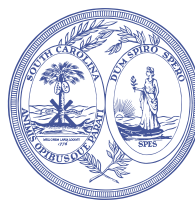


2022

Insurance Summary



PEBASM
SC Retirement Systems
and State Health Plan

What's inside

Welcome.....	1
Open enrollment.....	1
Health plan options.....	2
Dental plan options.....	4
Vision coverage.....	6
Life insurance coverage.....	7
Long term disability coverage.....	8
MoneyPlus elections.....	9
MoneyPlus worksheet	11
Health Savings Account	12
Membership ID cards.....	13
Your benefits on the go.....	14
My Health Toolkit®	15
Explanation of Benefits.....	16
Resources for a better you.....	17
Get the care you need.....	18
Adult well visits.....	19
PEBA Perks.....	21
Member messaging.....	22
Prior authorization.....	23
Helpful terms.....	24
Plan your 2022 insurance coverage.....	25
Notices.....	25
Language assistance.....	26

2022 Insurance vendors





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 2022 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 the state, a public higher education institution, a public school district 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.

Open enrollment is October 1-31, 2021.

During open enrollment, eligible employees may change their coverage for the following 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, 2022.

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



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



Download your open enrollment worksheet at peba.sc.gov/oe to plan your coverage for 2022.



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

OPEN ENROLLMENT
READY. SET. ELECT!



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. Learn more about the plans at peba.sc.gov/health.

	Standard Plan	Savings Plan
Annual deductible	You pay up to \$490 per individual or \$980 per family.	You pay up to \$3,600 per individual or \$7,200 per family. ¹
Coinsurance²	In network, you pay 20% up to \$2,800 per individual or \$5,600 per family.	In network, you pay 20% up to \$2,400 per individual or \$4,800 per family.
Physician's office visits³	You pay a \$14 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 \$105 copayment (outpatient services) or \$175 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 hospitalization⁶	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 at a network pharmacy)	Tier 1 (generic): \$9/\$22 Tier 2 (preferred brand): \$42/\$105 Tier 3 (non-preferred brand): \$70/\$175 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.
Tax-favored accounts	Medical Spending Account (See Page 9)	Health Savings Account (See Page 12) Limited-use Medical Spending Account (See Page 9)

The TRICARE Supplement Plan provides secondary coverage to TRICARE for members of the military community who are not eligible for Medicare. For eligible employees, it provides an alternative to the State Health Plan.



2022 Monthly premiums

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

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

¹ If more than one family member is covered, no family member will receive benefits, other than preventive benefits, until the \$7,200 annual family deductible is met.

² Out of network, you will pay 40 percent 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 \$14 copayment is waived for routine mammograms 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 \$14 copayment for a physician's office visit. After Standard Plan and Savings Plan members meet their deductible, they will pay 10 percent coinsurance, rather than 20 percent, for care at a PCMH.

⁴ The \$105 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 \$175 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 \$490 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 2022. 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.

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 premium will be \$60 monthly.

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 subscribers.

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



Include this amount on the worksheet on Page 11 to determine how much you should contribute to your Medical Spending Account (MSA).

Amount \$ _____



Your dental plan options

You 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.

	Dental Plus	Basic Dental
Diagnostic and preventive <i>Exams, cleanings, X-rays</i>	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 <i>Fillings, oral surgery, root canals</i>	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 <i>Crowns, bridges, dentures, implants</i>	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.
Orthodontics² <i>Limited to covered children ages 18 and younger.</i>	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.

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.

2022 Monthly premiums

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

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



Scenario 1: Routine checkup

Includes exam, four bitewing X-rays and adult cleaning

	Dental Plus		Basic Dental
	In network	Out of network	
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 <i>Dentist writes off this amount</i>	\$20.00	\$123.40
You pay	\$0.00	\$20.00 <i>Difference in allowed amount and charge</i>	\$123.40 <i>Difference in allowed amount and charge</i>

Scenario 2: Two surface amalgam fillings

	Dental Plus		Basic Dental
	In network	Out of network	
Dentist's initial charge	\$190.00	\$190.00	\$190.00
Allowed amount ^{3,4}	\$145.00	\$177.00	\$44.80
Amount paid by the Plan (80%)	\$116.00	\$141.60	\$35.84
Your coinsurance (20%)	\$29.00	\$35.40	\$8.96
Difference between allowed amount and charge	\$45.00 <i>Dentist writes off this amount</i>	\$13.00	\$145.20
You pay	\$29.00 <i>20% coinsurance</i>	\$48.40 <i>20% coinsurance plus difference</i>	\$154.16 <i>20% coinsurance plus difference</i>

³ Allowed amounts may vary by network dentist and/or the physical location of the dentist.

⁴ Example assumes the \$25 annual deductible has been met.

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



Include this amount on the worksheet on Page 11, to determine how much you should contribute to your Medical Spending Account (MSA).

Amount \$ _____



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.

	In-network member cost	Out-of-network reimbursement
	You pay:	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.

2022 Monthly premiums

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

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

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

Include this amount on the worksheet on Page 11 to determine how much you should contribute to your Medical Spending Account (MSA).



Amount \$ _____



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. 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.

	Coverage level	Coverage details
Optional Life with AD&D	Elect in \$10,000 increments up to a maximum of \$500,000.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.

2022 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
Under 35	\$0.58	60-64	\$6.00
35-39	\$0.78	65-69	\$13.50
40-44	\$0.86	70-74	\$24.22
45-49	\$1.22	75-79	\$37.50
50-54	\$1.94	80 and older	\$62.04
55-59	\$3.36		

Dependent Life-Child

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



Your long term disability 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.

Supplemental Long Term Disability

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.

SLTD benefits summary

	Benefit
Benefit waiting period	90 or 180 days
Monthly SLTD benefit¹	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 adviser about your tax liability.

2022 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	0.00062	0.00049
31-40	0.00086	0.00067
41-50	0.00170	0.00129
51-60	0.00343	0.00263
61-65	0.00412	0.00316
66 and older	0.00504	0.00387



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 2023 up to \$570 in unused funds from your account. You forfeit funds over \$570 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 12), 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 2023 up to \$570 in unused funds from your account. You forfeit funds over \$570 left in your account after the reimbursement deadline. You must re-enroll each year.

Pretax Group Insurance Premium feature

This feature allows you to pay insurance premiums before taxes for health, 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 only for expenses incurred January 1, 2022, through March 15, 2023. You forfeit funds left in your account after the reimbursement deadline. You must re-enroll each year.





MoneyPlus continued

Account features

Account	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 \$570	✓
Limited-use MSA	Savings	January 1		✓		Up to \$570	✓
DCSA	N/A	As deposited			✓		✓

2022 Monthly administrative fees

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

2022 Contribution limits

Account	Limit
Medical Spending Account ²	\$2,850
Limited-use Medical Spending Account ²	\$2,850
Dependent Care Spending Account ^{2,3}	\$2,500 (married, filing separately) \$5,000 (single, head of household) \$5,000 (married, filing jointly)

2022 Reimbursement deadlines

Account	Grace period	Deadline
Medical Spending Account	None	March 31, 2023
Limited-use Medical Spending Account	None	March 31, 2023
Dependent Care Spending Account	March 15, 2023	March 31, 2023

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.

² These are 2021 limits; contribution limits for 2022 will be released by the IRS at a later date.

³ Contribution limit for highly compensated employees is \$1,700.



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 3, 5 and 6 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 \$570 of unused MSA funds into the 2023 plan year. You cannot carry over DCSA funds, and you cannot transfer funds between flexible spending accounts. Refer to Page 10 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	\$

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	\$



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.

HSA limitations

- You cannot be covered by any other 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.

2022 Monthly fees

Type	Fee
Administrative fee	\$0.50
Paper statements	\$3.00

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 9.

2022 Contribution limits

Your health coverage level determines your contribution limit.

Coverage level	Limit
Self only	\$3,650
Family	\$7,300
Catch-up for members ages 55 and older	\$1,000

How to enroll

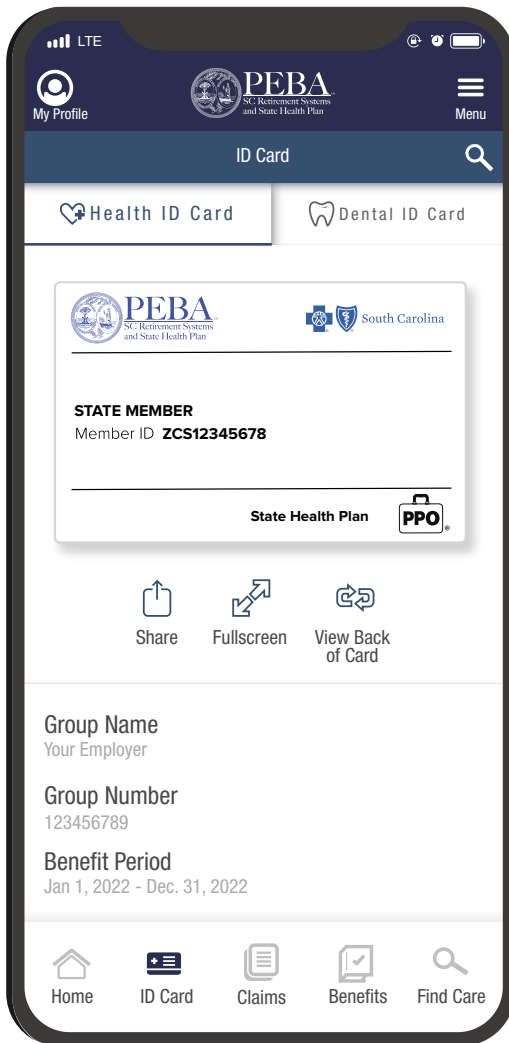


To contribute money pretax through payroll deduction, you must enroll in an HSA through MyBenefits (mybenefits.sc.gov). HSA Central will automatically set up the bank account based on enrollment information from PEBA. You will receive a welcome email from HSA Central with instructions on how to fully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



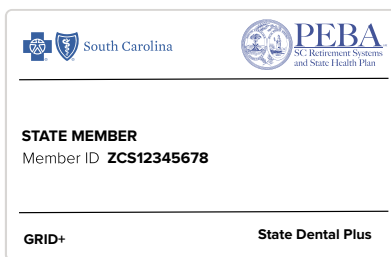
You're covered with membership ID cards

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.



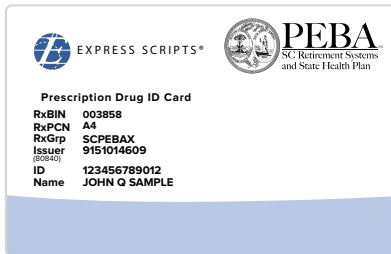
State Health Plan

For help accessing your card, call BlueCross at **800.868.2520** or log in to **My Health Toolkit**.



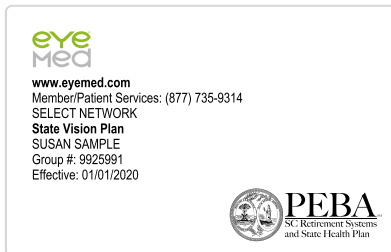
Dental Plus

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



Vision care

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

You can also contact vendors to order a replacement card.



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 flexible spending accounts and Health Savings Account.



BlueCross BlueShield of South Carolina

Search for My Health Toolkit.

Health and dental benefits

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



Express Scripts

Search for 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.



EyeMed

Search for EyeMed Members.

Vision benefits

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



ASIFlex

Search for ASIFlex Self Service.

Flexible spending accounts

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

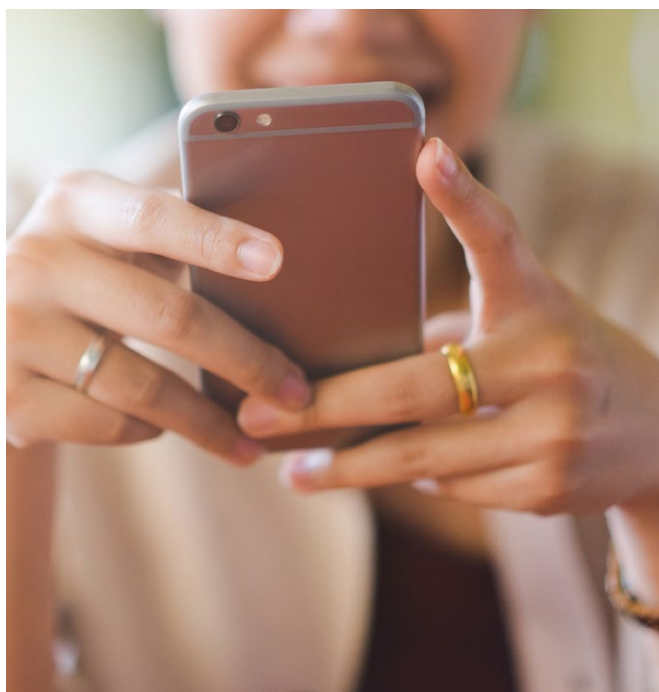


HSA Central

Search for HSA Central.

Health Savings Account

- 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.





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.

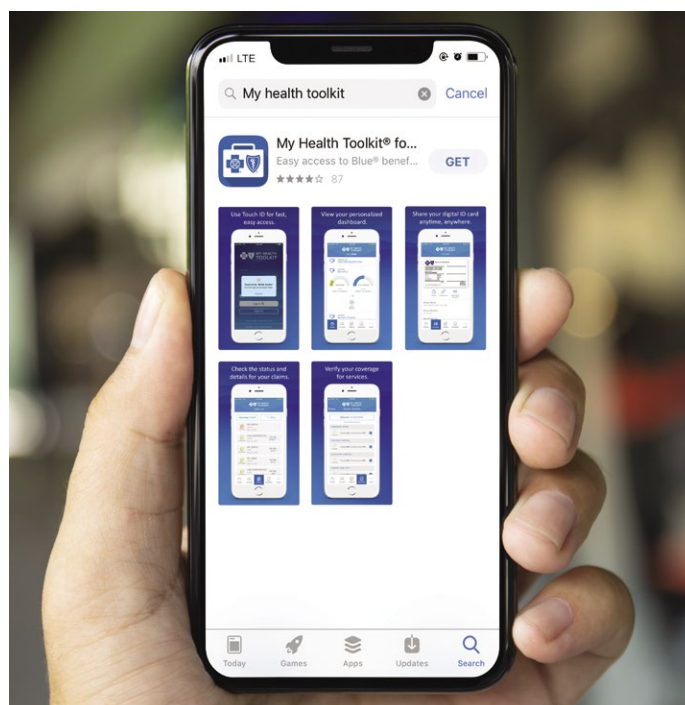
Get started by signing up today.

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**.
You can also 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**.





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).

EOB

1. Summary information

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

2. Detailed information

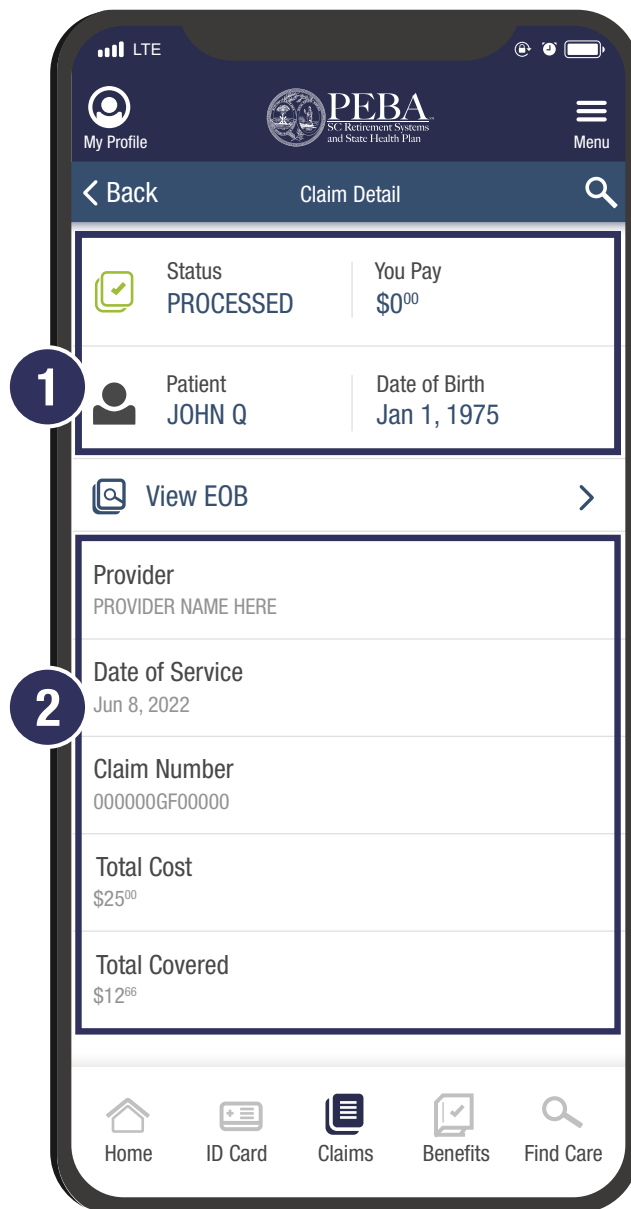
Here you'll see the provider's name, the service date and the claim number. You'll also find the total charge for the claim from the provider and the amount covered by the Plan.

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 good thing is you don't have to figure it out on your own. The State Health Plan offers a variety of resources to you, most of which are available at no cost.



Behavioral health visits through Blue CareOnDemand

Don't let emotional difficulties affect your well-being. Video chat with a licensed counselor, therapist, psychologist or psychiatrist from the comfort of your home. And help doesn't have to stop after your first consultation. Continue follow-up visits as long as you need to. Appointments are available at the time and frequency that are right for you. You pay a \$14 copayment,¹ plus the remaining allowed amount until you meet your deductible. Visit www.BlueCareOnDemandSC.com or download the free app today to schedule your first appointment.



Health coaching

A health coach can help you with behavioral health issues, chronic conditions, healthy lifestyles and maternity support. Health coaching is available online or via phone at no cost to State Health Plan subscribers and their covered adult family members. To learn more, visit peba.sc.gov/health-coaching.



Patient-centered medical homes

A patient-centered medical home (PCMH) offers a team approach to care to help you reach your goals for better health. You can also save money when you use a PCMH. Standard Plan members do not pay the \$14 copayment for an in-person PCMH office visit. Plus, Standard Plan and Savings Plan members pay a 10 percent coinsurance, rather than 20 percent, 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. To learn more and enroll, visit www.quitnow.net/SCStateHealthPlan.



Rally®

Sign up for Rally, a digital health platform that makes it easier for you to improve and maintain your overall health. Based on your responses to a quick health survey, you'll get personalized recommendations to help you move more, eat better and feel great. Log in to your **My Health Toolkit** account to sign up for Rally.







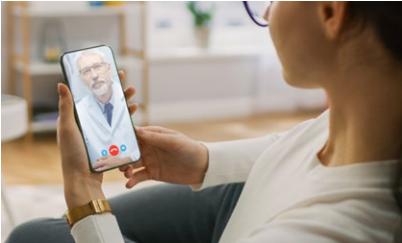

Wondr Health (formerly Naturally Slim®)

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 Health 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 for any visits, but they will 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	 Telehealth	 Emergency room
 <p>Your primary care physician, or regular doctor, is the best option for medical care, such as:</p> <ul style="list-style-type: none"> • Managing your chronic condition. • Prescription refills. • Cold and flu symptoms, including fever, coughing, sore throat and mild nausea. • 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. <p>You pay a \$14 copayment,¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.</p> <p>To find a PCMH near you, log in to My Health Toolkit and search for a Blue Distinction Center.</p> <p>Your primary care physician may offer telehealth services, too. Contact your provider for more information.</p>	 <p>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:</p> <ul style="list-style-type: none"> • Cold and flu symptoms. • Pinkeye. • Rashes and other skin irritations. • Seasonal allergies. • Sinus or respiratory infections. • Urinary tract infections. <p>Blue CareOnDemand</p> <p>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.</p> <p>You pay a \$14 copayment,¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.</p> <p>MUSC Health Virtual Care</p> <p>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.</p> <p>This service is available at no cost for all State Health Plan members, including Medicare primary members.</p>	 <p>Go to the ER or call 911 for serious or life-threatening conditions, such as:</p> <ul style="list-style-type: none"> • 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. <p>You pay a \$175 copayment,¹ plus the remaining allowed amount until you meet your deductible. Then, you pay the copayment plus your coinsurance.</p>

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



Adult well visits and the Standard Plan

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

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. Adult well visits are subject to copayments, deductibles and coinsurance in covered years.

Who is eligible?

The benefit is available to all non-Medicare primary adults ages 19 and older who are covered by the Standard Plan. Adult members can take advantage of this benefit at an eligible network provider.

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

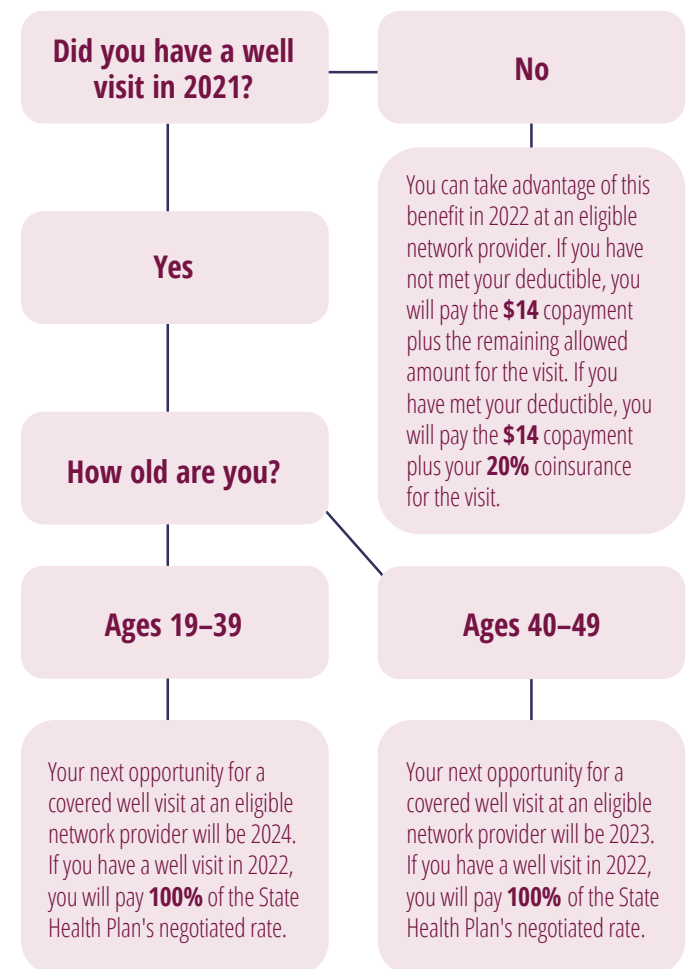
Frequency of visits

The Plan will cover only one visit in covered years, based on the following schedule:

	Once a year	Once every two years	Once every three years
Ages 19–39			✓
Ages 40–49		✓	
Ages 50 and older	✓		

Can you get a well visit in 2022 if you're younger than age 50?

Members ages 50 and older can have a well visit every year. Members younger than age 50 can determine when they may have a well visit below.



In non-covered years, the amount you pay for a well visit will not apply toward your deductible or coinsurance maximum.



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. Plus, you can set aside money pretax in your Medical Spending Account to pay for your adult well visit. Learn how to coordinate your MoneyPlus and PEBA Perks benefits with your adult well visit below.

Step
1

Set aside money in your MoneyPlus account. Estimate how much you will spend on your adult well visit in a covered year or a non-covered year. Include this amount on the worksheet on Page 11 to determine how much you should contribute to your Medical Spending Account. \$_____

Step
2

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

Step
3

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
4

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.

Step
5

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. Learn more on Page 21.

Services not included as part of an adult well visit

Services not included as part of the adult well visit are those without an A or B recommendation by the USPSTF. Find these recommendations 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.

Adult well visits and the Savings Plan

Savings Plan members are eligible for one well visit each year at no member cost. Evidence-supported services, based on the USPSTF A and B recommendations, are included as part of an adult well visit. After talking with your doctor during a visit, your doctor can decide which services you need and build a personal care plan for 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.

Have your adult well visit after your preventive screening.



Share your results with your network provider to eliminate the need for retesting at a well visit. Sharing your results will minimize the cost of your adult well visit.

Flu vaccine

The flu affects between 5 and 20 percent 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 Rally each quarter, members can receive certain generic drugs the next quarter 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.

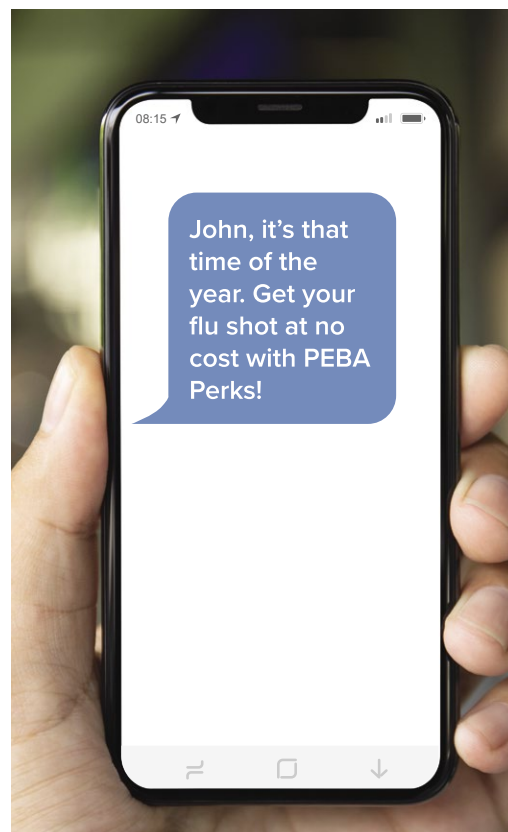
Mobile messaging is completely optional, but we encourage you to sign up! It's a simple and secure way to get information you can use.



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 \$490 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:

- 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 \$114 and the member has met his deductible. After a Standard Plan member pays the \$14 copayment, his coinsurance payment of 20 percent 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 2022 insurance coverage

Open enrollment | October 1-31, 2021

During open enrollment, you may change your coverage for 2022. 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, 2022.

Your next step



Learn about what 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, 2021, to change your coverage for 2022. 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 2022 *Insurance Benefits Guide* is available online at peba.sc.gov/publications.

Summaries of Benefits and Coverage

The 2022 *Summaries of Benefits and Coverage* for the Standard Plan and Savings Plan are available online 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. Rally is a product of Rally Health Inc., an independent company that offers a digital health platform on behalf of the State Health Plan. 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 નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.888.260.9430.

. 1.888.260.9430 إف، غلغل لكذا شذحت تنك اذا: فظوحم
مقرب لصتا. ناجملاب لكل رفاوتت فيوغلل ددعاسلما تامدخ

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 हंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.888.260.9430 पर कॉल करें।

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សំេងន្ទូលជូនកែភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំបុំប្រើអ្នក។ ចូរ ទូរស័ព្ទ

1.888.260.9430

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PEBASM

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

