PUBLIC COMMENT #35 8/11/15 D. SERCHIA

Time Ticking for Pollock Pines Man in Need of Non-Embryonic Stem Cell Treatment

Accepted to stem cell treatment, but insurance won't cover it

Jul 15, 2014, 09:37 ET from Marc Serchia

POLLOCK PINES, Calif., July 15, 2014 /PRNewswire/ -- Marc Serchia, 56, is waiting on a miracle, and if the doctors are correct he doesn't have much more time. At the age of 39, Marc suffered a massive heart attack, faced a 5-hour surgery to repair blocked arteries, and died on the surgical table six separate times. Unbelievably, he survived, but with a severely damaged heart. Doctors wouldn't put him near the top of the heart transplant list because they didn't thin he'd live to find a match. Defying the odds, Marc has lived 17 years by eating healthy, making daily changes, and his sheer will to survive.

Photo - http://photos.prnewswire.com/prnh/20140715/127036
Photo - http://photos.prnewswire.com/prnh/20140715/127037

The damage to his heart is extensive. A normal, healthy heart has an ejection fraction — how much the heart compresses to circulate oxygenated blood to the body — between 50-70%. In September 2013, Marc's ejection fraction was 13%, and doctors were — *and still are* — amazed he is still standing.

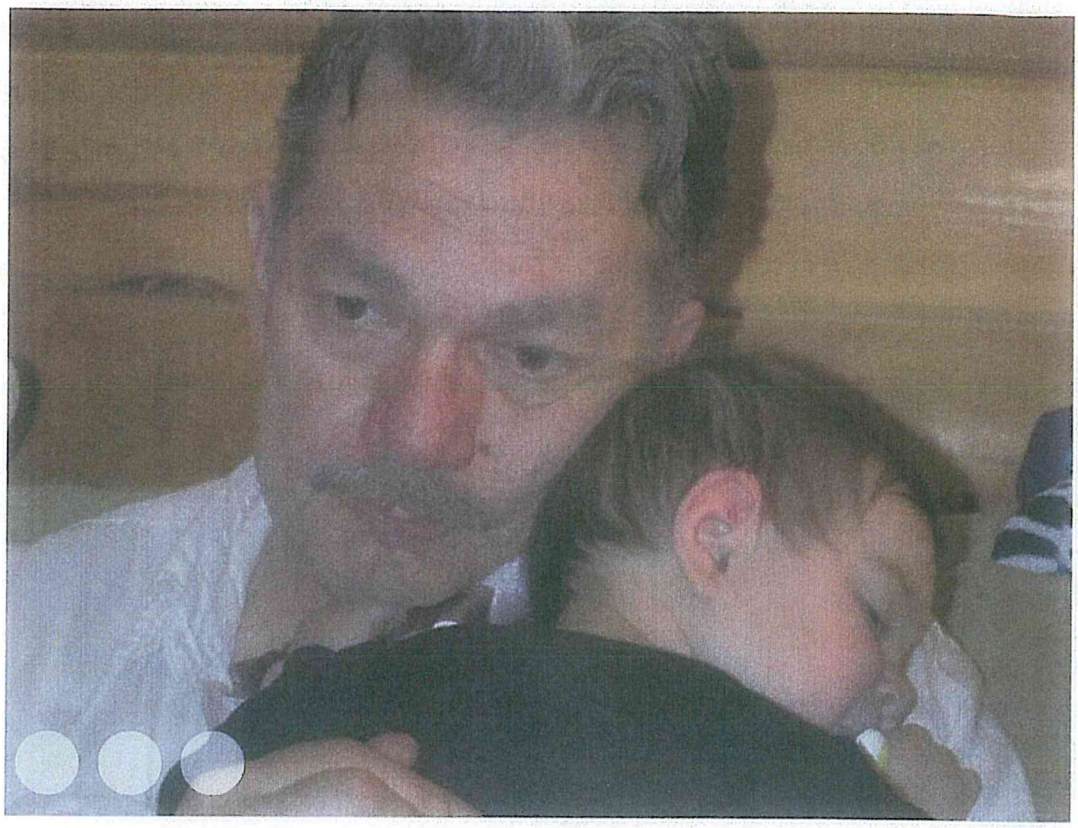
After applying to the Cell Surgical Network (CSN), he was accepted into the program, with one large roadblock in the way — insurance does not cover stem cell therapy as it is seen as experimental, and Marc is unable to work per his doctors' orders. Marc's daughters rallied his

friends, neighbors, even strangers, and after raising $7,000 of the $35,000 needed for treatment, Marc received a stem cell therapy treatment at the Silicon Valley Stem Cell Treatment Center in January 2014. The process entails doctors harvesting Marc's own stem cells from his body fat, which are then spun in a centrifuge where the stem cells are separated, then mixed in a saline IV drip, and returned to Marc. After three months, his ejection fraction rose to 16-18%. Doctors say Marc can have stem cell therapies every 3-4 months, but he has been unable to

Marc Serchia (PRNewsFoto/Marc Serchia)

have another due to lack of funding.

Ideally, Marc would like to have his next treatment at the Stem Cell Rejuvenation Center in Phoenix, Ariz. Doctors take more of his fat cells during a single treatment, thus returning even more stem cells to Marc's body.



Marc Serchia and grandchild (PRNewsFoto/Marc Serchia)

Marc's goal is to not only see his grandchildren grow up, but to help doctors in their research of stem cell therapy. With high-profile athletes like NFL quarterback Peyton Manning and MLB pitcher Bartolo Colon completing stem cell therapies, Marc hopes to join them in spreading the message of stem cell therapy and proving its benefits so patients can demand insurance companies cover the procedures. Marc may not be a famous sports hero with the salary to match, but he is a hero to his family.

This release was previously published on the Mountain Democrat.

Fundraisers are ongoing at the following links:
www.youcaring.com/marcserchia
www.help-marc.com

Important information on stem cell treatments and therapies can be found at:

International Cellular Medicine Society — www.cellmedicinesociety.org

Silicon Valley Stem Cell Treatment Center — www.svstemcell.com

Patients for Stem Cells — www.patientsforstemcells.org

Stem Cell Rejuvenation Center — www.the-stem-cell-center.com

EL DORADO COUNTY

UnitedHealthcare®

UnitedHealthcare SignatureValue™ Offered by UnitedHealthcare of California

HMO Schedule of Benefits
15/100%

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (3 individual maximum per family[6])	$2,000/individual
PCP Office Visits	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits[2] (Member required to obtain referral to specialist or nonphysician health care practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services)	$15 Office Visit Copayment
Hospital Benefits	Paid in full
Emergency Services (Copayment waived if admitted)	$125 Copayment
Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$50 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	Paid in full
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Hospital Benefits[4]	Paid in full
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	Paid in full
Maternity Care[8]	Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.)	Paid in full
Newborn Care[4]	Paid in full
Physician Care	Paid in full

Benefits Available While Hospitalized as an Inpatient (Continued)

Reconstructive Surgery	Paid in full
Rehabilitation Care (Including physical, occupational and speech therapy)	Paid in full
Skilled Nursing Facility Care (Up to 100 days per benefit period)	Paid in full
Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $125 Copayment $125 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
Ambulance	Paid in full
Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices[5] (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	$15 Copayment per item
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$15 Copayment
Dialysis (Physician office visit Copayment may apply)	$15 Copayment per treatment
Durable Medical Equipment[5]	Paid in Full
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.)	Paid in Full
Family Planning (Non-Preventive Care)[9] Vasectomy Depo-Provera Injection – (other than contraception)[9] PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit Depo-Provera Medication – (other than contraception)[9] (Limited to one Depo-Provera injection every 90 days.) Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $50 Copayment $15 Office Visit Copayment $15 Office Visit Copayment $35 Copayment $125 Copayment $125 Copayment

Benefits Available on an Outpatient Basis (Continued)

Hearing Aid - Standard ($5,000 benefit maximum per calendar year. Limited to one hearing aid (including repair and replacement) per hearing impaired ear every three years.)	Paid in Full
Hearing Aid - Bone Anchored[7] Repairs and/or replacement are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits.
Hearing Exam[2,8] PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit[2]	 $15 Office Visit Copayment $15 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	Paid in Full
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Infertility Services	Not covered
Infusion Therapy[5] (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	Paid in Full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)[5,9] (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	$50 copayment per visit
Laboratory Services (When available through or authorized by your Participating Medical Group. Additional Copayment for office visits may apply)	Paid in full
Maternity Care, Tests and Procedures[8] PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 Paid in full Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**)	$15 Office Visit Copayment
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment
Oral Surgery Services[5]	Paid in full
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	Paid in full
Physician Care PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	 $15 Office Visit Copayment $15 Office Visit Copayment

Benefits Available on an Outpatient Basis (Continued)

Preventive Care Services[8,9] (Services as recommended by the American Academy of Pediatrics (AAP) including the Bright Futures Recommendations for pediatric preventive health care, the U.S. Preventive Services Task Force with an "A" or "B" recommended rating, the Advisory Committee on Immunization Practices and the Health Resources and Services Administration (HRSA), and HRSA-supported preventive care guidelines for women, and as authorized by your Primary Care Physician in your Participating Medical Group.) Covered Services will include, but are not limited to, the following: • Colorectal Screening • Hearing Screening • Human Immunodeficiency Virus (HIV) Screening • Immunizations • Newborn Testing • Prostate Screening • Vision Screening • Well-Baby/Child/Adolescent Care • Well-Woman, including routine prenatal obstetrical office visits Please refer to your UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form.	Paid in full
Prosthetics and Corrective Appliances[5]	Paid in Full
Radiation Therapy[5]	
Standard: (Photon beam radiation therapy)	Paid in full
Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	Paid in Full
Radiology Services[5]	
Standard (Additional Copayment for office visits may apply):	Paid in full
Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media) A separate Copayment will be charged for each part of the body scanned as part of an imaging procedure.	Paid in Full
Vision Refractions	
PCP Office Visit	$15 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	$15 Office Visit Copayment

Note: Benefits with Percentage Copayment amounts are based upon the UnitedHealthcare negotiated rate.

[1]The Annual Copayment Maximum includes Copayments for UnitedHealthcare benefits, including behavioral health and prescription drug benefits. It does not include standalone, separate and independent Dental, Vision, Acupuncture, and Chiropractic benefit plans offered to groups.

[2]Copayments for audiologist and podiatrist visits will be the same as for the PCP.

[3]Clinical Trial services require preauthorization by UnitedHealthcare. If you participate in a Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate UnitedHealthcare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by UnitedHealthcare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[4]The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

[5]In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate. (This footnote only applies to dollar copayments.)

[6]When an individual member meets the Annual Copayment Maximum no further copayments are required for the year for that individual.

[7] Bone anchored hearing aid will be subject to applicable medical/surgical categories (.e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Replacement of external hearing aid components are covered under the Durable Medical Equipment benefit. Deluxe model and upgrades that are not medically necessary are not covered.

[8]Preventive tests/screenings/counseling as recommended by the U.S. Preventive Services Task Force, AAP (Bright Futures Recommendations for pediatric preventive health care) and the Health Resources and Services Administration as preventive care services will be covered as Paid in Full. There may be a separate copayment for the office visit and other additional charges for services rendered. Please call the Customer Service number on your Health Plan ID card.

[9]FDA-approved contraceptive methods and procedures recommended by the Health Resources and Services Administration as preventive care services will be 100% covered. Copayment applies to contraceptive methods and procedures that are **NOT** defined as Covered Services under the Preventive Care Services and Family Planning benefit as specified in the Combined Evidence of Coverage and Disclosure Form.

EACH OF THE ABOVE-NOTED BENEFITS IS COVERED WHEN RENDERED OR AUTHORIZED BY YOUR PARTICIPATING MEDICAL GROUP OR UNITEDHEALTHCARE, EXCEPT IN THE CASE OF A MEDICALLY NECESSARY EMERGENCY OR AN URGENTLY NEEDED SERVICE. A UTILIZATION REVIEW COMMITTEE MAY REVIEW THE REQUEST FOR SERVICES.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the UnitedHealthcare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the UnitedHealthcare office and your employer's personnel office. UnitedHealthcare's most recent audited financial information is also available upon request.

P.O. Box 30968
Salt Lake City, UT 84130-0968

Customer Service:
800-624-8822
711 (TTY)
www.uhcwest.com

EIAHealth/El Dorado County Custom ASO PPO 200-80/60 Group #E10072

Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately through Express Scripts.

Effective: January 1, 2015

	Participating Providers[1]	Non- Participating Providers[1]
Calendar Year Medical Deductible (All providers combined) (4^{th} quarter carry-over)	$200 per individual / $400 per family	
Calendar Year Out-of-Pocket Maximum (included preferred deductible)	$1,200 per Individual / $2,400 per family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non- Participating Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	20%	40%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	20%	40%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	20%	40%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	40%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar-Year Deductible)	40%
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	40%[5]
• Outpatient surgery in a hospital	20%	40%[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	40%[5]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	20%	40%[5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	20%	40%[5]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	40%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	40%[5]
Skilled Nursing Facility Benefits[9] (Combined maximum of up to 120 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[6]
• Skilled Nursing Unit of a Hospital	20%	40%[5]
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$50 per visit + 20%	$50 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%

AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	40%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
• Breast Pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Durable Medical Equipment	20%	40%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]	Not Covered	Not Covered
SUBSTANCE ABUSE SERVICES[7]	Not Covered	Not Covered
HOME HEALTH SERVICES[8]		
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)[9]	20%	Not Covered[8]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[8]
OTHER		
Hospice Program Benefits[8]		
• Routine home care	20%	Not Covered[8]
• Inpatient Respite Care	20%	Not Covered[8]
• 24-hour Continuous Home Care	20%	Not Covered[8]
• General Inpatient care	20%	Not Covered[8]
Chiropractic Benefits[9]		
• Chiropractic Services (up to 30 visits per Calendar Year)	$10 per visit	50% (Plan payment maximum of $30 per visit)
Acupuncture Benefits		
• Acupuncture	20%	20%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	40%
Speech Therapy Benefits		
• Office location	20%	40%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	40%
• Abortion service[2]	20%	40%
Family Planning Benefits		
• Counseling and consulting[10]	No Charge (Not subject to the Calendar-Year Deductible)	40%
• Tubal ligation	No Charge (Not subject to the Calendar-Year Deductible)	40%
• Vasectomy[2]	20%	40%
• Intrauterine Device (IUD)	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Insertion and removal of IUD	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	40%
• Diabetes self-management training	20%	40%
Dependent Child Learning Impairment Benefit		
• Dependent child learning impairment benefit	80% of the first $200 of charges made by a Physician for administering an initial series of evaluation tests to diagnose the nature of the learning impairment	
Hearing aid[11] (Plan payment maximum of $1,200 per member every 24 months)		
• Hearing Aid Instrument and ancillary equipment	20%	20%
• Audiological exams	20%	40%

Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)

• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance is calculated based on allowable amounts. Participating providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered Services. Non- participating providers can charge more than these amounts. When members use non- participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the Calendar Year deductible or copayment maximum.

2 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply

3 Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4 Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

5 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 40% of this $600 per day, plus all charges in excess of $600.

6 Services may require prior authorization by the Plan. When services are prior authorized, members pay the participating provider amount.

7 All Mental Health and Chemical Dependency services, including medical acute detoxification, are accessed through MHN at (800) 977-7956.

8 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Participating Provider copayment.

9 For plans with a Calendar Year medical deductible amount, services with a day or visit limit accrue to the Calendar Year day or visit limit maximum regardless of whether the plan medical deductible has been met.

10 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

11 Benefits are not available for battery replacement, repair, parts or maintenance of hearing aids.

Plan designs may be modified to ensure compliance with federal requirements.

EIAHealth/El Dorado County
ASO HDHP Plan 1300
Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Highlights: $1,300 individual coverage deductible or $2,600 family coverage deductible

Effective: January 1, 2015

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Deductible (All providers combined) (Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services.)	$1,300 per individual / $2,600 per family	
Calendar Year Out-of-Pocket Maximum[1] (Includes the plan deductible) (For family coverage, the full family out-of-pocket maximum must be met before the enrollee or covered dependents can receive 100% benefits for covered services.)	$2,500 per individual / $5000 per family	$5,000 per individual / $6,000 per family
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	30%	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[2]	20%	50%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[2]	20%	50%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	30%	50%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar Year Deductible)	50%
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[3]	20%	50%[4]
• Outpatient surgery in a hospital	20%	50%[4]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	50%[4]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[2]	20%	50%[4]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[2]	20%	50%[4]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	50%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	50%[5]
Skilled Nursing Facility Benefits[7] (Combined maximum of up to 120 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[8]
• Skilled Nursing Unit of a Hospital	20%	40%[5]
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (The ER copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$50 per visit + 20%	$50 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport		

PRESCRIPTION DRUG COVERAGE [10, 11, 12, 13, 14, 15] (Subject to deductible)	Participating Pharmacy	Non-Participating Pharmacy
Outpatient Prescription Drug Benefits		
Retail Prescriptions (For up to a 30-day supply)		
• Contraceptive Drugs and Devices [16]	No Charge	Not Covered
• Formulary Generic Drugs	$10 per prescription	$10 per prescription
• Formulary Brand Name Drugs	$15 per prescription	$15 per prescription
• Non-Formulary Brand Name Drugs	$30 per prescription	$30 per prescription
Mail Service Prescriptions (For up to a 90-day supply)		
• Contraceptive Drugs and Devices [16]	No Charge	Not Covered
• Formulary Generic Drugs	$10 per prescription	Not Covered
• Formulary Brand Name Drugs	$15 per prescription	Not Covered
• Non-Formulary Brand Name Drugs	$30 per prescription	Not Covered
Specialty Pharmacies (up to a 30-day supply)		
• Specialty Drugs	30% up to $125 copayment maximum per prescription	Not Covered
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
• Breast pump	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
• Other Durable Medical Equipment	20%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC) [5]	Not Covered	Not Covered
SUBSTANCE ABUSE SERVICES [5]	Not Covered	Not Covered
HOME HEALTH SERVICES [17]		
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year) [7]	20%	Not Covered [17]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered [17]
OTHER		
Hospice Program Benefits [17]		
• Routine home Care	20%	Not Covered [17]
• Inpatient Respite Care	20%	Not Covered [17]
• 24-hour Continuous Home Care	20%	Not Covered [17]
• General Inpatient Care	20%	Not Covered [17]
Chiropractic Benefits [7]		
• Chiropractic Services (up to 30 visits per Calendar Year)	$10 per visit	50% (Plan payment maximum of up to $30 per visit)
Acupuncture Benefits		
• Acupuncture	30%	30%
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	50%
Speech Therapy Benefits		
• Office visit	20%	50%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	50%
• Abortion service [9]	20%	50%
Family Planning Benefits		
• Counseling and consulting [18]	No Charge (Not subject to the Calendar Year Deductible)	50%
• Tubal ligation	No Charge (Not subject to the Calendar Year Deductible)	50%
• Vasectomy [9]	20%	50%
• Intrauterine Device (IUD)	No Charge (Not subject to the Calendar Year Deductible)	Not Covered

• Insertion and removal of IUD	No Charge (Not subject to the Calendar Year Deductible)	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	50%
• Diabetes self-management training	20%	50%
Dependent Child Learning Impairment Benefit		
• Dependent Child Learning Impairment Benefit	80% of the first $200 of charges made by a Physician for administering an initial series evaluation tests to diagnose the nature of the learning impairment	
Hearing aid[19] (Plan payment maximum of $1,200 per member every 24 months)		
• Hearing Aid Instrument and ancillary equipment	20%	50%
• Audiological exams	20%	50%
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance is calculated based on allowable amounts. Preferred providers agree to accept Blue Shield's allowable amount plus the plan's and any applicable member's payment as full payment for covered Services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the Calendar Year deductible or out-of-pocket maximum. Payments applied to your Calendar Year deductible accrue towards the out-of-pocket maximum.

2 Participating non Hospital based ("freestanding") laboratory or radiology centers may not be available in all areas. Laboratory and radiology Services may also be obtained from a Hospital or from a laboratory and radiology center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

3 Participating Ambulatory Surgery Centers may not be available in all areas. Outpatient surgery Services may also be obtained from a Hospital or from an ambulatory surgery center that is affiliated with a Hospital, and paid according to the benefit under your health plan's Hospital Benefits.

4 The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.

5 All Mental Health and Chemical Dependency services, including medical acute detoxification, are accessed through MHN at (800) 977-7956.

6 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600. Payments that exceed the allowed charge do not count toward the Calendar Year out-of-pocket maximum, and continue to be owed after the maximum is reached.

7 For plans with a Calendar Year deductible amount, services with a day or visit limit accrue to the Calendar Year day or visit limit maximum regardless of whether the plan deductible has been met.

8 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

9 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.

10 If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand-name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their Calendar Year deductible and is not included in the Calendar Year out-of-pocket maximum responsibility calculations.

11 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

12 For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-of-Pocket Maximum for Preferred Providers.

13 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

14 Select formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, or when effective, lower cost alternatives are available.

15 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Specialty Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield. Infused or Intravenous (IV) medications are not included as Specialty Drugs.

16 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the Calendar Year deductible. If a brand-name contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand-name contraceptive and its generic drug equivalent. In addition, select contraceptives may need prior authorization to be covered without a copayment.

17 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider Copayment.

18 Includes insertion of IUD, as well as injectable and implantable contraceptives for women.

19 Benefits are not available for battery replacement, repair, parts or maintenance of hearing aids.

Plan designs may be modified to ensure compliance with federal requirements.

OPTION #1

HEALTH PLAN CONTRIBUTION RATES

For employees in Local 1 and OE3

(GE, PL, SU, TC, PR & CR)

Effective January 1, 2016

Contributions are deducted over 24 pay periods

FULL TIME 64+ HOURS (PER PAY PERIOD)			
	EE ONLY	**EE+1**	**FAMILY**
Blue Shield PPO $1300 ABHP	$441.63	$796.23	$1,106.99
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$452.18	$817.34	$1,138.65
Employer	$361.74	$653.87	$910.92
Employee	**$90.44**	**$163.47**	**$227.73**
	EE ONLY	**EE+1**	**FAMILY**
Blue Shield PPO $200	$574.63	$1,035.73	$1,439.49
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$585.18	$1,056.84	$1,471.15
Employer	$468.14	$845.47	$1,176.92
Employee	**$117.04**	**$211.37**	**$294.23**
	EE ONLY	**EE+1**	**FAMILY**
Kaiser HMO	$307.75	$615.50	$870.94
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$318.30	$636.61	$902.60
Employer	$254.64	$509.28	$722.08
Employee	**$63.66**	**$127.32**	**$180.52**
	EE ONLY	**EE+1**	**FAMILY**
Kaiser HMO $1300 ABHP	$253.35	$506.70	$716.97
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$263.90	$527.81	$748.63
Employer	$211.12	$422.24	$598.90
Employee	**$52.78**	**$105.56**	**$149.73**

THESE RATES DO NOT INCLUDE THE RATES FOR THE MANDATORY VISION AND DENTAL PLANS. PLEASE SEE THE DENTAL AND VISION RATE CARD FOR THOSE RATES.

OPTION #2

HEALTH PLAN CONTRIBUTION RATES

For employees in Local 1 and OE3

(GE, PL, SU, TC, PR & CR)

Effective January 1, 2016

Contributions are deducted over 24 pay periods

FULL TIME 64+ HOURS (PER PAY PERIOD)			
	EE ONLY	EE+1	FAMILY
Blue Shield PPO $1300 ABHP	$441.63	$796.23	$1,106.99
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$452.18	$817.34	$1,138.65
Employer	$361.74	$653.87	$910.92
Employee	**$90.44**	**$163.47**	**$227.73**
	EE ONLY	EE+1	FAMILY
Blue Shield PPO $200	$574.63	$1,035.73	$1,439.49
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$585.18	$1,056.84	$1,471.15
Employer	$468.14	$845.47	$1,176.92
Employee	**$117.04**	**$211.37**	**$294.23**
	EE ONLY	EE+1	FAMILY
Kaiser HMO	$317.55	$635.10	$898.67
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$328.10	$656.21	$930.33
Employer	$262.48	$524.96	$744.26
Employee	**$65.62**	**$131.24**	**$186.07**
	EE ONLY	EE+1	FAMILY
Kaiser HMO $1300 ABHP	$253.35	$506.70	$716.97
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$263.90	$527.81	$748.63
Employer	$211.12	$422.24	$598.90
Employee	**$52.78**	**$105.56**	**$149.73**

THESE RATES DO NOT INCLUDE THE RATES FOR THE MANDATORY VISION AND DENTAL PLANS. PLEASE SEE THE DENTAL AND VISION RATE CARD FOR THOSE RATES.

OPTION #3

HEALTH PLAN CONTRIBUTION RATES

For employees in Local 1 and OE3

(GE, PL, SU, TC, PR & CR)

Effective January 1, 2016

Contributions are deducted over 24 pay periods

FULL TIME 64+ HOURS (PER PAY PERIOD)			
	EE ONLY	EE+1	FAMILY
Blue Shield PPO $1300 ABHP	$441.63	$796.23	$1,106.99
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$452.18	$817.34	$1,138.65
Employer	$361.74	$653.87	$910.92
Employee	**$90.44**	**$163.47**	**$227.73**
	EE ONLY	EE+1	FAMILY
Blue Shield PPO $200	$574.63	$1,035.73	$1,439.49
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$585.18	$1,056.84	$1,471.15
Employer	$468.14	$845.47	$1,176.92
Employee	**$117.04**	**$211.37**	**$294.23**
	EE ONLY	EE+1	FAMILY
Kaiser HMO	$326.44	$652.88	$923.83
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$336.99	$673.99	$955.48
Employer	$269.59	$539.19	$764.38
Employee	**$67.40**	**$134.80**	**$191.10**
	EE ONLY	EE+1	FAMILY
Kaiser HMO $1300 ABHP	$258.50	$516.99	$731.55
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$269.05	$538.10	$763.20
Employer	$215.24	$430.48	$610.56
Employee	**$53.81**	**$107.62**	**$152.64**
	EE ONLY	EE+1	FAMILY
United Healthcare HMO	$481.53	$987.05	$1,396.35
EDC Admin Fee	$10.55	$21.11	$31.66
Total	$492.08	$1,008.16	$1,428.00
Employer	$393.66	$806.52	$1,142.40
Employee	**$98.42**	**$201.63**	**$285.60**

THESE RATES DO NOT INCLUDE THE RATES FOR THE MANDATORY VISION AND DENTAL PLANS. PLEASE SEE THE DENTAL AND VISION RATE CARD FOR THOSE RATES.