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Summary of Material Modifications

To: **All Participants in the UFCW National Health and Welfare Fund Plan of Benefits for Discovery Behavioral Healthcare / UFCW Local 3000**

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

Re: **New Benefit Plan – Summary Below**

Date: **Effective June 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 Discovery Behavioral Healthcare / UFCW Local 3000, Employer Number 9432, 9433. 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	$1,200	$1,200
Family	$2,400	$2,400
Coinsurance *(Member pays)*	30%	50%
Lifetime Maximum		
Amount payable per eligible individual includes all benefits paid for covered hospital, medical, and prescription benefits	Unlimited	
Maximum Out-of-Pocket		
Individual	$9,000	$18,000
Family	$18,000	$54,000
Physician Office Visit		
PCP Office	30% coinsurance, after deductible	50% 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.)	30% coinsurance, after deductible	50% 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)	$100 copay, plus 30% coinsurance	$100 copay, plus 30% coinsurance
Ambulance	30% coinsurance, after deductible	30% coinsurance, after deductible
Urgent Care	30% coinsurance, after deductible	30% coinsurance, after deductible
Diagnostic Services		
Diagnostic Testing (X-rays and blood tests)	30% coinsurance, after deductible	50% coinsurance, after deductible
Imaging (MRI, CT/PET scans)	30% coinsurance, after deductible	50% coinsurance, after deductible
Hospital Services		
Hospital Pre-Certification Penalty	$50% of benefits up to a maximum of $5,000	
Inpatient Facility	30% coinsurance, after deductible	50% coinsurance, after deductible
Inpatient Hospital – Physician / Surgeon fees	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Services	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient Surgery Facility	30% coinsurance, after deductible	50% coinsurance, after deductible
Outpatient – Physician / Surgeon fees	30% coinsurance, after deductible	50% coinsurance, after deductible
Mental Health & Substance Abuse		
Inpatient	No Charge	50% coinsurance, after deductible
Teladoc™	$0 Copay	
Outpatient	No charge, after deductible	50% coinsurance, after deductible
Other Services		
Home Health Care (100 visits maximum per calendar year)	30% coinsurance, after deductible	50% coinsurance, after deductible
Skilled Nursing Facility (60 days calendar year maximum)	No charge, after deductible	50% coinsurance, after deductible

SUMMARY OF BENEFITS	YOUR SHARE OF ELIGIBLE EXPENSE	
	IN-NETWORK	OUT-OF-NETWORK
Severe Disease Advocacy And Navigator Services	$0 Copay	
DME (Total rental not to exceed purchase price)	30% coinsurance, after deductible	50% coinsurance, after deductible
Virtual PT Option	$0 Copay	
Physical, Occupational, & Speech Therapy (excludes Chiropractic)	30% coinsurance, after deductible	50% coinsurance, after deductible
Chiropractic Services (up to 12 visits per calendar year)	30% coinsurance, after deductible	50% 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	Not Covered
Preferred Brand Name Drugs	20% Coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% Coinsurance, after deductible	Not Covered
Mail Order 90-Day Supply		
Generic Drugs	10% Coinsurance, after deductible	Not Covered
Preferred Brand Name Drugs	20% Coinsurance, after deductible	Not Covered
Non-Preferred Brand Name Drugs	20% 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.

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