

Employee Trustees

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WELFARE FUND

425 MERRICK AVENUE, WESTBURY, NY 11590
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November 2023

To: All Participants & Eligible Dependents of the Full-Time, Special Part-Time, PT ACA and Basic Part-Time Plans:

From: The Board of Trustees

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This notice, called a "Summary of Material Modification" ("SMM"), is being provided to advise you of changes the Board of Trustees has made to your Vision, Dental and Orthodontic Benefits under the UFCW Local 1500 Welfare Fund ("Fund"), effective January 1, 2024. After you have read this SMM, please keep it with your Summary Plan Description ("SPD") so you will be reminded of this change.

If you have any questions regarding any of the information in this notice, please contact the Fund Office at info@ufcw1500.org or 1-800-522-0456 or Associated Administrators, LLC at 1-855-266-1500.

OPTICAL (VISION) FEE SCHEDULE - INCREASE IN REIMBURSEMENT

Effective January 1, 2024 – In an effort to assist you with your vision care needs, the Trustees of the Fund have voted to increase the fee schedule allowance for reimbursement of covered optical services.

On the following page, please find a chart of the increased fee schedule reimbursement to be paid for services rendered on or after January 1, 2024.

UFCW LOCAL 1500 WELFARE FUND	
OPTICAL FEE SCHEDULE EFFECTIVE 01/01/2024	
DESCRIPTION OF SERVICE	FEE SCHEDULE ALLOWANCE
EXAMINATION ONLY	\$30.00
FRAME ONLY (RETAIL VALUE UP TO \$300.00)	\$250.00
SINGLE VISION LENSES ONLY (PLASTIC)	\$250.00
BIFOCAL LENSES ONLY (PLASTIC) (INCLUDES FT 28,35, EXECUTIVE OR BLENDED)	\$250.00
TRIFOCAL LENSES ONLY (PLASTIC)	\$250.00
PROGRESSIVE LENSES ONLY (PLASTIC)	\$250.00
FRAME & SINGLE VISION LENSES (PLASTIC)	\$250.00
FRAME & BIFOCAL LENSES (PLASTIC) (INCLUDES FT 28, 35, EXECUTIVE OR BLENDED)	\$250.00
FRAME & TRIFOCAL LENSES (PLASTIC)	\$250.00
FRAME & PROGRESSIVE LENSES (PLASTIC)	\$250.00
EXAM, FRAME & SINGLE VISION LENSES (PLASTIC)	\$250.00
EXAM, FRAME & BIFOCAL LENSES (PLASTIC) (INCLUDES FT 28 ,35 OR EXECUTIVE OR BLENDED)	\$250.00
EXAM, FRAME & TRIFOCAL LENSES (PLASTIC)	\$250.00
EXAM, FRAME & PROGRESSIVE LENSES (PLASTIC)	\$250.00
CONTACT LENSES (HARD OR SOFT, NON-ASTIGMATIC, DAILY OR EXTENDED WEAR) OR \$250.00 CREDIT TOWARDS ANY OTHER TYPE OF CONTACT LENSES	\$250.00
EXAM & CONTACT LENSES (HARD OR SOFT, NON-ASTIGMATIC, DAILY OR EXTENDED WEAR)	\$250.00

IMPORTANT NOTE: All other rules that apply to your respective Plan, including but not limited to eligibility, medical necessity, annual maximums, etc. remain in effect.

DENTAL & ORTHODONTIC FEE SCHEDULES - INCREASE IN REIMBURSEMENT

Effective January 1, 2024 – In an effort to assist you with your dental and orthodontic needs, the Trustees of the Fund have voted to increase the fee schedule allowance for reimbursement of covered dental and orthodontic services rendered on or after January 1, 2024. Additionally, for new services beginning on or after January 1, 2024, the orthodontic lifetime maximum for treatment by a Board-Certified Orthodontist is increased to \$3,000. The lifetime maximum for treatment by an Orthodontist that is not Board-Certified Orthodontist remains the same.

The increase in the dental and orthodontic fee schedules is applicable to both In-Network and Out-of-Network providers.

On the following pages, please find examples of the increased fee allowance for some **common** dental services.

UFCW LOCAL 1500 WELFARE FUND		
EXAMPLES OF FEE ALLOWANCE FOR COMMON DENTAL PROCEDURES AS OF 01/01/2024		
ADA CODE	DESCRIPTION OF SERVICE	FEE SCHEDULE ALLOWANCE
D0120	PERIODIC ORAL EVALUATION-ESTABLISHED PATIENT	\$25.00
D0140	LIMITED ORAL EVALUATION-PROBLEM FOCUSED	\$25.00
D0150	COMPREHENSIVE ORAL EVALUATION-NEW OR ESTABLISHED	\$25.00
D0210	INTRAORAL-COMPLETE SERIES OF RADIOGRAPHIC IMAGES	\$55.00
D0220	INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE	\$12.00
D0270	BITEWING-SINGLE RADIOGRAPHIC IMAGE	\$12.00
D0272	BITEWINGS-TWO RADIOGRAPHIC IMAGES	\$15.00
D0273	BITEWINGS-THREE RADIOGRAPHIC IMAGES	\$20.00
D0274	BITEWINGS-FOUR RADIOGRAPHIC IMAGES	\$25.00
D1110	PROPHYLAXIS-ADULT	\$36.00
D1120	PROPHYLAXIS-CHILD	\$36.00
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	\$20.00
D1351	SEALANT-PER TOOTH	\$30.00
D1510	SPACE MAINTAINER-FIXED-UNILATERAL	\$92.00
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	\$45.00
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	\$55.00
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	\$75.00
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	\$90.00
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	\$500.00
D2720	CROWN-RESIN WITH HIGH NOBLE METAL	\$400.00
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$600.00
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	\$525.00
D2920	RE-CEMENT OR RE-BOND CROWN	\$45.00
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	\$100.00
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	\$100.00
D3310	ROOT CANAL, ANTERIOR (EXCLUDING FINAL RESTORATION)	\$400.00
D3320	ROOT CANAL, PREMOLAR (EXCLUDING FINAL RESTORATION)	\$500.00
D3330	ROOT CANAL, MOLAR (EXCLUDING FINAL RESTORATION)	\$600.00
D4341	PERIODONTAL SCALING AND ROOT PLANNING-FOUR OR MORE	\$50.00
D4342	PERIODONTAL SCALING AND ROOT PLANNING-ONE TO THREE	\$45.00
D4381	LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS	\$75.00
D4910	PERIODONTAL MAINTENANCE PROCEDURE	\$50.00
D5110	COMPLETE DENTURE-MAXILLARY	\$600.00
D5120	COMPLETE DENTURE-MANDIBULAR	\$600.00
D5281	REMOVABLE UNILATERAL PARTIAL DENTURE	\$345.00
D5630	REPAIR OR REPLACE BROKEN CLASP ON PARTIAL DENTURE	\$90.00
D5640	REPLACE BROKEN TEETH-PER TOOTH, PARTIAL DENTURE	\$40.00
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	\$40.00

UFCW LOCAL 1500 WELFARE FUND		
EXAMPLES OF FEE ALLOWANCE FOR COMMON DENTAL PROCEDURES AS OF 01/01/2024		
ADA CODE	DESCRIPTION OF SERVICE	FEE SCHEDULE ALLOWANCE
D6212	PONTIC-CAST NOBLE METAL	\$550.00
D6240	PONTIC-PORCELAIN FUSED TO HIGH NOBLE METAL	\$600.00
D6750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	\$600.00
D6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	\$525.00
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT	\$50.00
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	\$120.00
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	\$140.00
D7241	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$400.00
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	\$35.00
D9215	LOCAL ANESTHESIA IN CONJUNCTION WITH SURGERY	\$30.00
D9222	DEEP SEDATION/GENERAL ANESTHESIA-1ST.15 MINS	\$60.00

Additionally, please be advised that some dental services will require a copayment if received from an In-Network provider on or after January 1, 2024. Below, please find a chart of the treatment/services that will require a copayment if received from an In-Network provider on or after January 1, 2024.

UFCW LOCAL 1500 WELFARE FUND			
DENTAL FEE SCHEDULE & COPAYS AS OF 01/01/2024			
ADA CODE	DESCRIPTION OF SERVICE	FEE SCHEDULE ALLOWANCE	COPAYMENT
D0330	PANORAMIC RADIOGRAPHIC IMAGE	\$42.00	\$10.00
D2510	INLAY-METALLIC-ONE SURFACE	\$125.00	\$20.00
D2520	INLAY-METALLIC-TWO SURFACES	\$250.00	\$50.00
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	\$360.00	\$80.00
D3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	\$125.00	\$112.00
D3421	APICOECTOMY/PERIRADICULAR SURGERY-PREMOLAR	\$300.00	\$119.00
D3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR, FIRST ROOT	\$400.00	\$126.00
D3426	APICOECTOMY/PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)	\$108.00	\$126.00
D4260	OSSEOUS SURGERY (INCLUDING FLAP ENTRY & CLOSURE)	\$360.00	\$150.00
D6545	RETAINER-CAST METAL FOR RESIN BONDED FIXED	\$329.00	\$50.00
D6548	RETAINER-PORCE/CERAMIC-RESIN	\$329.00	\$50.00
D6549	RESIN RETAINER-RESIN FIXED PROSTHESIS	\$329.00	\$50.00
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	\$120.00	\$65.00
D7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	\$120.00	\$110.00
D7450	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR	\$100.00	\$48.00
D7451	REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR	\$202.00	\$48.00
D7460	REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR	\$100.00	\$48.00
D7510	INCISION AND DRAINAGE OF ABSCESS	\$65.00	\$20.00
D7511	INCISION & DRAINAGE OF ABSCESS-INTRAORAL SOFT TISSUE	\$65.00	\$20.00
D7520	INCISION & DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	\$100.00	\$20.00
D7521	INCISION & DRAINAGE OF ABSCESS-EXTRAORAL SOFT TISSUE	\$100.00	\$20.00

Below, please find examples of the increased fee allowance for some **standard** orthodontic services.

UFCW LOCAL 1500 WELFARE FUND		
ORTHODONTIC FEE SCHEDULE AS OF 01/01/2024		
ADA CODE	DESCRIPTION OF SERVICE	FEE SCHEDULE ALLOWANCE
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$500.00
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	\$500.00
D8040	LIMITED ORTHODONTIC TREATMENT OF THE ADULT DENTITION	\$500.00
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$500.00
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	\$500.00
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	\$500.00
D8090	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADULT DENTITION	\$500.00
D8210	REMOVABLE APPLIANCE THERAPY	\$350.00
D8220	FIXED APPLIANCE THERAPY	\$350.00
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	\$103.00
D8680	ORTHODONTIC RETENTION (INCLUDES RETAINERS)	\$350.00

A full copy of the increased fee schedule, by specific service and American Dental Association (“ADA”) code, is posted on the Associated Administrator’s website, www.associated-admin.com. You may also request a copy free of charge from the Fund at info@ufcw1500.org or contact the Medical Department at (516) 214-1337/(516) 214-1336.

IMPORTANT NOTE: All other rules that apply to your respective Plan, including but not limited to eligibility, medical necessity, annual maximums, service limitations, etc., remain in effect.

Si tiene problemas para leer esta carta y necesita una en español, comuníquese con el Fondo al 1-800-522-0456.

This SMM is intended to provide you with an easy-to-understand description of certain changes to the UFCW Local 1500 Welfare Fund. While every effort has been made to make this description as complete and as accurate as possible, this SMM, of course, cannot contain a full restatement of the terms and provisions of the Plan. If any conflict should arise between this SMM and the Plan, or if any point is not discussed in this SMM or is only partially discussed, the terms of the Plan will govern in all cases.

The Board of Trustees 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"). The Trust Agreement is available upon request at the above address and may be inspected by you free of charge during normal business hours.

No individual other than the Board of Trustees 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 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.