How much will you spend out of pocket on dental care?

Include this amount on the worksheet on Page 13 to determine how much you should contribute to your Medical Spending Account (MSA).

Amount: $_____

Comparison of dental plans

	Dental Plus	Basic Dental
Diagnostic and preventive Exams, cleanings, X-rays	You do not pay a deductible. The Plan will pay 100% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You do not pay a deductible. The Plan will pay 100% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Basic Fillings, oral surgery, root canals	You pay up to a **$25** deductible per person.[1] The Plan will pay 80% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You pay up to a **$25** deductible per person.[1] The Plan will pay 80% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Prosthodontics Crowns, bridges, dentures, implants	You pay up to a **$25** deductible per person.[1] The Plan will pay 50% of a **higher allowed amount**. In network, a provider **cannot charge you for the difference** in its cost and the allowed amount.	You pay up to a **$25** deductible per person.[1] The Plan will pay 50% of a **lower allowed amount**. A provider **can charge you for the difference** in its cost and the allowed amount.
Orthodontics[2] Limited to covered children ages 18 and younger	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.	You do not pay a deductible. There is a $1,000 lifetime benefit for each covered child.
Maximum payment	$2,000 per person each year for diagnostic and preventive, basic and prosthodontics services.	$1,000 per person each year for diagnostic and preventive, basic and prosthodontics services.

Routine checkup example

Includes exam, four bitewing X-rays and adult cleaning

	Dental Plus (in network)	Dental Plus (out of network)	Basic Dental
Dentist's initial charge	$191.00	$191.00	$191.00
Allowed amount[3]	$135.00	$171.00	$67.60
Amount paid by the Plan (100%)	$135.00	$171.00	$67.60
Your coinsurance (0%)	$0.00	$0.00	$0.00
Difference between allowed amount and charge	$56.00 Dentist writes this off	$20.00	$123.40
You pay	$0.00	$20.00 Difference in allowed amount and charge	$123.40 Difference in allowed amount and charge

[1]If you have basic or prosthodontics services, you pay only one deductible. Deductible is limited to three per family per year.
[2]There is a $1,000 maximum lifetime benefit for each covered child, regardless of plan or plan year.
[3]Allowed amounts may vary by network dentist and/or the physical location of the dentist.

Your vision coverage

Good vision is crucial for work and play. It is also a significant part of your health. An annual eye exam can help detect serious illnesses. You can have an exam once a year and get either frames/lenses or contacts. Learn more about your vision coverage at peba.sc.gov/vision.

2023 Monthly premiums

If you work for an optional employer, verify your rates with your benefits office.

	State Vision Plan
Employee	$5.94
Employee/spouse	$11.88
Employee/children	$12.76
Full family	$18.70

How much will you spend out of pocket on vision care?

Include this amount on the worksheet on Page 13 to determine how much you should contribute to your Medical Spending Account (MSA).

Amount: $_____

State Vision Plan at a glance

	In network, you pay:	Out of network, you receive:
Comprehensive exam with dilation as necessary	A **$10** copay.	Up to $35.
Retinal imaging	Up to **$39**.	No reimbursement.
Frames	A **$0** copay and **80%** of balance over **$150** allowance.	Up to $75.
Standard plastic lenses	A **$10** copay.	Up to $55.
Standard progressive lenses	A **$35** copay.	Up to $55.
Premium progressive lenses	**$35–$80** for Tiers 1–3. For Tier 4, you pay copay and **80%** of cost less **$120** allowance.	Up to $55.
Standard contact lenses fit & follow-up	A **$0** copay.	Up to $40.
Premium contact lenses fit & follow-up	A **$0** copay and receive 10% off retail price less **$40** allowance.	Up to $40.
Conventional contact lenses	A **$0** copay and **85%** of balance over **$130** allowance.	Up to $104.
Disposable contact lenses	A **$0** copay and balance over **$130** allowance.	Up to $104.

Your life insurance coverage

You are automatically enrolled in Basic Life insurance at no cost if you enroll in health insurance. This policy provides $3,000 in coverage.[1] You'll also get a matching amount of Accidental Death and Dismemberment (AD&D) insurance. You may elect more coverage for yourself, spouse and/or children. Learn more about your life insurance options and value-added services at peba.sc.gov/life-insurance.

2023 Monthly premiums

Optional Life and Dependent Life-Spouse

Your premiums are determined by your or your spouse's age as of the previous December 31 and the coverage amount. Rates shown are per $10,000 of coverage. Remember to review your premium, even if you don't change your coverage levels. Your monthly premium will change when your age bracket changes.

Age	Rate	Age	Rate	Age	Rate
Under 35	$0.40	50-54	$1.44	70-74	$24.22
35-39	$0.50	55-59	$2.84	75-79	$37.50
40-44	$0.60	60-64	$6.00	80 and older	$62.04
45-49	$0.82	65-69	$13.50		

Dependent Life-Child

$1.26 per month; you pay only one premium for all eligible children.

Life insurance at a glance

	Coverage level	Coverage details
Optional Life with AD&D	Elect in **$10,000** increments up to a maximum of $500,000.	• Lesser of three times annual earnings or $500,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance. • Coverage reduces to 65% at age 70, to 42% at age 75, and to 31.7% at age 80 and beyond.
Dependent Life-Spouse with AD&D	Elect in **$10,000** increments up to a maximum of $100,000 or 50% of your Optional Life amount, whichever is less.	• If you are not enrolled in Optional Life, spouse coverages of $10,000 or $20,000 are available. • $20,000 of coverage guaranteed within 31 days of initial eligibility. • Includes matching amount of AD&D insurance.
Dependent Life-Child	**$15,000** per child.	• Coverage guaranteed. • Children are eligible from live birth to ages 19 or 25 if a full-time student. • Child can be covered by only one parent under this Plan.

[1]Reduces to $1,500 for employees ages 70 and older.

Your long term disabilty coverage

You are automatically enrolled in Basic Long Term Disability at no cost if you enroll in health insurance. The maximum benefit is $800 per month. You may elect more coverage for added protection. Learn more about long term disability coverage at peba.sc.gov/long-term-disability.

2023 Monthly premium factors

Multiply the premium factor for your age and plan selection by your monthly earnings to determine your monthly premium.

Age preceding January 1	90-day waiting period	180-day waiting period
Under 31	0.00068	0.00053
31-40	0.00094	0.00073
41-50	0.00185	0.00141
51-60	0.00374	0.00287
61-65	0.00449	0.00344
66 and older	0.00549	0.00422

SLTD at a glance

The Supplemental Long Term Disability (SLTD) benefit provides:

- Competitive group rates;
- Survivor's benefits for eligible dependents;
- Coverage for injury, physical disease, mental disorder or pregnancy;
- Return-to-work incentive;
- SLTD conversion insurance;
- Cost-of-living adjustment; and
- Lifetime security benefit.

	Benefit
Benefit waiting period	**90** or **180** days
Monthly SLTD benefit[1]	Up to **65%** of your predisability earnings, reduced by your deductible income
Minimum benefit	**$100** per month
Maximum benefit	**$8,000** per month

[1]Basic Long Term Disability and Supplemental Long Term Disability benefits are subject to federal and state income taxes. Check with your accountant or tax advisor about your tax liability.

Your MoneyPlus elections

Are you leaving money on the table? MoneyPlus is a tax-favored accounts program that allows you to save money on eligible medical and dependent care costs. You fund the accounts with money deducted pretax from your paycheck. Learn more about your MoneyPlus options at peba.sc.gov/moneyplus.[1]

Medical Spending Account

Your Standard Plan works great with a Medical Spending Account (MSA). Use your MSA to pay for eligible medical expenses, including copayments and coinsurance. As you have eligible expenses, you can use a debit card for your account or submit claims for reimbursement. You can carry over into 2024 up to $610 in unused funds from your account. You forfeit funds over $610 left in your account after the reimbursement deadline. You must re-enroll each year.

Limited-use Medical Spending Account

If you have a Health Savings Account (see Page 14), you can also use a Limited-use Medical Spending Account to pay for those expenses the Savings Plan does not cover, like dental and vision care. You can carry over into 2024 up to $610 in unused funds from your account. You forfeit funds over $610 left in your account after the reimbursement deadline. You must re-enroll each year.

Pretax Premium Feature

This feature allows you to pay insurance premiums before taxes for health (including the tobacco-use premium), vision, dental and up to $50,000 of Optional Life coverage. You do not need to re-enroll each year.

Dependent Care Spending Account

You can use a Dependent Care Spending Account (DCSA) to pay for day care costs for children and adults. It cannot be used to pay for dependent medical care. You submit claims for reimbursement as you have eligible expenses. The funds can be used for expenses incurred January 1, 2023, through March 15, 2024. You forfeit funds left in your account after the reimbursement deadline. You must re-enroll each year.

[1]Contributions made before taxes lower your taxable earned income. The lower your earned income, the higher the earned income tax credit. See IRS Publication 596 or talk to a tax professional for more information.

Account features

	Plan	Funds available	Medical expenses	Dental, vision expenses	Child care expenses	Balance carries from year to year	Re-enroll each year
MSA	Standard	January 1	✓	✓		Up to $610	✓
Limited-use MSA	Savings	January 1		✓		Up to $610	✓
DCSA	N/A	As deposited			✓		✓

2023 Monthly administrative fees

Account	Fee
Medical Spending Account	$2.32
Limited-use Medical Spending Account	$2.32
Dependent Care Spending Account	$2.32

2023 Reimbursement deadlines

Account	Grace period	Deadline
Medical Spending Account	None	March 31, 2024
Limited-use Medical Spending Account	None	March 31, 2024
Dependent Care Spending Account	March 15, 2024	March 31, 2024

2023 Contribution limits

Account	Limit
Medical Spending Account	$3,050
Limited-use Medical Spending Account	$3,050
Dependent Care Spending Account[2]	$2,500 (married, filing separately) $5,000 (single, head of household) $5,000 (married, filing jointly

[2]Contribution limit for highly compensated employees is $1,600.

MoneyPlus worksheet

Use the worksheet below to calculate the amount you may wish to contribute to an MSA or a DCSA. Be sure to include the amounts you listed on Pages 4, 6 and 8 in the worksheet. Be conservative in your planning. Remember that any unclaimed funds cannot be returned to you. You can, however, carry over up to $610 of unused MSA funds into the 2024 plan year. You cannot carry over DCSA funds, and you cannot transfer funds between flexible spending accounts. Refer to Page 12 for annual contribution limits.

Medical Spending Account

Estimate your eligible out-of-pocket medical expenses for the plan year.

Medical expenses	
Health insurance deductible	$
Copayments and coinsurance	$
Prescription drugs	$
Dental care	$
Vision care	$
Travel costs for medical care	$
Other eligible expenses	$
Annual contribution	$ **0.00**

Dependent Care Spending Account

Estimate your eligible dependent care expenses for the plan year.

Child care expenses	
Day care services	$
In-home care/au pair services	$
Nursery/preschool	$
After-school care	$
Summer day camps	$
Elder care expenses	
Day care center services	$
In-home care services	$
Annual contribution	$ **0.00**

Your Health Savings Account

State Health Plan Savings Plan members can contribute to a Health Savings Account, or HSA. An HSA helps you get the most out of your health plan by reducing your taxes while you save for future medical expenses. Learn more about HSAs at peba.sc.gov/hsa.

Benefits of an HSA

An HSA is essential to help you prepare for your health expenses.

- **Carry over all funds from one year to the next.** You don't have to spend the funds in the year you deposit them.
- **Keep your account.** The money in your account belongs to you. If you leave your job or retire, you can take the account with you and continue to use it for qualified expenses.
- **There's no limit to how much you can save**. While there is an annual contribution limit, there's no limit to how much you can accumulate in your account.
- **Invest your savings.** You can invest your funds once your account balance reaches $1,000 to earn investment income tax-free.
- **Make payments online.** Use the Online Bill Pay feature to pay your medical bills or reimburse yourself.
- **Pay for eligible healthcare items with your debit card.** Use your HSA debit card for transactions in-store, online or at your doctor.

Limited-use Medical Spending Account

If you have an HSA, you can enroll in a Limited-use Medical Spending Account to pay for dental and vision care expenses. Doing so allows you to save your HSA funds for future medical expenses. Learn more on Page 11.

2023 Contribution limits

Your health coverage level determines your contribution limit.

Coverage level	Limit
Self only	$3,850
Family	$7,750
Catch-up for members ages 55 and older	$1,000

HSA limitations

- You cannot be covered by any other health plan that is not a high deductible health plan, including Medicare or TRICARE.
- No one else can claim you as a dependent on their income tax return.
- You cannot use your HSA funds to pay premiums.
- You have not received Veterans Administration (VA) benefits within the past three months.

2023 Monthly fees from HSA Central

Type	Fee
Administrative fee	$0.50
Paper statements	$3.00

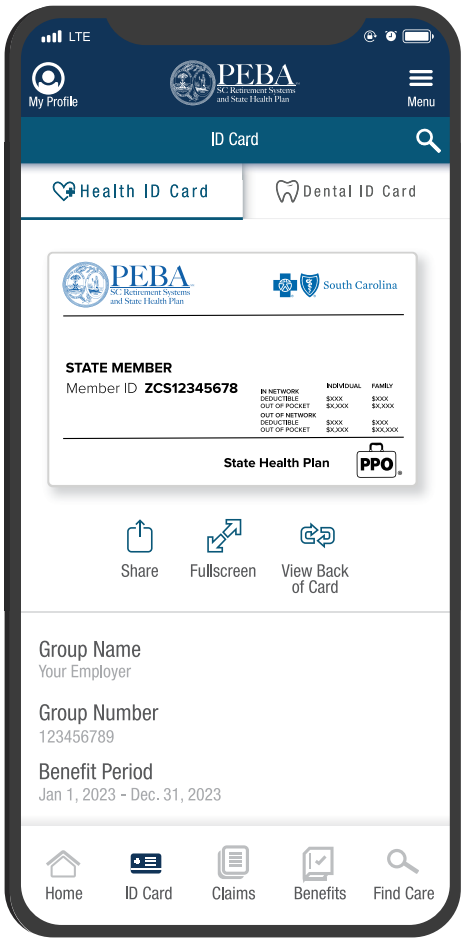
How to enroll

To contribute money pretax through payroll deduction, you must enroll in an HSA through MyBenefits. HSA Central will automatically set up the bank account based on enrollment information from PEBA. You will receive a welcome email from HSA Central with instructions on how to fully open the account once it is set up.

You're covered with membership ID cards

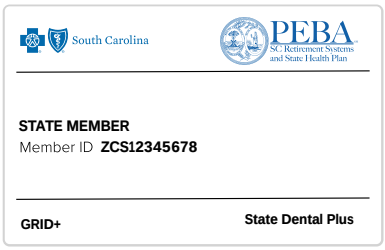
You receive insurance cards for health, prescription, dental and vision benefits. You can also access your digital identification cards from the BlueCross, Express Scripts and EyeMed apps. Only the subscriber's name will be on the cards, but all covered family members can use them.

Missing one of your insurance cards? Any one of them can be replaced using the contacts below, and you will need your Benefits Identification Number (BIN). If you don't know your BIN, visit mybenefits.sc.gov and select "Get My BIN" in the lower right corner.



State Health Plan

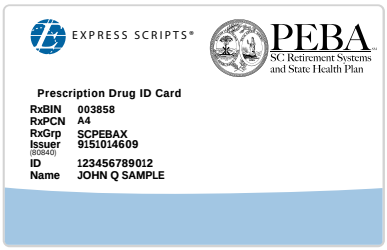
For help accessing or replacing your card, call BlueCross BlueShield of South Carolina at **800.868.2520** or log in to My Health Toolkit®.



Dental Plus

For help accessing or replacing your card, call BlueCross at **888.214.6230** or log in to My Health Toolkit.

If you need a Basic Dental card, contact your benefits administrator.



Prescription drug

For help accessing or replacing your card, call Express Scripts at **855.612.3128** or visit www.Express-Scripts.com.

Vision care

For help accessing or replacing your card, call EyeMed at **877.735.9314** or visit www.EyeMed.com.

Your benefits on the go

Did you know your phone can be your go-to resource for accessing your insurance benefits information? Mobile apps are available for your health, dental, prescription and vision benefits, as well as your MoneyPlus flexible spending accounts and Health Savings Account.

Search for My Health Toolkit

BlueCross BlueShield of South Carolina

Health and dental benefits

- Learn about your coverage.
- Find a provider.
- Check status of claims.
- Access your identification card.

Search for ASIFlex Self Service

ASIFlex

Flexible spending accounts

- Submit and view status of a claim.
- Submit documentation.
- View account details.
- Read secure account messages.

Search for Express Scripts

Express Scripts

Prescription benefits

- Check if a drug requires prior authorization and compare drug prices.
- Locate a network pharmacy.
- Refill and renew mail order prescriptions.
- Access your identification card.

Search for HSA Central

HSA Central

Health Savings Accounts

- Make HSA transactions and view account activity.
- View and manage your contributions.
- Take photos of your receipt for tax-purposes.
- Scan items to see if they are eligible medical expenses.

Search for EyeMed Members

EyeMed

Vision benefits

- Learn about your coverage.
- Search for network providers.
- Set eye exam and contact lens change reminders.
- Access your identification card.

Manage your health and pharmacy benefits with My Health Toolkit

When you're a member of the State Health Plan, you have one convenient place for managing your health and pharmacy benefits. My Health Toolkit is your one-stop destination.

Using the My Health Toolkit app is easy.

Learn more about your coverage.
Look up your medical coverage, deductible and out-of-pocket spending.

Check medical claims.
View the status of a current or previous medical claim, the date of service, the amount charged by your provider and the amount you may owe.

Check dental claims.
Look up your dental coverage, deductible and out-of-pocket spending on dental care.

View or replace your identification card.
Access an electronic version of your card or order a replacement card by visiting the full site.

Manage your prescriptions.
You're just a click away from all your medication details. Select the **full site** link to access your Express Scripts account. You can see prescription drug claims and payment history, find and compare drug prices, check to see if a medication is subject to clinical rules, see your prescription order status, order a temporary ID card and much more.

Find a provider.
Use the **find care** link to view a list of network doctors and medical facilities or dentists in your area. Filter your search and compare results side by side. You can even view feedback from other members about a specific provider.

Get started today

It's easy to sign up for My Health Toolkit. Follow these steps to have everything you need at your fingertips.

1. Search for **My Health Toolkit** in your app store.
2. In the app, select **Sign Up**.
   *Or, visit www.StateSC.SouthCarolinaBlues.com and select **Create An Account**.*
3. Enter your member identification number on your State Health Plan identification card and your date of birth.
4. Choose a username and password.
5. Enter your email address and choose to go paperless.

If you have not created an Express Scripts account, you'll be prompted to create one the first time you access your pharmacy benefits through My Health Toolkit.

If you have any questions about your My Health Toolkit account, call BlueCross at **800.868.2520**.

Coordination of benefits

All State Health Plan benefits are subject to coordination of benefits, a process which is used to make sure a person covered by more than one insurance plan will not be reimbursed more than once for the same expenses. With coordination of benefits, the primary plan pays first. The secondary plan pays after the primary plan. To ensure benefits are paid correctly, members must complete coordination of benefits questionnaire every year. BlueCross will not process or pay claims until it receives your information. Log in to your My Health Toolkit account to update this information.

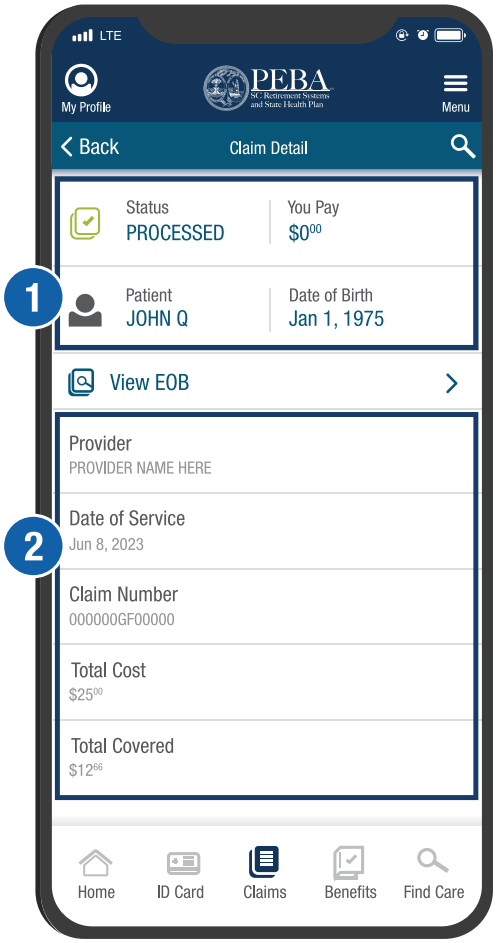
Don’t pay more than you should

Be a smart health care consumer. Look at your Explanation of Benefits (EOB) after you receive services and compare your provider’s bill to the amount listed on your EOB.

What’s an EOB?

This is a report that’s created whenever the health and dental plans process a claim. An EOB shows you:

- How much your provider charged for services.
- How much the Plan paid.
- The amount you will be responsible for, such as your copayment, deductible and coinsurance.
- The total amount you may owe the provider (does not include any amount you’ve already paid).



1
Summary info

This is a view of the status of your claim and the amount you may owe or have already paid to providers.

2
Detailed info

Here you’ll see the provider’s name, the service date and the claim number. You’ll also find the total charge for the claim from the provider and the amount covered by the Plan.

Go green!

View your EOBs on the My Health Toolkit app! Plus, you can choose paperless notifications, and we’ll email you whenever a new EOB is ready to view.

1. Log in to your account via the mobile app.
2. Select the **My Profile** link under the menu.
3. Select **Contact Preferences**.
4. Set your preferences to email, text or both.

Resources for a better you

Are you ready to get on track with your health but not sure where to start? The State Health Plan offers a variety of resources to you, most of which are available at no cost.

Blue CareOnDemand behavioral health

Video chat with a licensed counselor, therapist, psychologist or psychiatrist from the comfort of your home. Help doesn't have to stop after your first consultation. Follow-up visits may continue for as long as they are needed. Appointments are available at the time and frequency that are right for you. You pay a $15 copayment,[1] plus the remaining allowed amount until you meet your deductible. Visit www.BlueCareOnDemandSC.com or download the free app today.

Care management

Whether you feel comfortable handling your condition or you don't know where to begin, a care manager offers stability, insight and peace of mind. Visit www.MyHealthPlanner.com and enter access code SCVISIT to start accessing resources today. A member of our team will also be in touch with you by phone to identify any additional resources you might find helpful. You may also call 855.838.5897 and select Option 2.

Meru Health

Meru offers 12-week treatment program at no cost to reduce anxiety, stress, depression and burnout. It combines therapist and psychiatrist support, a biofeedback training device, anonymous peer support, meditation practices and habit-changing activities. The program is divided into weekly themes focusing on tackling mental health challenges with multiple approaches and building habits to prevent relapses.

Patient-centered medical homes (PCMHs)

A PCMH offers a team approach to care to help you reach your goals for better health, and you can save money. Standard Plan members do not pay the $15 copayment for an in-person PCMH office visit. Plus, Standard Plan and Savings Plan members pay 10% coinsurance, rather than 20%, after meeting their deductible. Visit www.StateSC.SouthCarolinaBlues.com and search for a BlueCross Blue Distinction Center to find a PCMH near you.

Quit For Life

If you want to quit using tobacco or e-cigarettes, the confidential Quit For Life tobacco cessation program can help you meet your goals. The program is available at no cost to State Health Plan members and covered dependents ages 13 and older. Learn more and enroll at www.quitnow.net/SCStateHealthPlan.

Strive

Strive is designed to help you adopt easy-to-maintain changes in behavior that can lower health risks. Everyone has different health goals and needs, and you deserve better than a one-size-fits-all platform. Whether you just want to stay healthy or you need to manage certain health concerns, Strive helps you get on a path to success. Members will have access to Strive beginning January 1, 2023.

Wondr Health

Learn the skills to lose weight and keep it off while still eating your favorite foods in this 10-week, clinically-proven online program. Wondr will teach you it's not what you eat, but when and how you eat that will help you lose weight. Wondr Health is available at no cost to you. Learn more at www.wondrhealth.com/PEBA.

[1]Savings Plan members do not pay copayments, but pay the full allowed amount until meeting their deductible.

Save money and get the care you need

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it's an emergency? Avoid needless worry, out-of-pocket expenses and hours sitting in the emergency room by knowing your health care options.

Primary care physician

Your primary care physician, or regular doctor, is the best option for medical care, such as:

- Managing your chronic condition.
- Prescription refills.
- Cold and flu symptoms, such as fever, coughing, and sore throat.
- Migraines.
- Minor cuts and bruises.
- Pinkeye.
- Rashes, insect bites, sunburn and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Sprained muscles.
- Urinary tract infections.

Your primary care physician may offer telehealth services, too. Contact your provider for more information.

You pay a $15 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

To find a PCMH near you, log in to My Health Toolkit and search for a Blue Distinction Center.

Telehealth

If your doctor's office is closed, you're traveling or you feel too sick to drive, use a video visit for non-emergency health issues, such as:

- Cold and flu symptoms.
- Pinkeye.
- Rashes and other skin irritations.
- Seasonal allergies.
- Sinus or respiratory infections.
- Urinary tract infections.

Blue CareOnDemand Search for Blue CareOnDemand in your app store. You can see a doctor who can diagnose your symptoms and call in a prescription to your local pharmacy, if needed.
MUSC Health Virtual Care Visit www.MUSChealth.org/virtual-care to start a visit. A doctor will diagnose your symptoms and call in a prescription to your local pharmacy, if needed. You must be in South Carolina at the time of the visit.

For Blue CareOnDemand, you pay a $15 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

For MUSC visits, you pay $0. This is available to Medicare primary members, too.

Emergencies

Go to the ER or call 911 for serious or life-threatening conditions, such as:

- Coughing up or vomiting blood.
- Heavy, uncontrolled bleeding.
- Loss of consciousness or sudden dizziness.
- Major injuries, such as broken bones or head trauma.
- Severe allergic reactions.
- Signs of a heart attack, such as chest pain that lasts more than two minutes.
- Signs of stroke, such as numbness, or sudden loss of speech or vision.

You pay a $193 copayment,[1] plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.

[1]Standard Plan members who receive in-person care at a PCMH will not pay a copayment. Savings Plan members do not pay copayments for any visits, but pay the full allowed amount until meeting their deductible.

Adult well visits

Well visits may be a key part of preventive care. They can reassure you that you are as healthy as you feel, or prompt you to ask questions about your health. Learn more about adult well visits and when they are covered at peba.sc.gov/well-visits.

How the benefit works

State Health Plan primary members are eligible for one well visit each year at no member cost. Evidence-supported services, based on United States Preventive Services Task Force (USPSTF) A and B recommendations, are included as part of an adult well visit under the State Health Plan. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.

Who is eligible?

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan or Savings Plan. Adult members can take advantage of this benefit at a network provider specializing in general practice, family practice, pediatrics, internal medicine, gerontology, and obstetrics and gynecology.

Eligible female members may use their well visit at their gynecologist or their primary care physician, but not both. If a woman visits both doctors in the same year, only the first routine office visit received will be covered. Women ages 18-65 can also receive a Pap test each calendar year at no member cost through PEBA Perks.

Services not included in an adult well visit

Services not included as part of an adult well visit are those without an A or B recommendation by the USPSTF. Learn more at www.USPreventiveServicesTaskForce.org. Other services, including a complete blood count (CBC), EKG, PSA test and basic metabolic panel, if ordered by your physician to treat a specific condition, may still be covered. These services are subject to copayments, deductibles and coinsurance, as well as normal Plan provisions. Follow-up visits and services as a result of your well visit are also subject to normal Plan provisions.

How to get the most out of your benefits

The State Health Plan offers many value-based benefits at no member cost to its primary members through PEBA Perks. Learn how to coordinate your PEBA Perks benefits with your adult well visit below.

Step 1

Get your preventive screening. You can receive a biometric screening at no cost, which will minimize cost to the Plan at your adult well visit.

Step 2

Have your adult well visit after your preventive screening. USPSTF A and B recommendations are included as part of an adult well visit. After talking with your doctor during a visit, the doctor can decide which services you need and build a personal care plan for you.

Step 3

Share your preventive screening results with your doctor. You will receive a confidential report with your screening results, and we recommend you share it with your doctor to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your adult well visit to the Plan.

Step 4

Follow your doctor's recommendations and stay engaged with your health. We encourage you to take advantage of the other PEBA Perks available to you. If you're eligible, sign up for No-Pay Copay to receive certain generic drugs at no cost to you.

Value-based benefits at no cost to you

It's always better to address a health issue before it becomes a health crisis. Visit a network provider or pharmacy to take advantage of these value-based benefits at no cost to you. These benefits can help make it easier for you and your family to stay healthy. For more details about PEBA Perks, including eligibility, visit www.PEBAperks.com.

Preventive screening

Identifying health issues early can prevent serious illness and help save you money. This benefit, worth more than $300, allows you to receive a biometric screening at no cost.

Flu vaccine

The flu affects 5-20% of the U.S. population each year. An annual flu vaccine is the best way to reduce your risk of getting sick and spreading it to others.

Adult vaccinations

Vaccines are one of the safest ways to protect your health and the health of those around you. The State Health Plan covers adult vaccinations, including the Shingrix vaccine, based on age, interval and medical history recommendations from the Centers for Disease Control and Prevention (CDC).

Well child benefits (exams and immunizations)

This benefit aims to promote good health and prevention of illness in children. Covered children through age 18 are eligible for this benefit. The State Health Plan covers doctor visits based on recommendations from the American Academy of Pediatrics and immunizations based on recommendations from the CDC at network providers.

Colorectal cancer screening

Colorectal cancer is the second-most common cause of cancer deaths in the U.S. The State Health Plan covers the cost for both diagnostic and routine screenings based on age ranges recommended by the United States Preventive Services Task Force (USPSTF). Any facility charges or associated lab work as a result of the screening may be subject to copayments, deductibles and coinsurance.

Cervical cancer screening

Cervical cancer deaths have decreased since the implementation of widespread cervical cancer screenings. The State Health Plan allows women ages 18-65 to receive a Pap test each calendar year at no cost. For women ages 30-65, the Plan covers the HPV test in combination with a Pap test once every five years at no cost.

No-Pay Copay

No-Pay Copay encourages members to be more engaged in their health — and saves them money. By completing activities in Strive each year, members can receive certain generic drugs the remainder of the year and the following year at no cost. Covered conditions include:

- High blood pressure and high cholesterol.
- Cardiovascular disease, congestive heart failure and coronary artery disease.
- Diabetes.

Mammography

A mammogram is an important step in taking care of yourself. This benefit provides one baseline routine mammogram (four views) for women ages 35-39. Women ages 40 and older can receive one routine mammogram (four views) each calendar year. The State Health Plan also covers diagnostic mammograms, which are subject to copayments, deductibles and coinsurance.

Diabetes education

Managing your diabetes can help you feel better. It can also reduce your chance of developing complications. This benefit provides diabetes education through certified diabetes educators.

Tobacco cessation

This benefit provides enrollment in the Quit For Life program at no cost. It also includes a $0 copay for some tobacco cessation drugs to eligible participants.

Breast pump

This provides members with certain electric or manual breast pumps at no cost. Members can learn how to get a breast pump by enrolling in the maternity management program, Coming Attractions.

Lactation consultations through Blue CareOnDemand

This benefit allows members to video chat with a lactation consultant at no cost. Get help for many of the common issues associated with breastfeeding from the comfort and privacy of your own home. And it doesn't have to stop after the first visit. You can schedule follow-up appointments at a time and frequency that are right for you. Appointments are available seven days a week.

Health help in the palm of your hand

Text messages are a great way to keep up with kids, friends and appointments. They can help you stay on top of your health, too.

Sign up for secure State Health Plan mobile messages. You'll get benefits information, health and wellness reminders, and cost-saving tips.

Learn how to avoid catching a cold. Find out about benefits available at no cost. Get information about healthy lifestyle programs, health coaching and value-based benefits.

Mobile messaging is completely optional, but we encourage you to sign up! It's a simple and secure way to get information you can use.

Sign up for mobile messaging.

1. Call 844.284.5417 from your mobile phone; or
2. Text PERKS to 735-29.

Data rates may apply.

Avoid costs by getting the green light for your care

Some medical and behavioral health services need prior authorization for the State Health Plan to provide coverage. This means you or your provider needs to make a phone call. **Not calling for prior authorization may lead to a $515 penalty.** Prior authorization does not guarantee payment.

Medical services

For prior authorization of your medical treatment, call Medi-Call at **800.925.9724** at least two business days before:

- Non-emergent inpatient care in a hospital, including admission to a hospital to have a baby.
- An outpatient service that results in a hospital admission.
- Outpatient surgery for a septoplasty (surgery on the septum of the nose).
- Outpatient or inpatient surgery for a hysterectomy.
- Sclerotherapy (vein surgery).
- Chemotherapy or radiation therapy.
- Admission to a long-term care facility or nursing facility.
- Ordering durable medical equipment.
- In vitro fertilization or other infertility procedures.
- An organ transplant.
- Inpatient rehabilitation services and related outpatient physical, speech or occupational therapy.

Pregnancy

You should contact Medi-Call at **800.925.9724** within the first three months of a pregnancy.

Emergencies

In a hospital emergency, you should contact Medi-Call at **800.925.9724** to report your admission within 48 hours or the next business day.

Radiology services

For prior authorization of your radiology services, call National Imaging Associates at **866.500.7664**:

- CT scan.
- MRI.
- MRA.
- PET scan.

Behavioral health services

For prior authorization of your behavioral services, call Companion Benefit Alternatives at **800.868.1032**.

- Inpatient hospital care.
- Intensive outpatient hospital care.
- Partial hospitalization care.
- Outpatient electroconvulsive therapy.
- Repetitive transcranial magnetic therapy.
- Applied behavioral analysis therapy.
- Psychological/neuropsychological testing.

Some outpatient behavioral health services may not be covered by the Plan if you do not receive prior authorization.

Helpful terms

Insurance lingo can be confusing. But, it's important to understand your benefits and how they work. Here are some terms you may need to know.

Allowed amount
The maximum amount you may pay a network provider for a covered service. Network providers have agreed to accept the Plan's negotiated rates as their total fee.

Benefits
The items or services covered by your insurance plan.

Claim
A request for payment that you or your provider submits after you receive services.

Coinsurance
This is a percentage of the cost of health care you pay after you meet your deductible. For example, say the State Health Plan's allowed amount for an office visit is $115 and the member has met his deductible. After a Standard Plan member pays the $15 copayment, his coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount, or $80.

Coinsurance maximum
The amount of coinsurance you are required to pay each year before you are no longer required to pay coinsurance.

Copayment
The fixed amount you pay for a covered health care service or drug. Standard Plan members pay prescription drug copayments and copayments for office visits, emergency care and outpatient facility services. Savings Plan members do not pay copayments. Standard Plan members will continue to pay copayments even after meeting their deductible.

Coverage review
A blanket term for the different types of processes the Plan uses to ensure the safe and effective use of prescription drugs and to encourage the use of lower-cost alternatives when possible.

Deductible
The amount you pay for covered services before your health plan begins to pay.

Dependent
An eligible child or spouse covered by your health plan.

National Preferred Formulary
The formulary, or list of preferred drugs, used by Express Scripts.

Negotiated rate
The maximum amount you may pay a network provider for a covered service. Network providers have agreed to accept the Plan's negotiated rates as their total fee. The negotiated rate is the same as the allowed amount.

Network
A group of facilities, providers and suppliers under contract to provide care for people covered by a health, dental or vision plan.

Out-of-pocket costs
These are your costs for expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus all costs for services that aren't covered.

Prior authorization
A decision that a service, prescription drug or piece of equipment is medically necessary. Certain services and medications require prior authorization before you receive them, except in an emergency. You may also hear this referred to as precertification or preauthorization.

Premium
The amount you pay for insurance coverage.

Provider
This can refer to the medical professional who delivers care or the location where you receive health care services.

Plan your 2023 insurance coverage

Open enrollment

October 1-31, 2022

During open enrollment, you may change your coverage for 2023. Review your current coverage in MyBenefits (mybenefits.sc.gov). If you are satisfied with your current elections, the only thing you need to do is re-enroll in MoneyPlus flexible spending accounts. All open enrollment changes take effect January 1, 2023.

Your next steps

Learn about the open enrollment changes you can make and download your open enrollment worksheet at peba.sc.gov/oe.

Then, log in to MyBenefits at mybenefits.sc.gov by October 31, 2022, to change your coverage for 2023. Your benefits administrator can also assist you.

New hires

Your employer will initiate the enrollment process. You will need to provide a valid email address to your employer, then make your elections online by following the instructions in the email you receive from PEBA.

From the date you become eligible, you have 31 days to enroll in your health insurance and other available insurance benefits..

Your next step

Follow the link in the email you receive from PEBA to make your elections online. Your benefits administrator can also assist you.

Insurance Benefits Guide

The 2023 *Insurance Benefits Guide* is available at peba.sc.gov/publications.

Summaries of Benefits and Coverage

The 2023 *Summaries of Benefits and Coverage* for the Standard and Savings Plans are available at peba.sc.gov/publications. To request a copy, call PEBA at 803.737.6800 or 888.260.9430.

Disclaimer

Benefits administrators and others chosen by your employer to assist you with your participation in the employee benefit programs administered by the South Carolina Public Employee Benefit Authority (PEBA) are not agents or employees of PEBA and are not authorized to bind PEBA or make representations on behalf of PEBA.

Grandfathered notice

The S.C. Public Employee Benefit Authority believes the State Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 803.737.6800 or 888.260.9430.

Third-party disclosures

These companies provide services on behalf of the South Carolina Public Employee Benefit Authority, which administers the State Health Plan and other insurance benefits. BlueCross BlueShield of South Carolina is the third-party administrator for the State Health Plan and dental benefits. BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association. Strive is a product of Virgin Pulse, an independent company that provides a digital health and well-being platform on behalf of BlueCross. The Quit For Life Program is brought to you by the American Cancer Society and Optum. Optum is a registered trademark of Optum, Inc. The American Cancer Society name and logo are trademarks of the American Cancer Society. Optum administers the Quit For Life Program. Wondr Health is an independent company that provides health information on behalf of the State Health Plan. Companion Benefit Alternatives, Inc. administers behavioral health services. National Imaging Associates administers radiology services. Express Scripts administers pharmacy benefits. EyeMed administers vision benefits. MetLife administers life insurance benefits. The Standard administers long term disability benefits. ASIFlex administers the MoneyPlus program. HSA Central administers Health Savings Accounts.

Notice of non-discrimination

The South Carolina Public Employee Benefit Authority (PEBA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PEBA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. PEBA:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact PEBA's Privacy Officer.

If you believe that PEBA has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PEBA Privacy Officer, 202 Arbor Lake Dr., Columbia, SC 29223, 888.260.9430 (phone), 803.570.8110 (fax), or at privacyofficer@peba.sc.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, PEBA's Privacy Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.260.9430.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.260.9430

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.260.9430

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.260.9430 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.888.260.9430.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.260.9430.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.260.9430.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.888.260.9430.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.888.260.9430.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.260.9430.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1.888.260.9430.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.888.260.9430 まで、お電話にてご連絡ください。

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1.888.260.9430.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.888.260.9430 पर कॉल करें।

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.888.260.9430

PEBA℠
SC Retirement Systems
and State Health Plan

South Carolina Public Employee Benefit Authority

Serving those who serve South Carolina

202 Arbor Lake Drive | Columbia, SC 29223

803.737.6800 | 888.260.9430

peba.sc.gov

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Data classification: public information

This document does not constitute a comprehensive or binding representation regarding the employee benefits offered by PEBA. The terms and conditions of insurance plans offered by PEBA are set out in the applicable plan documents and are subject to change. The language on this flyer does not create any contractual rights or entitlements for any person. PEBA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.260.9430. 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.260.9430