MO-KAN SHEET METAL WORKERS WELFARE FUND

SUMMARY PLAN DESCRIPTION

SUPPLEMENT FOR

ROUTINE DENTAL BENEFIT

(FOR ACCIDENTAL DENTAL, SEE DOCUMENT TITLED: MO-KAN SHEET METAL WORKERS WELFARE FUND SUMMARY PLAN DESCRIPTION)

JANUARY 1, 2024

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INTRODUCTION

This Routine Dental Summary Plan Description is a supplement to the Mo-Kan Sheet Metal Workers Summary Plan Description, which sets forth the Medical provisions of the Mo-Kan Sheet Metal Workers Welfare Fund ("Fund.") This Routine Dental benefit is paid for by the Fund, but the network provider is different from the Medical benefit network provider. This Routine Dental Summary Plan Description describes in detail the Routine Dental benefit that is provided by the Fund.

For a description of the Dental benefits provided under the Medical Plan due to Accidental Injury or Illness, or for more information about the Fund and its administrative processes (such as Plan definitions, a list of the Trustees and their ultimate decision making authority, eligibility to participate in the Fund, the Fund's claims and appeals procedures, COBRA continuation coverage rules, your ERISA rights, required notices, and other important information), please refer to the document titled "Mo-Kan Sheet Metal Workers Welfare Fund Summary Plan Description ("SPD")." This document can be found on the Fund's website, www.mokansheetmetal.org, or by contacting the Fund Office at (816) 531-0334, or by writing the address: Mo-Kan Sheet Metal Workers Welfare Fund, 300019, Kansas City, MO 64130-0019.

ROUTINE DENTAL BENEFITS

The Benefits described below will be payable if You or Your Eligible Dependent incur Covered Dental Charges from a Dentist which exceed the Deductible amount listed herein.

Dental Services - Levels of Coverage

Benefits are payable for Covered Dental and orthodontic charges at the current Reasonable and Customary allowance. The Maximum Payment is also shown in this Benefit Summary.

The Deductible is the dollar amount, as shown below, which You and Your Dependent(s) are responsible to pay before Dental Expense Benefits are payable. Only Covered Dental Charges may be used to satisfy the Deductible. This dollar amount will not be reimbursed by the Fund.

The Deductible only applies once in a Calendar Year. Any expenses incurred in the last three (3) months of a Calendar Year which are used to satisfy the Deductible, in part or in full, will also be applied to reduce the Deductible for the following Calendar Year.

Covered services and limitations on their frequency are listed below. If no frequency is stated, coverage is subject to Medical Necessity. All services and limitations are subject to the list of Exclusions located in the separate main SPD document (the "Mo Kan Sheet Metal Workers Welfare Fund Summary Plan Description.")

Coverage A: Preventive Dental Services

- Oral examinations (evaluations, either periodic or new patient, twice in any Calendar Year.
- Periapical x-rays: As required.

- Bitewing x-rays: Two sets per Calendar Year.
- Full mouth x-ray, cone beams or Pano: Once in any thirty- six (36) month period
- Dental prophylaxis (cleaning and polishing): Twice in any Calendar Year.
- Topical fluoride application for dependent children under age 26: Twice in any Calendar Year.
- Emergency palliative treatment: As needed for minor procedures to temporarily reduce or eliminate pain.
- Space maintainers that replace prematurely lost teeth of eligible dependent children: As needed.
- Sealants for dependent children under age 26: Limited to caries-free occlusal surfaces of the first and second permanent molars, once in a lifetime.
- Treatment of temporomandibular joint disorder ("TMJ") is not a covered benefit. Occlusal guards are covered once every twelve (12) month period.

Coverage B: Basic Dental Services

- Problem-focused exams: As required.
- Restorative services using amalgam, synthetic porcelain, and plastic filling material: As required. Composite fillings are a benefit on all teeth.
- Periodontal maintenance visits: Limited to twice per Calendar Year, **shares frequency with routine cleaning.**
- Periodontics: Treatment for diseases of the gums and bone supporting the teeth. Periodontal surgery is covered only once in a thirty-six (36) month period for the same site. Coverage for scaling and root planing are limited to once per thirty-six (36) months.
- Endodontics: Root canal filling and pulpal therapy (therapy for the soft tissue of a tooth).
- Simple and surgical extractions. Note, certain procedures caused by Accident or Illness may need to be processed through the Medical Plan of benefits to be covered. Contact the Fund Office with any questions.
- General anesthesia in conjunction with covered surgical procedures.
- Oral surgery.
- Nitrous oxide in conjunction with restorative procedure or extractions.
- Full mouth debridement: Once every thirty-six (36) months.

- Occlusal guards: Once every twelve (12) months. A sleep apnea device is covered under the Medical Benefit with prior authorization. See the main SPD or contact the Fund Office for more details.

Coverage C: Major Dental Services

- The incurred date of service of major dental work is based on the preparation date, with a standard frequency of once every five (5) years. Covered procedures include the following:
    - Prosthetics, including bridges and dentures, are covered once in five (5) years from the date of initial installation of full or partial, or fixed bridgework.
    - Repair or re-cementing of crowns, inlays, and fixed bridgework is covered if the result of improper installation.
    - Repair and relining of dentures.
    - Crowns, jackets, labial veneers, inlays, and onlays, when required for restorative purposes and when teeth cannot be restored with a filling material: Once in five (5) years from date of placement.
    - Implants are a covered benefit: Limited to once in five (5) years per tooth. Bone grafts in conjunction with implants are a covered benefit under the Medical Plan only.

Coverage D: Orthodontic Dental Services

- Orthodontic care: Treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. Includes care, treatment, service, and supplies (including retainers), including fixed and removable space maintainers (other than for missing primary teeth.) Applies to all eligible participants.

ADDITIONAL COVERAGE LIMITATIONS

All services and limitations are subject to the list of Exclusions located in the separate medical plan SPD document (the "Mo Kan Sheet Metal Workers Welfare Fund Summary Plan Description.")

See "Introduction" above, for how to access this document.

In addition to the Exclusions and Limitations listed in the main SPD document, the following coverage limitations apply:

- Endodontic (root canal treatment) on the same tooth is covered only once in a two (2) year period.

- Charges for replacement of filling restorations are only covered once in a twenty-four (24) month period, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

- A replacement of an existing bridge or denture will be covered only once in five (5) years.

- Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in five (5) years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

- If you receive care from more than one dentist or service provider for the same procedure, benefits will not exceed what would have been paid to one dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy.

- In addition to the above limitations, no benefits are payable under the Routine Dental Benefit for expenses incurred for dental care or services:

    1. For which Benefits are payable under any other part of the Medical Plan;

    2. Due to any Injury or Illness which results from war, declared or undeclared, including armed aggression resisted by the forces of any country or combination of countries, or any act incident to war, while You or Your Dependent(s) are covered under this Plan;

    3. Incurred for treatment of any Injury or Illness that is employment-related or covered under any Workers' Compensation law, Occupational Disease law, or similar law;

    4. Charges that You or Your Dependent(s) are not required to pay;

    5. Paid for or reimbursable by or through the government of a nation, state, province, country, municipality, or other political subdivision, or any instrumentality or agency of such a government;

    6. Made by any person, Hospital, or entity which would normally not make a charge for the services, supplies, or treatments rendered, regardless of the existence of coverage or of the patient's financial condition;

    7. Adult fluoride is not covered for Dependent(s) age 26 and older;

    8. Temporary/Interim services;

    9. Cosmetic services;

    10. Oral hygiene instruction, nutritional counseling, and/or tobacco counseling;

    11. Unspecified dental procedures;

12. Items that are being paid under the medical portion, but not related to any type of accident: Gingival flap procedure, Osseous surgery, bone replacement graft, guided tissue regeneration, surgical stent, biopsy of oral tissue, excision of lesion and/or benign tumor, and removal of cyst(s);

13. Sterile tray;

14. Desensitizing medicaments;

15. Therapeutic drug injection;

16. Fees which are in excess of the Reasonable and Customary charges for services, supplies, or treatment;

17. Behavior management, unless Medically Necessary for a participant with a Mental Illness diagnosis;

18. Fluoride gel carrier;

19. Replacement of lost or broken retainers; and

20. Missed appointments.

See the Exclusions and Limitations Section of the Medical Plan SPD for additional exclusions.

COST AND COST LIMITATIONS TO YOU

The following shows the amount of the Deductible You will pay and to which levels of coverage the Deductible applies. After satisfying the dental Deductible (if it applies), dental benefits will be provided for a specific percentage of the allowed amount of covered services, up to the benefit maximum for each Calendar Year. You will be responsible for the remaining coinsurance amount.

Coverage Levels and Percentages	**In-Network**	**Out-of-Network**
Deductible (Your pay)	**$25**	**$25**
Coinsurance (Plan pays)	80%	80%
Preventative (Plan pays)*	100%	100%
Basic (Plan pays)*	80% after deductible	80% after deductible
Major (Plan pays)*	80% after deductible	80% after deductible
Orthodontic (Plan pays) ($1,800 lifetime maximum**)	50% after deductible	50% after deductible

***Benefit Maximum for Preventative, Basic, and Major dental benefits is a total of $1,600** for all Participants except eligible Dependents under age 20.

****Orthodontic lifetime maximum** does not apply to Phase 1 orthodontic treatment for eligible Participants under age 20, if deemed Medically Necessary by the Plan, in its sole and absolute discretion. Contact the Fund Office for more details.

Dependent Age Limit: 26

Effective Date of Program: 01/01/2024

Benefit Period: Dental benefits are provided according to a Calendar Year benefit period. The Calendar Year begins on January 1 and ends on December 31st of each year. A new Calendar Year benefit period begins each year on January 1st.

MO-KAN SHEET METAL WORKERS WELFARE FUND OFFICE

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