

**Plan of Medical and Prescription Drug Benefits for Eligible Employees of the
Gallo Glass Company**

United Steelworkers

Provided by the UFCW NATIONAL HEALTH & WELFARE FUND

1212 W. Robinhood Drive, Suite 3E, Stockton CA 95207

209-952-6533

SUMMARY OF BENEFITS – EPO PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual	\$200	N/A
Family	\$600	N/A
Coinsurance	10%	N/A
Maximum Out-of-Pocket		
Individual	\$1,500	N/A
Family	\$4,500	N/A
Physician Office Visit		
PCP Office	\$25 copay	Not Covered
Premise Health MyHealth Center On-Site Clinic	\$0 Copay	
Teladoc™	\$0 Copay	
Specialist Office	\$35 copay	Not Covered
Preventative Care	No Charge	Not Covered
Well Baby Care	No Charge	Not Covered
Emergency Services		
Urgent Care	10% Coinsurance, after deductible	Same as In-Network
Emergency Room	10% Coinsurance, after deductible	Same as In-Network
Ambulance	10% Coinsurance, after deductible	Same as In-Network
Diagnostic Services		
X-Ray and Lab Tests	10% Coinsurance, after deductible	Not Covered
Imaging (MRI, CT/PET scans) <i>requires prior authorization</i>	10% Coinsurance, after deductible	Not Covered
Hospital Services		
Inpatient Facility	10% Coinsurance, after deductible	Not Covered
Outpatient Services	10% Coinsurance, after deductible	Not Covered
Outpatient Surgery Facility	10% Coinsurance, after deductible	Not Covered
Physician, Surgeon Fees	10% Coinsurance, after deductible	Not Covered
Skilled Nursing Facility (<i>Inpatient</i>)	10% Coinsurance, after deductible	Not Covered
Mental Health & Substance Abuse		
Inpatient	10% Coinsurance, after deductible	Not Covered
Teladoc™	\$0 Copay	
Outpatient	\$25 copay	Not Covered

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	IN-NETWORK	OUT-OF-NETWORK
Other Benefits		
Cancer Navigator Services (No member out-of-pocket) You may reach an Oncology Nurse Navigator at: (201) 308-6555 (Mon-Fri 8am – 6pm EST)	\$0 Copay	
Chiropractic (limit to \$400 annual maximum)	20% Coinsurance, after deductible	Not Covered
Durable Medical Equipment	10% Coinsurance, after deductible	Not Covered
Hearing Aid (Limit 1 per ear, every 24 mos)	10% Coinsurance, after deductible	Not Covered
Home Health Care	10% Coinsurance, after deductible	Not Covered
Physical, Occupational & Speech Therapy	10% Coinsurance, after deductible	Not Covered
Virtual Physical Therapy (Digital Therapy using motion sensor technology) You may obtain information on their website at: https://meet.swordhealth.com/ufcwnational	\$0 Copay	
Vision Care – provided by VSP		

PRESCRIPTION DRUG PROGRAM	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of_Network
Pharmacy Benefit Management (PBM) Advocacy – Payer Matrix		
Pharmacy Maximum Out-of-Pocket		
Individual	\$5,100	Not Covered
Family	\$9,750	Not Covered
Retail 30-day Supply		
Generic	10% Coinsurance, after deductible up to \$150 max	Not Covered
Brand Name Drugs	20% Coinsurance, after deductible up to \$150 max	Not Covered
Non-Preferred Brand Name Drugs	40% Coinsurance, after deductible up to \$150 max	Not Covered
Mail Order 90-day Supply		
Generic Drugs	10% Coinsurance, after deductible up to \$150 max	Not Covered
Brand Name Drugs	20% Coinsurance, after deductible up to \$150 max	Not Covered
Non-Preferred Brand Name Drugs	40% Coinsurance, after deductible up to \$150 max	Not Covered