Group Name: SC State Federal Credit Union **Group Number/Plan: 764/Base**

ALL BENEFITS ARE SUBJECT TO FEE SCHEDULE & BENEFIT YEAR DEDUCTIBLE UNLESS OTHERWISE INDICATED. PLEASE MAIL CLAIMS TO THE ADDRESS PRINTED ON YOUR ID CARD. PRE-CERTIFICATION IS REQUIRED FOR ALL HOSPITAL ADMISSIONS. FOR PRE-CERT, PLEASE REFER TO YOUR ID CARD.

BENEFIT YEAR (BY) DEDUCTIBLE		**PPO Collective**	**NON-PPO Collective**
	Per Participant	$600	$600
	Per Family	$1,200	$1,200
OUT-OF-POCKET		**Collective**	**Collective**
	Per Participant	$3,000	$3,000
	Per Family	$6,000	$6,000
HOSPITAL PER CONFINEMENT COPAYMENT		$0	$0

BENEFITS	**PPO**	**NON-PPO**
Inpatient (Preauthorization Required)		
Room/Board (semi-private room rate)	70%	60%
Skilled Nursing Facility -within seven (7) days of a five (5) day stay; maximum 60 days per BY.	70%	60%
Physical Rehab Facility	70%	60%
Anesthesia	70%	60%
Nursery, Newborn Care	70%	60%
ICU, CCU, Burn Unit	70%	60%
Outpatient		
Hospital and Physician Charges	70%	60%
Surgery	70%	60%
Emergency Room Services-accident	70%	70%
Emergency Room Services-illness	70%	70%
X-Ray/Lab/Pathology/Radiology-hospital	70%	60%
X-Ray/Lab/Pathology/Radiology-physician	70%	60%
Colonoscopy-diagnostic	70%	60%
Ambulance	70%	70%
Chemotherapy	70%	60%
Pre-Admission Testing	70%	60%
Physician Office Visit		
Generalist	$30 copay/100%*	60%
Specialist	$30 copay/100%*	60%
Urgent Care	$30 copay/100%*	60%
Allergy Services	$30 copay/100%*	60%
Second Surgical Opinion (not mandatory)	$30 copay/100%*	60%
Mental Health & Substance Use		
Inpatient Mental Health (Preauthorization Required)	70%	60%
Outpatient Mental Health (Preauthorization Required)	70%	60%
Office Visit Mental Health	$30 copay/100%*	60%
Inpatient Substance Use (Preauthorization Required)	70%	60%
Outpatient Substance Use (Preauthorization Required)	70%	60%
Office Visit Substance Use	$30 copay/100%*	60%
Other		
Home Health Care - 100 visits per BY	70%	60%
Hospice Care Limited to 30 days Inpatient—40 visits Outpatient per Benefit Year	70%	60%
Physical, Speech, & Occupational Therapy	70%	60%
Chiropractic - $500 limit per BY	$30 copay/100%*	60%

	PPO	NON-PPO
Vision		
Limited to $300 for employees/$200 for dependents per BY		
Exam	100%*	100%*
Frames	100%*	100%*
Lenses	100%*	100%*
Single	100%*	100%*
Lenticular	100%*	100%*
Bifocal	100%*	100%*
Trifocal	100%*	100%*
Aphakic (plastic)	100%*	100%*
Contacts	100%*	100%*
Transplant		
Organ/Tissue Transplant (Preauthorization Required)	70%	60%
DME (Preauthorization, if $500 or more)	70%	60%
Hearing Imparirment (including hearing aids) - $500 maximum per BY	100%*	100%*
Wellness Services		
Routine Mammogram	100%*	60%
Prostate Screening	100%*	60%
Colonoscopy Exam	100%*	60%
Annual Gynecological Exam	100%*	60%
Annual Physical Exam	100%*	60%
Well-Child Care	100%*	60%

Prescription Drugs (Caremark)	**Retail (34 day supply)**	**Mail Order (90 day supply)**
Generic	$10 copay/100%	$20 copay/100%
Preferred Brand	$35 copay/100%	$70 copay/100%
Non-Preferred Brand	$70 copay/100%	$140 copay/100%
	$100 copay/100%	$200 copay/100%

Prescription Drug Annual Out-of-Pocket Maximum - $4000 per participant/$8000 per family per Benefit Year at a participating provider. Allowed amounts paid at 100% after the Out-of Pocket Maximum is met.

*Deductible waived.
This patient's plan year runs from 10/1-9/30. 20181025Ski