IMPORTANT ANNOUNCEMENT
NEW DENTAL PROGRAM FOR ACTIVE EMPLOYEES COVERED UNDER THE PHS REPLACEMENT PROGRAM

TO: **Active Employees Covered Under the**
PHS REPLACEMENT PROGRAM DENTAL PLANS
DHS - Dental Health Services (Washington State)
HDS - Kaiser Dental Plan (Hawaii)
UHC - United Health Care (California)

FROM: **Board of Trustees**
MFOW Welfare Fund

DATE: **September 2025**

The Board of Trustees is pleased to announce that effective **October 1, 2025, a new employee DENTAL plan insured by Blue Shield of California will replace the current active employee dental plans provided by DHS, Kaiser Hawaii and UHC.** These three dental plans will be terminated effective September 30, 2025.

There will be no change to the Kaiser Oregon dental plan and employees should continue to receive their dental services from that plan.

New Blue Shield ID cards will be sent to eligible employees prior to the end of the month and are to be used when receiving dental services on or after October 1, 2025.

The new Blue Shield dental plan is a preferred provider plan (PPO) allowing you to pick any participating dentist or dental office throughout the United States. You can find a participating dental provider through the website ***www.blueshieldca.com***. You are free to use any dentist, however, you and the Trust will save money when you elect to receive dental services by a Blue Shield preferred dental provider.

A brief outline of the plan benefits is attached. Your dentist must submit approval for treatment programs for major dental services such as crowns, bridges, dentures and implants. Only services determined to be necessary will be covered by the Plan and we recommend that you have all proposed treatment programs approved before you begin your dental procedures and use a preferred dental provider to minimize out-of-pocket costs.

Any Welfare Fund reimbursements for out-of-pocket expenses (such as deductible and coinsurance) will only be made for covered dental services that have been authorized by Blue Shield and only after you submit an Explanation of Benefits from the carrier. You will not be reimbursed for expenses incurred for dental services not approved by Blue Shield.

If you have any questions regarding this new program, please contact the Fund Office at (415) 986-1028.

If you have any specific benefit questions, you can also call the Dental Customer Service at (888) 702-4171. The dental plan name is called Spectrum Premier Plus PPO and the group number is **W3001700**.

blue of california

Summary of Benefits

MFOW Welfare Fund
Effective October 1, 2025
DPPO Plan

Custom Smile℠ Spectrum Premier Plus 50/5000/Ortho/U90

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)[1]. Please read both documents carefully for details.

Dental Provider Network: DPPO Network

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Deductible	*Individual coverage*	$50 per individual
	Family coverage	$50: individual $150: Family

Calendar Year Benefit Maximum[5]

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Benefit Maximum	$5,000: individual

Calendar Year Benefit Maximum (Orthodontic Services)[5]

This maximum for covered Orthodontic Services is separate and in addition to the Calendar Year Benefit maximum listed above. Orthodontic Benefits are covered for adults and children.

	When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Benefit Maximum	$1,000: individual

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Benefits[6,7,8]	Your payment			
	When using a Participating Dentist[3]	CYD[2] applies	When using a Non-Participating Dentist[4]	CYD[2] applies
Diagnostic and preventive services				
Oral exam	$0		$0	
Two in a consecutive 12-month period.				
Preventive – cleaning	$0		$0	
Two in a consecutive 12-month period.				
Preventive – x-ray	$0		$0	
Topical fluoride application	$0		$0	
Two in a consecutive 12-month period.				
Periodontal maintenance	$0		$0	
Enhanced dental benefits for pregnant women	$0		$0	
Basic services				
Sealants per tooth	$0	✔	$0	✔
Space maintainers – fixed	$0	✔	$0	✔
Restorative procedures	$0	✔	$0	✔
Oral Surgery	$0	✔	$0	✔
Endodontics	$0	✔	$0	✔
Periodontics (other than maintenance)	$0	✔	$0	✔
Major services				
Crowns and casts	20%	✔	20%	✔
Prosthodontics	20%	✔	20%	✔
Implants	20%	✔	20%	✔
Orthodontics	50%		50%	
Orthodontic Benefits are covered for adults and children.				

Notes

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time.

Capitalized terms are defined in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

If this Plan has any Calendar Year Deductible(s), Covered Services subject to that Deductible are identified with a check mark (✔) in the Benefits chart above.

Covered Services not subject to the Calendar Year Deductible. Some Covered Services are paid by Blue Shield before you meet any Calendar Year Deductible. These Covered Services do not have a check mark (✔) next to them in the "CYD applies" column in the Benefits chart above.

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

The Non-Participating Dentist reimbursement amount is the usual, customary, and reasonable rate or UCR rate. The UCR rate is the cost for a typical service within a specified region and it may differ depending on where you receive services. When you receive services from a Non-Participating Dentist, you pay any amount above the UCR rate. The Allowable Amount is based off the 90th percentile of UCR.

5 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

All Covered Services count towards the Calendar Year Benefit maximum except for Orthodontic services. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

All Orthodontic Covered Services count towards the Calendar Year Orthodontic Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

Enhanced dental benefits for pregnant women do not apply towards the Calendar Year Benefit Maximum.

Notes

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

7 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Orthodontic Covered Services. The Copayment or Coinsurance for Orthodontic Covered Services applies to one course of treatment per lifetime. The course of treatment must be received in a 24 consecutive month period. This applies only if the Member remains enrolled in the Plan. All procedures performed in connection with Orthodontic treatment are payable as Orthodontic Covered Services.

8 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than $250 is started, you should obtain prior authorization of Benefits, except in an emergency.

Plans may be modified to ensure compliance with State and Federal requirements.