UFCW NATIONAL FUND
small enough to care...BIG enough to make a difference!®

Summary of Material Modifications

To: **All Participants in the UFCW National Health and Welfare Fund Plan of Benefits for Riedell Shoes, Inc / UFCW Local 527**

From: **Glenn L. Di Biasi, Fund Administrator**

Re: **Plan Change – Summary Below**

Date: **Effective May 1, 2026**

This document is a Summary of Material Modifications ("Summary") intended to notify you of important provisions in the UFCW National Health and Welfare Fund Plan of Benefits ("the Plan") for Riedell Shoes, Inc / UFCW Local 527, Employer Number 8142. You should take the time to read this Summary carefully and keep it with the copy of the Summary Plan Description that was previously provided to you. If you need another copy of the Summary Plan Description or if you have any questions regarding the Plan, please contact the Fund Office during normal business hours at 66 Grand Avenue, Englewood, NJ 07631, 1-201-569-8801 or visit our website at www.ufcwnationalfund.org

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible		
Individual	$3,400	$3,400
Family	$6,800	$6,800
Coinsurance *(Member pays)*	10%	20%
Lifetime Maximum		
Amount payable per eligible individual includes all benefits paid for covered hospital, medical, and prescription benefits	Unlimited	
Maximum Out-of-Pocket		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Physician Office Visit		
PCP Office	10% Coinsurance, after deductible	20% coinsurance, after deductible
Teladoc™	$0 Copay	

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Specialist Office (Include cardiologists, podiatrists, etc.)	10% coinsurance, after deductible	20% coinsurance, after deductible
Preventative Care (One annual exam per calendar year, including blood screening, urine tests, chest X-ray, EKG, and mammography)	No Charge	Not Covered
Emergency Services		
Emergency Room (Waived if admitted)	10% Coinsurance, after deductible	10% Coinsurance, after deductible
Ambulance	10% Coinsurance, after deductible	10% Coinsurance, after deductible
Urgent Care	10% Coinsurance, after deductible	10% Coinsurance, after deductible
Diagnostic Services		
Diagnostic Testing (X-rays and blood tests)	10% coinsurance, after deductible	20% coinsurance, after deductible
Imaging (MRI, CT/PET scans)	10% coinsurance, after deductible	20% coinsurance, after deductible
Hospital Services		
Hospital Pre-Certification Penalty	$250	
Inpatient Facility	10% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient Hospital – Physician / Surgeon fees	10% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient Services	10% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient Surgery Facility	10% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient – Physician / Surgeon fees	10% coinsurance, after deductible	20% coinsurance, after deductible
Maternity Services		
Office Visits	10% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
Outpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
Childbirth/Professional Delivery Services (Obstetrician, Surgeon, etc.)	10% coinsurance, after deductible	20% coinsurance, after deductible
Childbirth/Delivery Facility Services (Hospital, Childbirth Center, etc.) Prior Authorization is required	10% coinsurance, after deductible	20% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Mental Health & Substance Abuse		
Inpatient	10% coinsurance, after deductible	20% coinsurance, after deductible
Teladoc™	$0 Copay	
Outpatient	No charge, after deductible	20% coinsurance, after deductible
Dental Services		
Anesthesia and outpatient hospital charges for children under age 5, severely disabled, or has a medical condition requiring hospitalization or general anesthesia for dental treatment	10% coinsurance, after deductible	20% coinsurance, after deductible
Other Services		
Organ Transplants	10% coinsurance, after deductible	Not Covered
Home Health Care (100 visits maximum per calendar year)	10% coinsurance, after deductible	20% coinsurance, after deductible
Skilled Nursing Facility (60 days calendar year maximum)	10% coinsurance, after deductible	20% coinsurance, after deductible
Hospice Care ($5,000 Lifetime maximum)	10% coinsurance, after deductible	20% coinsurance, after deductible
Severe Disease Advocacy And Navigator Services	$0 Copay	
DME (Total rental not to exceed purchase price)	10% coinsurance, after deductible	20% coinsurance, after deductible
External Prosthetic Devices Wigs, Toupees or hair pieces (Limited up to 2 per diagnosis/course of treatment. Does not cover for the diagnosis of androgenetic alopecia-male pattern baldness. Limited to a maximum benefit of $350)	No charge, after deductible	No charge, after deductible
Virtual PT Option	$0 Copay	
Physical, Occupational, & Speech Therapy	10% coinsurance, after deductible	20% coinsurance, after deductible
Chiropractic Services	10% coinsurance, after deductible	20% coinsurance, after deductible

PRESCRIPTION DRUG PLAN	YOUR SHARE OF ELIGIBLE EXPENSE	
	In-Network	Out-of-Network
Pharmacy Benefit Management (PBM) Advocacy		
Retail 30-Day Supply:		
Generic Drugs	10% Coinsurance, after deductible	20% coinsurance, after deductible
Preferred Brand Name Drugs	10% Coinsurance, after deductible	20% coinsurance, after deductible
Non-Preferred Brand Name Drugs	10% Coinsurance, after deductible	20% coinsurance, after deductible
Retail 90-Day Supply		
Generic Drugs	10% Coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
Mail Order 30-Day Supply only		
Specialty Drugs (Requires prior authorization)	10% Coinsurance, after deductible	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	10% Coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	10% Coinsurance, after deductible	Not Covered

This Summary of Material Modifications is intended to provide you with an easy-to-understand description of certain changes to the Summary Plan Description. The Summary Plan Description previously provided to you also serves as the Plan Document. While every effort has been made to make this description as complete and as accurate as possible, this Summary of Material Modifications, of course, cannot contain a full restatement of the terms and provisions of the Plan. The Board of Trustees or its duly authorized designee, reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Plan, or any benefits provided under the Plan, in whole or in part, at any time and for any reason, in accordance with the applicable amendment procedures established under the Plan and the Agreement and Declaration of Trust establishing the Plan (the "Trust Agreement"). No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the Plan, or to change any provision of the Plan. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the Plan and decide all matters arising under the Plan.

SMM.RiedellShoesInc.EN8142.UFCWLoca527_PlanChange_V3.0_Effect050126.050426