RETIREE GENERAL INFORMATION

To help you become familiar with your benefits, your summary plan descriptions include a description of each of the plans in your benefit program as of January 1, 2026. This summary plan description, or SPD, outlines general information.

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Member Services

As your benefit administrator, DMBA wants to help you maximize your benefits. In addition to useful tools and information on our website, we have a helpful staff of qualified representatives and experts in various fields, such as registered nurses and financial planners.

Our office hours are 8 a.m. to 5 p.m. (Mountain Time) on weekdays except for Wednesdays, when office hours begin at 9 a.m. You can visit our website anytime to access your personalized benefit information.

Local number	801-578-5600
Toll free	800-777-3622
Website	www.dmba.com

If you're deaf or hard of hearing, please contact us using a relay service.

For your information, we record incoming telephone calls to ensure the quality of the information you receive.

Our offices are located at 150 Social Hall Ave., Suite 170, in downtown Salt Lake City. To schedule an in-person or virtual appointment, go to www.dmba.com, navigate to *Contact Us* (upper left menu on mobile or phone icon on computer), and under *Schedule an Appointment* select *Schedule an appointment with a Member Services Associate*.

Our mailing address:

DMBA
P.O. Box 45530
Salt Lake City, UT 84145-0530

DMBA's Participating Employers

- AgReserves, Inc.
- American Samoa Service Center
- Beneficial Financial Group
- Bonneville Communications
- Bonneville International Corporation
- Brigham Young University
- Brigham Young University–Hawaii
- Brigham Young University-Idaho
- BYU-Pathway Worldwide
- The Church of Jesus Christ of Latter-day Saints
- City Creek Reserve, Inc.
- Deseret Book Company
- Deseret Cattle Feeders, LLC
- Deseret Digital Media
- Deseret Management Corporation
- Deseret News
- Deseret Trust Company
- DMBA
- East Central Florida Services
- EFY, LLC
- Ensign College
- Ensign Peak
- Family Services
- Hawaii Reserves, Inc.
- HSDL-Cano, LLC
- North Point Consolidated Irrigation Company
- OLL Services, LLC
- Polynesian Cultural Center
- Property Reserve, Inc.
- River Point Farms
- South Valley Almond Company, LLC
- Suburban Land Reserve, Inc.
- Taylor Creek Management
- Temple Square Hospitality Corporation
- Utah Property Management Associates

Retiree Benefit Plans

DMBA's retiree benefit program includes the following plans:

Basic benefits

- Medical
- Group Term Life (GTL)

Retirement benefits

- Deseret 401(k) Plan
- Master Retirement Plan

Supplemental benefits

- Dental
- Supplemental Group Term Life (SGTL)

Value-added benefits

- TruHearing
- VSP (vision care)
- Group auto and home insurance

Eligibility and Enrollment Processes

Your eligibility is based on the eligible credit you earned while you were actively employed. If you were at least 55 when you retired and you were employed by a participating employer on that date, you must have had at least 10 years of eligible credit to participate in these post-retirement benefit plans.

Medical and dental benefits

Medical plan eligibility

Eligibility for post-retirement medical and dental benefits depends on your hire date, years of eligible credit, and your participating employer. Please contact DMBA Member Services to confirm your eligibility.

If you don't meet all of DMBA's eligibility requirements and you aren't eligible for Medicare or another group medical plan, you may be eligible for COBRA coverage.

Available medical plans

If you're at least age 55 but not yet 65, you may enroll in certain DMBA active employee plans. At age 65, you must enroll in Medicare Parts A and B and enroll in DMBA's Medicare Supplement plan, Deseret Alliance.

In some areas, HMOs are also available to those with or without Medicare. Before you enroll, contact DMBA to find out what plans are available.

If you have retired and been rehired by a participating employer, you can enroll in an active medical plan made available to you by your employer.

Dental benefits eligibility

You may enroll in the Senior Dental Plan if you meet the eligibility requirements for continued medical benefits. After you retire, dental benefits are optional. You will be responsible for paying the entire premium.

If you don't enroll in dental benefits at the time you retire, you won't be able to enroll later. If, after enrolling, you decide to drop dental benefits, you can do so during any Open Enrollment period, but you will be unable to re-enroll later.

Medical and dental enrollment

Initial enrollment

If you're eligible, you must enroll for retiree medical and/or dental benefits within 30 days after you retire, end employment, or waive enrollment. To enroll, you, your spouse, and any dependents you want to enroll must have been covered by an active DMBA medical and/or dental plan or another employer-based group medical plan for the 12 months immediately before the end of your employment. All members on a policy must be enrolled in the same plans—medical only, dental only, or both.

If you don't enroll within this 30-day window, you are not eligible to enroll later.

Waiving enrollment because of other coverage

At the time you end employment, you may waive initial enrollment if you and your eligible dependents are covered by another employer-based group medical plan.

After waiving enrollment, you may later enroll in DMBA's retiree medical benefits if you do so within 60 days of involuntarily losing the other coverage. You may not voluntarily drop your other coverage and later enroll in DMBA's benefits.

Life benefits

Depending on your hire date, you may be eligible to keep some GTL benefits if you've been enrolled in this program for at least 12 months immediately before you retire.

If you don't enroll in SGTL at the time you retire, you won't be able to enroll later. For more information, see the appropriate life benefits SPD.

Value-added benefits

DMBA offers several value-added benefits. When applicable, you pay the entire cost for these benefits.

Value-added benefits may change at any time without notice. These benefits are available to participants who choose to use these services on a voluntary basis, separate and apart from the benefits program administered by DMBA.

To see the value-added benefits currently available to you, log in to www.dmba.com. Navigate to *My Plans* and under *Benefit Summaries* select *Discount Programs*.

Eligible dependents

Your eligible dependents include your spouse and dependent children. The following dependents may be included in benefits:

- Your natural child, stepchild, legally adopted child, or child lawfully placed for adoption who is younger than age 26, whether married or unmarried
- A grandchild who
  - » is younger than age 26;
  - » is the child of your covered, unmarried, dependent child;
  - » lives in your home with his or her parent (your covered, unmarried dependent child);
  - » depends primarily on you for support; and
  - » has a direct lineal relationship to you through birth or adoption
- A child who is appointed by a court of law to be under your or your spouse's permanent legal guardianship (not temporary guardianship) until legal guardianship terminates or the child reaches age 26, whichever is earlier
- Your unmarried child who
  - » is age 26 or older,
  - » is incapable of self-support because of mental or physical incapacity that existed before age 26,
  - » lives in your home,
  - » depends primarily on you for support,
  - » is an eligible dependent according to IRS guidelines, and
  - » was covered by your DMBA health plan before age 26

To apply for inclusion under the last category, submit proof of these circumstances within 60 days from the end of the month when the child reaches age 26. Any requests made after

this time will not be considered. Please contact DMBA for a copy of the *Application for Dependent Coverage After Age 26*.

If one of your dependents is hospitalized before benefits become effective and is still in the hospital on the date benefits become effective, medical benefits do not begin for that dependent until the day after he or she is discharged from the hospital.

If an eligible child is adopted, coverage is effective the date of placement.

You have 60 days to enroll a new dependent.

Guidelines for dependents who are 19 and older

Your dependent children who are 19 and older are eligible to be included in your medical and dental plans and most life benefit plans until they turn 26. However, if your dependent is covered under his or her employer-sponsored health plan, you must notify DMBA of the coverage. That coverage will be the dependent's primary coverage.

Re-enrollment

If a dependent who is younger than 26 loses eligibility for his or her own medical plan, you can re-enroll the dependent within 60 days of the end of that coverage.

Surviving spouses and dependents

If other medical benefits are available through the survivor's employment, the survivor benefits with DMBA ends. If your dependent is covered under his or her employer-sponsored health plan, you must notify DMBA of the coverage. That coverage will be the dependent's primary coverage.

If those other medical benefits are later lost, eligible surviving spouses or dependent children may re-enroll in DMBA benefits within 60 days of the end of the other benefits.

Guidelines for stepchildren

You may enroll your stepchild as an eligible dependent within 60 days after your marriage to the child's parent. If you do not enroll the stepchild within 60 days you will not be allowed to enroll the child at any other time.

Coverage may continue until the stepchild turns 26 as long as you continue to be married to the stepchild's parent. If your stepchild is covered under his or her employer-sponsored health plan, you must notify DMBA of the coverage and that coverage will be the primary coverage for the dependent.

In cases of divorce, we may request a copy of the divorce decree for the purpose of coordinating benefits.

Open Enrollment

Generally, Open Enrollment is held annually during the fall. Changes in benefits are effective January 1 of the following year.

During Open Enrollment, you may change from your current medical plan to another plan available in your area if you meet plan guidelines. If enrolled in the Senior Dental Plan, you may drop this coverage. You can also enroll in any value-added benefits.

To see which medical plans are available to you, visit www.dmba.com, contact your employer, or call DMBA Member Services.

Medical plans have limitations on when you can enroll if you've previously waived benefits or have not enrolled your dependents (other than newly acquired dependents). For more information, please contact Member Services.

Coordination of Benefits

When you or your dependents have medical or dental benefits from more than one health plan, coordinating benefits avoids duplication of benefit payments. It involves determining which plan provider is required to pay benefits as the primary payer, which insurer must pay as the secondary payer, and so on.

You must inform DMBA 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 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, it calculates the amount of eligible benefits it would normally pay in the absence of other benefits 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.

If you're enrolled in Deseret Alliance, please see the *Deseret Alliance* SPD for more complete information about coordination of benefits.

Coordination of benefit determinations are based on National Association of Insurance Commissioners (NAIC) guidelines.

Premiums

Medical benefits

If you qualify to participate in DMBA's retiree medical benefits, your employer contributes a portion toward your monthly premiums. **Your employer's maximum contribution does not pay the entire monthly premium. You're responsible for paying the balance.**

The employer contribution you are eligible to receive toward retiree medical benefits depends on your hire date, your years of eligible credit, and your participating employer. The following table shows eligibility for your employer's contributions to premiums as percentages of the maximum contribution your employer pays.

> For example, 50% in the table means 50% of the maximum contribution, not 50% of the premium.

Your years of eligible credit	Percentage of maximum employer contribution
Fewer than 10 years	Not eligible
10 to 11 years	50%
12 to 13 years	60%
14 to 15 years	70%
16 to 17 years	80%
18 to 19 years	90%
20 or more years	100%

Dental benefits

If you are eligible for and choose to enroll in the Senior Dental Plan, you pay the entire monthly premium.

Supplemental Group Term Life (SGTL)

Premiums vary depending on your age and the options you choose. For more information, see the appropriate life benefit SPD. You're responsible for the entire monthly premium.

Premium adjustments

Premium adjustments because of enrollment changes or errors are allowed for 12 months immediately preceding the date DMBA receives evidence that such adjustments should be made. These adjustments can be made with returned premium funds or additional premium charges.

In the case of a dependent's death, if you do not notify DMBA within 12 months, we still refund any extra premium you paid back to the date of the dependent's death.

Notification of Changes in Family Status

Please make sure your records at DMBA are current and accurate. If changes to any of the following occur, contact your employer and DMBA immediately:

- Address
- Dependents, through adoption or placement for adoption, birth, death, or permanent guardianship
- Dependent status
- Marital status—through divorce, death, or marriage—for you or your dependent children
- Name

- Medicare qualification for you or any of your dependents
- Other medical or dental benefits for you or any of your dependents
- Other status or circumstance that may affect your participation in the benefit program

Termination of Coverage

Your coverage automatically ends on the earliest of the following dates:

- Last day of the month for which the premium is paid
- Last day of the month in which you request your coverage to end
- Last day of the month in which you are no longer eligible for benefits
- Last day of the month in which you request benefits to end (life benefits)
- Date of termination of the plan

In addition, your dependent's coverage automatically ends on the earliest of the following dates:

- Last day of the month in which your dependent no longer qualifies as an eligible dependent
- Last day of the month you are divorced (for your spouse and any stepchildren)
- Date your dependent enters active duty in the armed forces of any country, except for life benefits (please contact DMBA for more information about military leave)
- Last day of the month in which you request benefits to end (life benefits)

If you're enrolled in Deseret Alliance, our Medicare supplement plan, please see your *Deseret Alliance* SPD for more information about termination of coverage.

Family Survivor Benefit

The Family Survivor Benefit provides a one-year continuation of medical and dental coverage at no cost to your survivors. When you die, your surviving dependents who are covered on the date of your death will be automatically enrolled in the medical and dental plans they were enrolled in at the time of your death.

After one year, your dependents may continue to receive medical and dental benefits through COBRA, as long as they notify DMBA within 60 days of your death and continue to pay applicable monthly premiums.

Surviving dependents may also continue some SGTL benefits if they choose to do so. (See the applicable life benefit SPD.)

Other available medical benefits

If a survivor has other employment-based medical benefits available, coverage with DMBA ends after the first free year of coverage. Likewise, if your surviving spouse is eligible for other benefits and that plan covers any of your dependents, the dependents are no longer eligible for benefits from DMBA after the free year of coverage ends.

This applies to survivors who enrolled in health benefits offered by their employers, as well as those who previously chose not to enroll in their employers' plans. Surviving

dependents who have not enrolled in their employers' plans have at least 30 days to do so after their DMBA coverage ends (one year from the time of your death).

Employers are required by law to offer eligible employees this window to enroll when they lose eligibility for the other benefits they had when they originally declined enrolling in the employer's group plan.

Other eligible survivors (unemployed survivors or survivors working for employers who do not offer them health benefits) may continue to be covered by DMBA until they obtain employment that offers health benefits or they otherwise no longer qualify as dependents.

If employment-based medical coverage is later lost, eligible surviving spouses or dependent children may re-enroll in DMBA benefits within 60 days of the end of the other coverage.

Newly acquired dependents of your survivors may not be added to the survivor benefits.

Protection for You and Your Benefits

Protecting your privacy

Protected health information

DMBA does not disclose your personal, protected health information without your express permission. If you would like other individuals (including your spouse or other family members) to have access to your protected health information, you must submit an *Authorization to Use and/or Disclose Protected Health Information (PHI)* form to DMBA. Your dependents 18 and older must also submit an authorization form before you can access their protected health information.

DMBA ID number

We are committed to protecting the confidentiality of the personal information we receive—either from or about you. Although we use your Social Security number when communicating financial information to the federal government, generally we use your personal DMBA ID number to identify you.

All physicians, dentists, and any other business partners must use your DMBA ID number. Otherwise, your claims may be delayed or denied.

For added security when accessing your information on our website, we ask you to provide a web password and security phrase to accompany your DMBA ID number.

Protecting you: HIPAA special enrollment notice

If you are declining enrollment for yourself and your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 60 days after your or your

dependents' other coverage ends or after the employer stops contributing toward the coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or for more information, contact DMBA Member Services.

Protecting your benefits: ERISA

As a participant in the benefit program, you are entitled to certain rights and protections from the Employee Retirement Income Security Act (ERISA). ERISA provides that all participants be entitled to

- examine, without charge—at the program administrator's (DMBA's) and/or employer's offices—all program documents, collective bargaining agreements, and copies of all documents filed by the program with the U.S. Department of Labor, such as annual reports and plan descriptions;
- obtain copies of all program documents and other program information upon written request to DMBA, which may charge a reasonable fee for the copies; and
- receive a summary of the program's annual financial report, which DMBA is required by law to furnish to each participant.

Your former employer may not discriminate against you to prevent you from obtaining a benefit or for exercising your rights under ERISA.

If your claim for benefits is denied, in whole or in part, DMBA sends you a written explanation of the reason for the denial. You have the right to have DMBA review and reconsider your claim. Based on ERISA, you can take steps to enforce the previously mentioned rights.

For instance, if you request materials from DMBA and you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require DMBA to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond DMBA's control.

If you have a claim for benefits denied or ignored, in whole or in part, you may file suit in federal court after you've exhausted all administrative remedies. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek help from the U.S. Department of Labor or you may file suit in federal court.

The court decides who pays court costs and legal fees. If you are successful, the court may order the party you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim to be frivolous.

If you have questions about the program, contact DMBA. If you have questions about this statement or about your rights under ERISA, contact the nearest area office of the U.S. Department of Labor.

Protecting DMBA: Fraud policy

It is unlawful to knowingly and intentionally provide false, incomplete, or misleading facts or information with the intent of defrauding DMBA. An application for benefits or statement of claim containing any materially false or misleading information may lead to reduction, denial, or termination of benefits or coverage from the plan and recovery of any amounts DMBA may have paid.

In extremely rare situations, a participant may seek to either bypass or ignore appropriate medical advice in an attempt to abuse the healthcare system. This may include, but is not limited to, changing from physician to physician, going from emergency room to emergency room, or seeking medications from multiple sources.

In these situations, DMBA has the right to place the participant on a medical compliance plan. That person must receive care from certain providers and facilities specifically named in the compliance plan (except in an emergency), as determined by DMBA, to comply with medically necessary advice and care.

If the participant then chooses to receive care from providers and facilities not included in the compliance plan, benefits will be denied and the participant will be responsible for all costs associated with this care.

Benefit Administration

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 any amount it has paid when damages are recovered from the third party. DMBA is reimbursed

- first;
- from any claim against the third party, the third party's liability insurer (including workers' compensation), or your uninsured or underinsured motorist insurer;
- whether the recovery is obtained by settlement, judgment, or any other source;
- regardless of how the settlement is allocated by the third party or insurer; and
- regardless of whether the settlement is considered to have recovered full compensation or damages.

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.

Your acceptance of DMBA benefits for the injury gives DMBA the right to subrogate. You must provide all information DMBA requests for subrogation purposes. If you don't, we'll withhold the payment of your benefits and you will be responsible for reimbursing all costs and expenses paid by DMBA for the injury.

Additional details about plan overpayments and the plan's right to subrogation and reimbursements are set forth in the respective legal plan document.

Non-assignability of benefits

Except as provided in the plan's subrogation and reimbursement rights, no benefit under the medical or dental benefits portion of this plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void. Neither you, nor any of your dependents, may assign your rights, benefits, or any other interest under this plan to a healthcare provider or any other individual or entity. DMBA may, however, in its discretion, pay a healthcare provider directly for services rendered to you or your covered dependent(s). The payment of benefits directly to a healthcare provider, if any, will be done as a convenience to you and your covered dependent(s) and will not constitute an assignment of rights, benefits or any other interest under the plan or a waiver of this anti-assignment provision.

Claims Review and Appeal Procedures

If your claim is denied and you feel the denial is in error, you have the right to file an appeal. **You must submit your appeal in writing within 12 months from the date we send your adverse benefit decision.**

What if I need help understanding a denial?

Call us at 801-578-5600 or 800-777-3622.

How do I file an appeal?

Log in to www.dmba.com, navigate to *My Health* and under *Medical* or *Dental* select *Claims*. Select a claim number to view an *Explanation of Benefits* (EOB). Below the benefit details it says, "You have the right to appeal this claim within 12 months from. . . . Click here for more details." This link will provide you with detailed information about appealing a claim. Use the *Member Appeal Form*, available in the *Forms Library*. Complete your appeal form and send it to DMBA's appeals coordinator at the address below.

What if my situation is urgent?

If your situation meets the definition of urgent by law, your review will typically be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also checking the boxes requesting an urgent appeal. Urgent appeals aren't available for disputes involving services you've already received.

Who may file an appeal?

You, or someone you name to act for you as your authorized representative, may file an appeal. To designate an authorized representative, you must provide a written statement designating an authorized representative to act on your behalf. The statement must state the specific date of service (if post-service), description of treatment or service, and claim

or preauthorization number the claimant is authorizing the representative to represent. The statement must be signed and notarized.

When you follow these procedures to designate an authorized representative to act and receive notices on your behalf with respect to a claim, DMBA will direct all information and notification to the designated personal representative authorized. However, if a claim involves urgent care, your treating physician may act as an authorized representative without regard to the authorization procedures listed above. Contact DMBA's appeals coordinator at 801-578-5600 or 800-777-3622 for information about how to authorize another person to represent you.

Can I provide additional information about my claim?

Yes. Include copies of all documents that support your position, such as doctors' letters, operative reports, bills, medical records, EOB statements, written comments, and any other information relating to the claim for benefits.

Can I request copies of information relevant to my claim?

Yes, you can request copies free of charge. This includes billing and diagnosis codes. Send a request in writing to DMBA's appeals coordinator at the address below.

What happens next?

If you appeal, we will review our decision and provide you with a written determination. If your appeal is denied and you still disagree with the decision, you can resubmit it to DMBA's appeals coordinator at the address below, requesting a second level of appeal.

If your second appeal is denied, you may request from DMBA an external review within four months after receiving notice of the appeal denial. The external review will be handled by an independent review organization (IRO), which will respond no later than 45 days after receiving your request, subject to any applicable extensions under ERISA. If the final decision of the IRO is to approve payment, DMBA will provide benefits for the service or procedure in accordance with the terms and conditions of the plan.

External review is only available if the denial involved (1) medical judgment (for example, a denial based on the plan's requirements for medical necessity, health care setting, level of care or effectiveness of a covered benefit or a determination that a treatment is experimental or investigational), (2) a rescission of coverage (i.e., coverage that was cancelled or discontinued retroactively) or (3) Sections 716 or 717 of ERISA (i.e., the balance billing restrictions set forth in the No Surprises Act).

You may also bring a civil action under ERISA Section 502(a) to challenge the adverse benefit determination after the second appeal or after the external review. You must complete the internal appeal processes before any outside action is taken, such as filing a civil action under Section 502(a) of ERISA to challenge the denial in court.

What timelines apply?

You have 12 months after an adverse benefit determination to appeal. Because this plan provides two levels of appeal to DMBA, you will receive notification about any one of the

two appeals for (i) preservice claims no later than 15 days after DMBA receives your appeal; and (ii) post-service claims no later than 30 days after we receive your appeal. For more information about timelines, see the *Claims Review Procedures* table.

Address for claims review and appeal communications

Attn: Appeals Coordinator
DMBA
P.O. Box 45530
Salt Lake City, UT 84145

Table: Claims Review Procedures

	Urgent care health claims	Pre-service health claims	Post-service health claims	Disability claims	Other non-health claims
Notice of initial benefit determination	72 hours after receiving your claim, if it was properly completed	15 calendar days after receiving your initial claim 15-day extension with notice	30 calendar days after receiving your initial claim 15-day extension with notice	45 calendar days after receiving your initial claim Two 30-day extensions with notice	90 calendar days after receiving your initial claim 90-day extension with notice
Incorrectly filed claim notice	24 hours after receiving your claim	Five calendar days after receiving your claim	Claim will be denied	45 calendar days after receiving your claim, extended 30 calendar days from the date we receive the required information	Not applicable
You must complete the claim within . . .	Not applicable	45 calendar days after receiving the notice to provide information	Not applicable	45 calendar days after receiving the notice to provide information	Not applicable
You must appeal the decision within . . .	12 months after receiving the claim denial	12 months after receiving the claim denial	12 months after receiving the claim denial	12 months after receiving the claim denial	60 calendar days after receiving the claim denial

	Urgent care health claims	Pre-service health claims	Post-service health claims	Disability claims	Other non-health claims
DMBA must provide a notice of the decision on the first level of appeal within . . .	72 hours after your request for review (either verbal or written)	15 calendar days after your request for review	30 calendar days after receiving your request for review	45 calendar days after your request for review 45-day extension with notice of special circumstances	60 calendar days after your request for review 60-day extension with notice of special circumstances
Notification of benefit determination on second level of appeal	72 hours after receipt of the appeal	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at its scheduled meeting (at least quarterly)	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at its scheduled meeting (at least quarterly) If special circumstances require a further extension of time, a benefit determination may be rendered no later than the third CRC meeting.	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at its scheduled meeting (at least quarterly) If special circumstances require a further extension of time, a benefit determination may be rendered no later than the third CRC meeting.	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at its scheduled meeting (at least quarterly) If special circumstances require a further extension of time, a benefit determination may be rendered no later than the third CRC meeting.

Definitions and Exclusions

Each benefit plan has unique limitations and exclusions. Please pay particular attention to the exclusions in each summary plan description, as well as 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; 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.