

**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 – HDHP/HSA PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Coinsurance	10%	30%
Maximum Out-of-Pocket		
Individual – Employee Only	\$4,500	\$9,000
Individual – within a Family	\$7,150	\$14,300
Family	\$9,000	\$18,000
Physician Office Visit		
PCP Office	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Premise Health MyHealth Center On-Site Clinic	\$10 Copay	
Teladoc™	\$0 Copay	
Specialist Office	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Preventative Care	No Charge	30% Coinsurance, after deductible
Well Baby Care	No Charge	30% Coinsurance, after deductible
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	30% Coinsurance, after deductible
Imaging (MRI, CT/PET scans) <i>requires prior authorization</i>	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Hospital Services		
Inpatient Facility	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Outpatient Services	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Outpatient Surgery Facility	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Physician, Surgeon Fees	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Skilled Nursing Facility (<i>Inpatient</i>)	10% Coinsurance, after deductible	30% Coinsurance, after deductible

SUMMARY OF BENEFITS – HDHP/HSA PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Maternity Care		
Office Visits	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Childbrth Delivery Professional Services (Obstetriicians, surgeons, etc.)	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Childbrth Delvery Facility Services (Hospitals, birthing centers, etc.)	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Mental Health & Substance Abuse		
Inpatient	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Teladoc™ (members & Dependents over the age of 18)	\$0 Copay	
Outpatient	10% Coinsurance, after deductible	30% Coinsurance, after deductible
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 (20 visits annual maximum)	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Durable Medical Equipment	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Hearing Aid (Limit 1 per ear, every 24 mos)	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Home Health Care	10% Coinsurance, after deductible	30% Coinsurance, after deductible
Physical, Occupational & Speech Therapy	10% Coinsurance, after deductible	30% Coinsurance, after deductible
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		
Retail 30-day Supply		
Generic Drugs	10% Coinsurance, after deductible	Not Covered
*Preventative Drug List	\$10 co-pay, deductible does not apply	Not Covered
Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
*Preventative Drug List	\$20 co-pay, deductible does not apply	Not Covered
Non-Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
*Preventative Drug List	\$40 co-pay, deductible does not apply	Not Covered
Mail Order 90-day Supply		
Generic Drugs	10% Coinsurance, after deductible	Not Covered
Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered