DESERET DENTAL

administered by MetLife

This summary plan description, or SPD, outlines the major provisions of DMBA's Deseret Dental Plan as of January 1, 2025.

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Key Points of the Plan

- The plan has an annual deductible of $50 per person and $150 per family, which does not apply to preventive care.
- The plan pays 100% of the cost for routine diagnostic exams and cleanings twice a calendar year. There is no copayment for preventive care.
- The plan pays 50% of the cost for most other services, such as restorative procedures (including fillings), up to an annual maximum of $1,500 per person.
- The plan pays 50% for orthodontic procedures, up to a lifetime maximum of $1,500 per person.
- Using contracted providers will maximize your benefits and minimize your out-of-pocket costs.
- If you have questions about benefits, please contact the appropriate administrator: MetLife (which administers most benefits in this plan) or DMBA.

Eligibility

You and your dependents are eligible to enroll in the dental plan as long as you remain actively employed. After enrolling, you and your dependents are eligible for benefits as soon as your coverage begins.

When you retire, you are no longer eligible for benefits, but you may be able to enroll in the Senior Dental Plan. For more information, call DMBA Member Services.

Benefit Maximums

The annual dental benefit maximum is $1,500 per person for you and each of your eligible dependents. For orthodontic services (a separate benefit), the lifetime benefit maximum is $1,500 per person.

For information about other benefit maximums, see *Supplemental Accident Benefit* and *Special Medical/Dental Benefit*.

Deductible

For services that aren't preventive care, you pay a deductible of $50 per person and $150 per family per calendar year.

MetLife's Dental Network

DMBA's contract with MetLife gives you access to MetLife's Preferred Dentist Program. Dentists in this program meet MetLife's strict credentialing standards and comply with claims and review processes.

It's in your best interest financially to receive care from MetLife's Preferred Dentist Program. Participating dentists accept what you pay (your deductible and coinsurance) and what MetLife pays as payment in full. They don't bill you for amounts that exceed the allowable amounts.

You are responsible for charges that are ineligible or not covered by the plan.

To find participating MetLife dentists in your area, please contact MetLife at 800-942-0854 or www.metlife.com/dental.

Your Dental Benefits

All benefits are based on medical or dental necessity and are subject to the allowable amounts determined by MetLife or DMBA. Charges are considered incurred on the date of service, which is generally the date the treatment begins. One exception is for dentures: This service date is the date you receive the dentures.

Anesthesia

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Covered services:

- Anesthesia provided in conjunction with an outpatient surgical procedure or in a case approved for the outpatient hospitalization benefit
- Anesthesia provided for a child under (but not including) the age of five
- Anesthesia provided for a person who has a mental or sensory disability

General anesthesia included as part of an eligible outpatient hospitalization does not count toward your annual dental benefit maximum.

Local anesthetics and/or analgesia included in the cost of a complete procedure are not covered.

Endodontic procedures

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Covered services:

- Pulp therapy
- Root canal treatment
- Pulp capping
- Bases, as part of a restorative or prosthodontic procedure

Oral surgery

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Covered services:

- Extractions
- Tooth reimplantation due to trauma
- Single-tooth implants, once every five years to the date

Tooth transplant surgery and related expenses are not covered. Routine post-operative visits billed separately from the surgical procedure are not covered.

Orthodontic procedures

The plan pays 50% of MetLife's allowable amount; you pay 50%. The lifetime benefit maximum is $1,500 per person.

All benefits are subject to the allowable amounts.

MetLife makes an initial payment of 20% of the total eligible charges, and then benefits are paid monthly for the duration of the treatment.

To determine the monthly payment amount, MetLife divides the remaining cost by the number of months of treatment. Monthly payments stop when you or your dependent becomes ineligible or if you end treatment before it is completed.

Some charges for molds, X-rays, and exams in connection with orthodontic treatment count toward the orthodontic benefit maximum.

Habit-control appliances, such as night guards and finger-sucking appliances, are not covered.

Outpatient hospitalization

The plan pays 50% of DMBA's allowable amount; you pay 50%.

Outpatient hospital expenses for dental treatment may be covered if

- a medical problem exists that must be monitored in connection with general anesthesia and surgical procedures;
- general anesthesia is required because of extended work on a child younger than 5; or
- dental or surgical procedures are performed on a patient who has a mental disability, such as Down syndrome, or a sensory disability, such as deafness or blindness.

Preauthorize with a doctor's statement to DMBA, including the treatment plan, fees, and a description of medical necessity.

Eligible outpatient hospitalization expenses do not count toward your annual dental benefit maximum.

Periodontal procedures

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Periodontal maintenance is covered twice each calendar year.

Services covered on a case-by-case basis after review by a consultant:

- Non-surgical procedures
  - » Deep scaling
  - » Root planing
  - » Full mouth debridement
  - » Chemotherapeutic agents
  - » Post-operative care
- Surgical procedures
  - » Gingivectomy
  - » Osseous surgery
  - » Grafting

All benefits are subject to the allowable amounts.

» Mucogingival surgery
» Subgingival curettage

Submit periapical X-rays to receive payment.

Preventive/diagnostic procedures

The plan pays 100% of MetLife's allowable amount.

Services covered twice each calendar year:

- Cleaning (prophylaxis)
- Exams, including specialist and emergency exams, which count toward the benefit maximum
- Fluoride treatment topical application
- A series of bitewing X-rays for patients aged 18 and younger

Other covered services:

- A series of bitewing X-rays, once per calendar year, for patients aged 19 and older
- Sealants, based on plan guidelines
- Space maintainers, for individuals younger than 19
- Complete mouth X-rays or panoramic X-rays, once every five years to the date
- Periapical X-rays, as necessary

Preventive care does not count toward your annual dental benefit maximum. The annual deductible does not apply.

Replacement of lost or stolen space maintainers is not covered.

Prosthodontic procedures

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Covered services:

- Bridges, onlays, inlays, and partial and complete dentures, once every five years to the date
- Crowns and veneers, once every seven years to the date, unless a replacement is needed sooner, is justified by a medical or dental problem causing an unavoidably damaged crown or veneer, and the exception is preapproved and meets MetLife's specific dental criteria
- Relining or rebasing dentures, once every three years to the date
- Replacement of removable dentures with fixed bridgework

For most services, the service date is the date treatment begins. For dentures, the service date is the date you receive the dentures.

Submit periapical X-rays to receive payment for crowns, veneers, onlays, and bridges.

Replacement of lost or stolen dentures is not covered. Tooth preparation, temporary restorations, impressions, analgesia, and local anesthesia billed separately from a prosthodontic procedure are not covered.

Restorative procedures

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Amalgam, porcelain, composite or resin, and metal restorations are covered.

Changing restorations from amalgam to composite fillings because of amalgam/mercury sensitivity is not covered. Tooth preparation, temporary restorations, cement bases, impressions, analgesia, and local anesthesia billed separately from a restorative procedure are not covered.

Ridge augmentation/extension

The plan pays 50% of MetLife's allowable amount; you pay 50%.

Procedures to restore the alveolar ridge to accommodate dentures are covered.

These expenses do not apply toward your annual dental benefit maximum.

Sealants

The plan pays 100% of MetLife's allowable amount.

Up to two sealants on each permanent molar per lifetime for individuals younger than 16 are covered.

These expenses do not apply toward your annual dental benefit maximum. The annual deductible does not apply.

Temporomandibular joint (TMJ) dysfunction

Not covered.

Some benefits for temporomandibular joint (TMJ) dysfunction are covered by most of DMBA's medical plans.

For more information, please see your medical plan's SPD or call Member Services. If you're enrolled in a contracted HMO, please contact your HMO representative for more information.

Other benefits

These benefits are covered at the following percentages:

- Eligible application of desensitizing medications (subject to review): 50% of the allowable amount
- Eligible drugs or medications: 50% of the allowable amount
- Eligible treatment for pain: 50% of the allowable amount
- Eligible therapeutic drug injections (subject to review): 50% of the allowable amount
- Recementing space maintainers: 100% of the allowable amount

All benefits are subject to the allowable amounts.

Special Medical/Dental Benefit

The plan pays 70% of DMBA's allowable amount; you pay 30%. The lifetime benefit maximum is $10,000 per person.

This benefit is provided by DMBA. Dental services needed because of some medical conditions or the treatment of some medical conditions, as defined by the plan, may be covered.

Examples of conditions that may be covered:

- Cleft palate
- Jaw tumors
- Radiation therapy

Preauthorize with a doctor's statement to DMBA, including the treatment plan, fees, and a description of medical necessity.

Expenses covered by this benefit do not count toward your annual dental benefit maximum.

For more information about this benefit, please call DMBA Member Services.

Supplemental Accident Benefit

This benefit is provided by DMBA. Dental services needed because of an accident are covered based on the following guidelines:

- The injury must occur while the individual is covered by DMBA's dental plan administered by MetLife.
- The cause of the condition must meet the definition of an accident as defined by the plan.
- In most cases, eligible expenses must be incurred within two years of the accident date and while the individual remains covered by the plan.

The first $2,000 paid per accident does not count toward your annual dental benefit maximum. If five or more teeth are involved, additional benefits may be available up to $5,000 per accident, and do not count toward your annual dental benefit maximum. The allowable amount is determined by DMBA.

Eligible services are covered at the appropriate benefit levels for those services.

Orthodontic expenses are not covered by the supplemental accident benefit.

For more information about this benefit, please call DMBA Member Services.

Submitting Claims

You or your dental provider must submit claims **within 12 months from the date of service**. It is your responsibility to ensure claims are submitted by the deadline. To submit a claim, follow these steps:

- Request a *Dental Expense Claim Form* from MetLife for each individual.
- Complete the information in the *Employee* section of the claim form and sign the form.
- Take the claim form to your dental appointment.
- Ask the dentist to complete the form. For most prosthodontics procedures, the dentist must also provide periapical X-rays.
- Send the completed claim form and X-rays, if applicable, to MetLife:

  MetLife
  Group Dental Claims
  P.O. Box 981282
  El Paso, TX 79998-1282

After your claim has been processed, MetLife will send you an *Explanation of Benefits* (EOB) statement explaining how your claim has been handled and verifying payment. Please review your statements for accuracy.

If you have questions about your claim, call MetLife at 888-466-8673.

The supplemental accident benefit and the special medical/dental benefit are administered by DMBA. For information about how to submit claims for these services, please call DMBA Member Services.

Errors on Bills or EOBs

If you see services listed on a MetLife *Explanation of Benefits* (EOB) statement that were not performed or could be considered fraudulent, please call MetLife at 800-942-0854.

Benefits administered by DMBA

If you see services listed on a DMBA *Explanation of Benefits* (EOB) statement that were not performed or could be considered fraudulent, please call DMBA at 801-578-5600 or 800-777-3622. For more information, see the *Fraud Policy Statement*.

If you find an error on any of your bills after your claims have been processed and paid, please verify the charges with your provider. Then submit a written description of the error to DMBA:

DMBA
P.O. Box 45530
Salt Lake City, UT 84145

This is referred to as an audit reimbursement request. If the mistake is not otherwise detected, you may receive 50% of the eligible savings, up to $250 per incident, as defined by DMBA. An audit reimbursement request follows DMBA policy and procedures in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). Not every error is eligible for participant reimbursement.

Claims Review and Appeal Procedures

If your claim is denied and you feel that the denial is in error, you have the right to file an appeal with MetLife or DMBA, depending on who administers the benefit.

For MetLife appeals, you must submit your request in writing within 180 days of the date of the *Explanation of Benefits* (EOB) denying your claim.

Explain why you believe the claim for benefits was improperly denied and submit comments, questions, documents, X-rays, or other information that support your reason. Include a copy of the original EOB with your appeal.

MetLife will review your claim within 30 days of receiving it and send you a reply by mail or email. If your first appeal is denied, you may request a second-level appeal.

Send your appeal to MetLife:

MetLife
Group Claims Review
P.O. Box 14589
Lexington, KY 40512

If you are still unsatisfied with the benefits decision after the second-level appeal, you may have rights under the Employee Retirement Income Security Act of 1974 (ERISA) to bring a civil action.

For DMBA appeals, you must submit your request in writing within 12 months from the date we send your adverse benefit decision. For more information about how to appeal a claim, please refer to your *General Information* SPD.

Fraud Policy Statement

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding the plan or DMBA. An application for benefits or a claim containing any materially false or misleading information, or any non-compliance with the terms of the plan, as determined by DMBA, may lead to reduction, denial or termination of benefits or coverage under the plan.

Coverage under the plan may be retroactively canceled or terminated ("rescinded") if a participant acts fraudulently or intentionally makes material misrepresentations of material fact with respect to the plan. A participant whose coverage is rescinded will be provided with no less than 30 days' advance written notice of such rescission, and the rescission will be deemed to be a claim denial subject to the plan's claim and appeal procedures.

Coordination of Benefits

When you or your dependents have medical or dental benefits from more than one health plan, your benefits are coordinated between the plans to avoid duplication of payments.

Coordination of benefits involves determining which insurer is required to pay benefits as the primary payer, which insurer must pay as the secondary payer, and so on.

You must inform DMBA and MetLife of other medical or dental benefits in force when you enroll or when other benefits become effective. If applicable, you may be required to submit court orders or decrees. You must also keep DMBA and MetLife informed of any changes in the status of the other benefits.

Coordination of benefits rules

When DMBA is the primary plan, eligible benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits.

When DMBA is the secondary plan, DMBA calculates the amount of eligible benefits it would normally pay in the absence of other benefits, including the application of credits to any plan maximums, and applies the payable amount to unpaid covered charges after eligible benefits have been paid by the primary plan. This amount includes deductibles and copayments you may owe.

DMBA will use its own deductible and copayments to calculate the amount it would have paid in the absence of other benefits. In no event will DMBA pay more than the participant is responsible to pay after the primary carrier has paid.

DMBA does not coordinate benefits among DMBA group health plans (Deseret Alliance, Deseret Choice Hawaii, DMBA PPO 90, DMBA PPO 70, DMBA HSA 80, DMBA HSA 60, Kaiser of Northern California, Kaiser of Southern California, and Kasier of Hawaii), nor does it coordinate among group dental plans (Deseret Dental, Deseret Dental *PLUS*, and Senior Dental—including those with MetLife).

Subrogation

If you have an injury or illness that is the liability of another party and you have the right to recover damages, DMBA requires reimbursement for the amount it has paid when damages are recovered from the third party.

If you do not attempt to recover damages from the third party as described above, DMBA has the right to act in your place and initiate legal action against the liable third party to recover the amount it has paid for your injuries.

For more information about subrogation, please see your *General Information* SPD.

Eligible Dependents

Your eligible dependents include your spouse and dependent children. Your spouse is the person to whom you are legally married.

Exclusions

Services that do not meet the definition of eligible, as previously defined, are not eligible for benefits. In addition, the following services and their associated costs are excluded from benefits:

1. Cosmetic

1.1. Surgery or dentistry done for cosmetic reasons
1.2. Services for primarily non-therapeutic purposes

2. Diagnostic and experimental services

2.1. Dental treatments or procedures that on the effective date or renewal date of this coverage are

- considered dental research,
- investigative/experimental technology,
- not recognized by the U.S. dental profession as usual and/or common,
- determined by DMBA or MetLife not to be usual and/or common dental practice, or
- illegal

That a dentist might prescribe, order, recommend, or approve services or dental equipment does not, of itself, make it an allowable expense, even though it is not specifically listed as an exclusion.

Investigative/experimental technology means a treatment, procedure, facility, equipment, drug, device, or supply that does not, as determined by DMBA or MetLife on a case-by-case basis, meet all of the following criteria:

- The technology has final approval from all appropriate governmental regulatory bodies, if applicable.
- The technology is available in significant numbers outside the clinical trial or research setting.
- The available research about the technology is substantial.

For plan purposes, *substantial* means sufficient to allow DMBA to conclude the technology is

- both necessary and appropriate for the covered person's treatment,
- safe and efficacious,
- more likely than not beneficial to the covered person's health, and
- generally recognized as appropriate by the regional dental community as a whole.

Procedures or treatments falling in these categories will be excluded from DMBA's dental plan administered by MetLife until they are specifically included in MetLife's plan or DMBA's plan.

3. Education

3.1. Expenses for educational programs, plaque control, myofunctional therapy, and oral hygiene or dietary instruction

4. Government/war

4.1. Services that would have been covered by any governmental plan had the participant complied with the requirements of the plan, including, but not limited to, Medicare, except as required by federal law

4.2. Services required as a result of war or act of war, or service in the military forces of any country at war, declared or undeclared, except when the employee is actively engaged in pursuing a specific assignment given and authorized by the employer

War includes hostilities conducted by force or arms by one country against another, or between countries or factions within a country, either with or without a formal declaration of war.

5. Legal exclusions

5.1. Services the individual is not charged for or is not legally obligated to pay

5.2. Services that began before the individual was covered by this plan

5.3. Treatment or care done after termination of coverage

5.4. Services incurred in connection with injury arising from participation in or attempt at committing a crime

5.5. Other dental services, except as outlined

6. Miscellaneous

6.1. Amounts that exceed MetLife's or DMBA's allowable amounts

6.2. Charges due to failure to keep a scheduled dentist appointment

6.3. Charges for completing claim forms

6.4. Charges for unfinished dental work

6.5. Care and treatment by anyone who

- ordinarily resides in the same household with you or your dependents, or
- has legal responsibility for financial support and maintenance of you or your dependents

7. Other insurance/workers' compensation

7.1. Injuries or conditions that are compensable by workers' compensation, no-fault auto insurance, employment liability laws, or services provided by a federal or state government agency

7.2. Services provided by a group, franchise, or other insurance or prepayment program approved through an employer, union, trust, or association

8. Replacements

8.1. Lost or stolen dentures, bridges, or appliances

8.2. Replacement of any of the following, unless otherwise covered by the plan:

- dentures or bridges less than five years old to the date
- crowns or veneers less than seven years old to the date

9. Specific products and services

9.1. Services or supplies not furnished and/or prescribed by a dentist or physician (for example, denturist services), except cleaning, scaling, or fluoride treatments that may be performed by a licensed dental hygienist under the dentist's supervision
9.2. Tooth preparation, temporary restorations, cement bases, impressions, or acid etching
9.3. Appliances, restorations, or treatment, other than full dentures, whose primary purpose is to alter vertical dimension or restore occlusion
9.4. Protective athletic mouth guards or habit-control appliances, such as night guards or finger-sucking appliances
9.5. Fluoride rinse, toothpaste, toothbrush, or other products or supplies intended for use at home
9.6. Study models or photos, unless used for orthodontic treatment
9.7. Emergency room services
9.8. Infection control
9.9. General anesthesia other than for oral surgery, unless otherwise covered by the plan
9.10. Treatment of disturbances of the temporomandibular joint (some TMJ benefits may be covered under the medical plan)

Definitions

For definitions of words and terms applicable to your dental plan, please refer to the *Definitions* SPD.

Notification of Discretionary Authority

DMBA is the plan administrator and, in its sole discretion, determines appropriate courses of action in light of the reason and purpose for which the plan is established and maintained. In particular, DMBA has full and sole discretionary authority to interpret and construe the terms of all plan documents, including but not limited to the following: resolve and clarify inconsistencies, ambiguities, and/or omissions in all plan documents; make determinations for all questions of eligibility for and entitlement to benefits; determine the status and rights of employees and other persons under this plan; make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of this plan; and determine the manner, time, and amount of payment of any benefits under this plan. Benefits will be paid under this plan only if the plan administrator decides in its sole discretion that the individual is entitled to them. All such interpretations and decisions by DMBA shall be final, binding, and conclusive on the employers, the employees, and any other parties affected thereby.

Any interpretation, determination, or other action of the plan administrator shall be given deference in the event the determination is subject to judicial review. Any review by a court of a final decision or action of plan administrator shall be based only on such evidence presented to or considered by DMBA at the time it made the decision that is the subject of the court's review. Accepting any benefits or making any claim for benefits under this plan constitutes agreement with and consent to any decisions that DMBA makes, in its sole discretion and, further, constitutes agreement to the limited and deferential scope of review described herein.

Notification of Benefit Changes

DMBA is subject to the Employee Retirement Income Security Act (ERISA) and reserves the right to amend or terminate this plan at any time.

Legal Notice

We have made every effort to accurately describe the benefits and ensure that information given to you is consistent with other benefit-related communications. However, if there is any discrepancy or conflict between information in this document and other plan materials, the terms outlined in the plan document will govern.