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

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.

		PPO	NON-PPO
BENEFIT YEAR (BY) DEDUCTIBLE		**Collective**	**Collective**
	Per Participant	$400	$400
	Per Family	$800	$800
OUT-OF-POCKET		**Collective**	**Collective**
	Per Participant	$2,500	$2,500
	Per Family	$5,000	$5,000
HOSPITAL PER CONFINEMENT COPAYMENT		$0	$0

BENEFITS	**PPO**	**NON-PPO**
Inpatient (Preauthorization Required)		
Room/Board (semi-private room rate)	80%	60%
Skilled Nursing Facility -within seven (7) days of a five (5) day stay; maximum 60 days per BY.	80%	60%
Physical Rehab Facility	80%	60%
Anesthesia	80%	60%
Nursery, Newborn Care	80%	60%
ICU, CCU, Burn Unit	80%	60%
Outpatient		
Hospital and Physician Charges	80%	60%
Surgery	80%	60%
Emergency Room Services-accident	80%	80%
Emergency Room Services-illness	80%	80%
X-Ray/Lab/Pathology/Radiology-hospital	80%	60%
X-Ray/Lab/Pathology/Radiology-physician	80%	60%
Colonoscopy-diagnostic	80%	60%
Ambulance	80%	80%
Chemotherapy	80%	60%
Pre-Admission Testing	80%	60%
Physician Office Visit		
Generalist	$20 copay/100%*	60%
Specialist	$20 copay/100%*	60%
Urgent Care	$20 copay/100%*	60%
Allergy Services	$20 copay/100%*	60%
Second Surgical Opinion (not mandatory)	$20 copay/100%*	60%
Mental Health & Substance Use		
Inpatient Mental Health (Preauthorization Required)	80%	60%
Outpatient Mental Health (Preauthorization Required)	80%	60%
Office Visit Mental Health	$20 copay/100%*	60%
Inpatient Substance Use (Preauthorization Required)	80%	60%
Outpatient Substance Use (Preauthorization Required)	80%	60%
Office Visit Substance Use	$20 copay/100%*	60%
Other		
Home Health Care - 100 visits per BY	80%	60%
Hospice Care	80%	
Limited to 30 days Inpatient—40 visits Outpatient per Benefit Year		60%
Physical, Speech, & Occupational Therapy	80%	60%
Chiropractic - $500 limit per BY	$20 copay/100%*	60%
Vision		
Limited to $300 for employees and $200 for dependents		
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%*

	PPO	NON-PPO
Transplant		
Organ/Tissue Transplant (Preauthorization Required)	80%	60%
DME (Preauthorization, if $500 or more)	80%	60%
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 - $3500 per participant/$7000 per family per Benefit Year at a participating provider. Allowed amounts are 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