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, 2025. This summary plan description, or SPD, outlines general information.

Table of Contents

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

Benefit Plans

DMBA's benefit program includes the following plans:

Basic benefits

- Medical, which includes the Living Healthy wellness program
- Dental
- Group Term Life (GTL)
- Occupational Accidental Death & Dismemberment (OAD&D)

- Disability Plan

Supplemental benefits

- Supplemental Group Term Life (SGTL)
- 24-Hour Accidental Death & Dismemberment (24-Hour AD&D)

Retirement benefits

- Deseret 401(k) Plan

Flexible benefits

- Flexible Spending program
- Premium Only Plan (POP)

Value-added benefits

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

Table: Enrollment Guidelines

Plan		Who can enroll?	What are the requirements?	When can you enroll?
Basic Benefits	**Medical Dental**	Employee and eligible dependents	Enroll within 30 days after your eligibility date. If you don't enroll within 30 days, you must wait until the following Open Enrollment.	Enroll within 30 days after your eligibility date or during the next annual Open Enrollment. Enroll newly acquired dependents within 60 days of their eligibility date or a HIPAA qualifying event.
	GTL	Employee and eligible dependents	Enroll within 30 days after your eligibility date. If you are a full-time employee hired on or after January 1, 2025, and do not make an election, you are automatically enrolled 30 days after your eligibility date. If you waive coverage or don't enroll within 30 days, you must meet our health standards. (Eligibility for these three plans is tied together.)	Enroll within 30 days after your eligibility date. If you are a full-time employee hired on or after January 1, 2025, you are automatically enrolled 30 days after your eligibility date. You may enroll later if you meet our health standards. Enroll newly acquired dependents within 60 days of their eligibility date or a HIPAA qualifying event.
	OAD&D Disability Plan	Employee only		
Supplemental Benefits	**SGTL**	Employee and eligible dependents	Complete the appropriate application and meet DMBA's health standards.	Anytime
	24-Hour AD&D	Employee and eligible dependents	Complete the appropriate application.	Anytime
Retirement Benefits	**Deseret 401(k) Plan**	Employee only	You must be 21 or older, in an eligible class of employment as defined by your employer, and scheduled to work at least 1,000 hours a year.	Enroll within 30 days of your eligibility date. If you don't opt out, you'll be automatically enrolled at 6% before-tax and in the BlackRock LifePath target date index fund corresponding to your 65th birthday (the Qualified Default Investment Alternative or QDIA).
Flexible Benefits	**Flexible Spending**	Employee only	You must meet your employer's eligibility requirements, determine your election, and then enroll. Re-enroll every year.	Enroll within 30 days after your eligibility date and during each annual Open Enrollment thereafter, or within 60 days of a HIPAA qualifying event.
	Premium Only Plan (POP)	Employee only	Same requirements as for medical and dental benefits.	Enrollment is automatic unless you waive participation within 30 days of your eligibility date or during Open Enrollment.

Table: Benefits Guidelines

Plan		Who pays for this benefit?	When does coverage begin or when are benefits available?	When does coverage end?
Basic Benefits	**Medical Dental**	Your employer pays a large portion of the premium on your behalf; you pay the remainder of the premium.	As a new employee, coverage begins on your eligibility date. If you enroll during Open Enrollment, your coverage begins the first day of the following year.	For information, see *Termination of Coverage*.
	GTL	Your employer pays the entire premium on your behalf.	As a new employee, coverage begins on your eligibility date. At any time thereafter, coverage begins the first day of the month after we approve your application.	
	OAD&D Disability Plan	Your employer pays a large portion of the premium on your behalf; you pay the remainder of the premium.		
Supplemental Benefits	**SGTL**	You pay the entire premium.	Coverage begins the first day of the month after we approve your application.	
	24-Hour AD&D	You pay the entire premium.	Coverage begins the first day of the month after we approve your application.	
Retirement Benefits	**Deseret 401(k) Plan**	You determine your contribution amount and your employer matches a percentage of your contribution.	Vesting is immediate. See the *Deseret 401(k) Plan* SPD for information about when benefits are available.	
Flexible Benefits	**Flexible Spending**	You choose how much of your pretax money to allocate to your Flexible Spending account (FSA) each year.	As a new employee, coverage begins on your eligibility date. If you enroll during Open Enrollment, coverage begins the first day of the following year. If you enroll within 60 days of a HIPAA qualifying event, coverage begins the first day of the qualifying event.	
	Premium Only Plan (POP)	Not applicable.	If you enroll during Open Enrollment, benefits begin the first day of the following year. As a new employee, benefits begin on your eligibility date.	

Eligibility and Enrollment Processes

You can participate in the benefit program when you meet the eligibility requirements of your participating employer and you have actively started work.

You can enroll in most benefit programs on our website, www.dmba.com. For help, work with your employer or call DMBA Member Services at 801-578-5600 or 800-777-3622.

Basic benefits

Enrolling in the basic benefits program within 30 days after your eligibility date is very important.

If you do not enroll within 30 days of your eligibility date, you cannot apply for medical or dental benefits until the next annual Open Enrollment, with coverage beginning the first day of the following year. Exceptions may apply. (See *Protecting you: HIPAA*.)

If you are a full-time employee hired on or after January 1, 2025, you will automatically be enrolled in GTL, OAD&D, and Disability 30 days after becoming eligible unless you waive coverage. To enroll in GTL, OAD&D, and Disability more than 30 days after becoming eligible, you must meet DMBA's health standards.

You may enroll up to 90 days before your eligibility date, but you are not covered until your eligibility date. Each year thereafter, you may review your enrollment decisions and possibly change benefits during Open Enrollment.

You may choose

- the entire basic benefits package;
- the dental, life, and disability option;
- the life and disability option (waive both medical and dental benefits); or
- to waive all benefits.

Some benefits (medical, dental, and life) are available to you and your eligible dependents.

Other benefits (OAD&D and Disability) are only available to you, the employee. For more information, see the *Enrollment Guidelines* table under the column heading *Who can enroll?*

In most cases, you cannot disenroll midyear. You can disenroll or choose another medical plan during the next Open Enrollment.

Supplemental benefits

You may apply anytime for SGTL or enroll in 24-Hour AD&D by logging in to www.dmba.com. Navigate to *My Plans* and under *My Benefit Information* select *Change My Enrollment*. You and/or your dependents must complete the health questionnaire if you're applying for SGTL.

Coverage begins the first day of the month after DMBA approves your application.

Retirement benefits

The Deseret 401(k) Plan is a defined contribution plan to which you can contribute. Your employer will match your contributions to a certain percentage. Eligible employees may

also receive additional employer contributions based on a percentage elected by their employer. (See the *Deseret 401(k) Plan* SPD.)

You're automatically enrolled in the Deseret 401(k) Plan if you don't enroll or opt out within 30 days of becoming eligible.

Flexible benefits

These programs may provide tax advantages to you. See the *Flexible Spending* SPD to learn about the Flexible Spending account (FSA) program and the *Premium Only Plan* (POP) SPD to learn about that plan.

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 who is younger than 26 or you must wait until the next Open Enrollment. (See *Protecting you: HIPAA*.)

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.

Guidelines for stepchildren

You may enroll your stepchild as an eligible dependent on your eligibility date or within 60 days after your marriage to the child's parent. If you do not enroll the stepchild within 60 days, you may not enroll the child until the next Open Enrollment.

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.

Guidelines for employees at high risk

Anyone (employee or dependent) who applies for GTL, SGTL, and Disability after 30 days from becoming eligible and does not meet our health standards may be classified as high risk. In this situation, benefits may be reduced or unavailable as indicated:

- GTL benefits: 50% of benefit
- SGTL benefits: Not available
- Disability Plan: Not available

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 or dental plan to another plan available in your area if you meet plan guidelines. You can also enroll in Flexible Spending or 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.

Unrestricted Open Enrollment

DMBA offers an unrestricted Open Enrollment. This means if you have waived medical or dental benefits in the past, you can enroll during Open Enrollment without meeting health standards. You may also enroll your eligible dependents.

Unrestricted Open Enrollment applies to medical and dental benefits only. It does not apply to life or disability benefits.

You may apply for GTL or Disability plans at any time, but you must meet our health standards to qualify. If you're interested, go to the *Forms Library* on www.dmba.com or contact us for a *Declaration of Insurability Form*.

Change in status and special enrollment events

Major family events may qualify you to enroll at times other than during Open Enrollment or as a new employee:

- Marriage, divorce, legal separation, or the death of a spouse
- Change in the number of your dependents, such as birth, death, adoption, or placement with you for adoption
- Change in employment status that affects eligibility, such as going from part-time to full-time employment and commencement of or return from an unpaid leave of absence
- Involuntary loss of eligibility for other medical benefits
- Change of spouse's employment status and ineligibility for health benefits through his or her employer
- HIPAA special enrollment events
- Eligibility or loss of eligibility for Medicare or Medicaid
- Significant cost or benefit option changes

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 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, 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 Kaiser of Hawaii), nor does it coordinate benefits among group dental plans (Deseret Dental, Deseret Dental *PLUS,* and Senior Dental—including those with MetLife).

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

Premiums

Your employer pays the majority of your monthly premiums; you are responsible for the remaining balance. For supplemental and value-added benefits, you pay the entire cost for the benefits you choose.

Basic benefits

For the basic benefits, monthly premiums are divided into three categories depending on who is covered:

- You (the employee) only
- You and one dependent
- You and two or more dependents

Supplemental benefits

Premiums vary depending on your age and the options you choose. Please refer to the appropriate life benefit SPD for more information.

Retirement benefits

These benefits do not have any associated premiums. For the Deseret 401(k) Plan, you determine your contribution amount and your employer makes a matching contribution up

to a percentage it determines. Eligible employees may also receive additional employer contributions based on a percentage elected by their employer.

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

Benefits During Leaves of Absence

Depending on the type of leave, benefits may continue for an employee on a leave of absence. Please contact DMBA for more information. For the leave to qualify, your employer must officially approve the leave and the clear intent must be for you to return to work for the participating employer.

Basic and supplemental benefits

You may continue your benefits during certain types of leaves of absence. Limitations apply to the length of time your benefits and your employer's premium contributions continue. For information about a specific leave of absence, please contact your employer or DMBA.

If you're outside your medical plan's service area during your leave, you can choose a plan in your new area for the duration of your leave. When you return, you can re-enroll in your original medical plan.

You may continue SGTL benefits if you keep basic GTL benefits. You may also continue your 24-Hour AD&D benefits.

If you discontinue your benefits while you're on leave, you can reinstate benefits in effect before an employer-approved leave of absence (such as full-time military service, professional development leave, or family leave) if you

- were enrolled for at least six months immediately before the leave,
- return to active employment within three months after release or the end of the designated leave, and
- request your benefits to be reinstated within 60 days after your return to work.

You may have to meet DMBA's health standards to continue life benefits.

Other benefits

If you are on paid leave, you may continue to contribute and receive employer contributions to the Deseret 401(k) Plan and participate in the Flexible Spending program.

If you are on unpaid leave, you cannot contribute to the Deseret 401(k) Plan. If you're enrolled in Flexible Spending, you may be able to make after-tax contributions. Please contact DMBA Member Services for more information about your options.

Military leaves of absence

Special provisions apply to military leaves. Please contact your employer and DMBA for more information.

Termination of Coverage

Basic and supplemental benefits

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 end employment and do not qualify to continue benefits
- Last day of the month in which you are no longer eligible for benefits
- Last day of the month in which you enter 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 (supplemental 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 (supplemental life benefits)

If you or your dependent is in the hospital on the date your coverage ends, you may extend medical benefits for the individual solely for the injury or illness for which you or your dependent was admitted.

In your case, coverage ends on the date of your release from the hospital. In the case of your dependents, coverage ends on the date of release from the hospital or no longer than 30 days from the date eligibility ends, whichever comes first.

Retirement benefits

Deseret 401(k) Plan

If you end employment for any reason, including retirement, you cannot make further contributions to your Deseret 401(k) Plan account and become ineligible to receive any additional employer contributions, but you may be able to roll over money to another qualified plan. See the *Deseret 401(k) Plan* SPD.

Flexible benefits

Flexible Spending

You must re-enroll to participate every year. This benefit ends each December 31 or when you end eligible employment. The plan year runs from January 1 to December 31. See the *Flexible Spending* SPD for more information.

POP

This benefit ends when you end eligible employment or disenroll. See the *Premium Only Plan* (POP) SPD for more information.

Continuing Life Benefits

If part or all of your Group Term Life (GTL) or Supplemental Group Term Life (SGTL) benefits terminate because you end employment (other than retirement) or you lose membership in an eligible class of employment, you may be able to purchase a continuing individual policy from The Hartford without having to meet health standards.

You must apply for this plan and pay the initial premium within 30 days from the time your group coverage ends. Please contact DMBA Member Services for an application.

Family Survivor Benefit

If you die while enrolled in DMBA medical benefits, your surviving dependents who were enrolled on the date of your death may continue receiving medical and/or dental coverage for a one-year period after your death. During this period, plan premiums for medical and/or dental coverage are waived for your surviving dependents. Surviving dependents must elect coverage under this benefit within 60 days of your death.

During the one-year premium waiver period, a surviving dependent's eligibility will terminate if his or her eligibility would have otherwise terminated in accordance with the terms of the plan. For example, a surviving child's eligibility terminates upon reaching age

26 even if that event occurs during the premium waiver period. In addition, the premium waiver will terminate before the end of the one-year period if your surviving dependent reaches age 65 or becomes eligible for Medicare (whichever is earlier).

After the one-year premium waiver period, coverage of your surviving dependents will end, subject to any COBRA rights.

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

The Health Insurance Portability and Accountability Act (HIPAA) provides you with important protections.

Special enrollment periods for qualifying events

HIPAA requires plan providers to offer special enrollment periods to individuals who initially decline enrollment because they have other insurance and subsequently or involuntarily lose eligibility for that benefit. A special enrollment period must also be offered to you if you gain a new dependent, either through marriage, birth, or adoption. (See *Change in status and special enrollment events*.)

If you waive medical or dental benefits and later want to enroll with DMBA, you must provide a *Certificate of Creditable Coverage* or other legal documentation of the qualifying event.

HIPAA prohibits group plans from using health criteria to determine an individual's eligibility to enroll. Special enrollment in DMBA's medical plans is only allowed if

- you or your eligible dependents had other insurance but became ineligible for it, in which case you and your dependents may enroll within 60 days after losing the other benefits; or
- you gain a newly eligible dependent, in which case you may enroll that dependent and any other eligible dependents who are not currently enrolled within 60 days after acquiring the dependent.

All other plan provisions and requirements apply to eligibility for medical benefits.

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 employer may not fire you or 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. As plan administrator, DMBA makes final benefit determinations for all claims except for (1) claims for medications through the prescription drug program, which is administered by Navitus, and (2) claims for professionally administered prescription drugs, which are administered by Archimedes. Navitus, the plan's pharmacy benefit manager, administers the prescription drug program and makes final benefit determinations for claims it administers. Archimedes administers certain professionally administered drugs (e.g., medications dispensed by a provider) and it makes final benefit decisions for such claims.

The timeframe to file appeals with Navitus for prescription drug program claims may be different from appeals administered by DMBA and Archimedes, which follow the plan's standard timeframe for filing appeals. For example, the plan's standard timeframe requires that you must submit an appeal in writing within 12 months from the date of your adverse benefit decision, whereas you must submit an appeal to Navitus within 180 days from the date you receive your adverse benefit decision. For information on filing appeals with Navitus, see *Filing a Prescription Drug Appeal*.

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. For information on filing appeals with Navitus, see *Filing a Prescription Drug Appeal*.

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. For information on filing appeals with Navitus, see *Filing a Prescription Drug Appeal*.

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

	Urgent care health claims	Pre-service health claims	Post-service health claims	Disability claims	Other non-health claims
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
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

	Urgent care health claims	Pre-service health claims	Post-service health claims	Disability claims	Other non-health claims
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.

Filing a Prescription Drug Appeal

The prescription drug benefit is administered by Navitus Health Solutions. Navitus has been delegated authority to, in its sole discretion, interpret plan provisions relating to the prescription drug benefit as well as facts and other information for claims and appeals. Navitus's decisions on claims and appeals are final and binding.

If your claim is denied and you feel that the denial was in error, you have the right to file an appeal. For prescription drug claims administered by Navitus, you must submit your appeal in writing to Navitus within 180 days from the date you receive your adverse benefit decision.

Your appeal should include a copy of the denial notice, an explanation as to why the initial decision should be reversed, and a copy of any information that will support your request. You may request copies (free of charge) from Navitus of all documents, records, and other information relevant to the claim.

If your situation meets the definition of an urgent care claim, your review will typically be conducted within 72 hours. To file an appeal for an urgent care claim for a prescription

drug, call Navitus at 833-354-2226. Urgent care claim appeals aren't available for disputes involving services you've already received.

There is one appeal available for a prescription drug claim denial. Navitus will respond to any appeal within a reasonable period of time but not later than (i) 15 days from receipt of your preservice claim appeal; and (ii) 30 days from receipt of your post-service claim appeal. Navitus will provide you with written notice of the plan's decision on appeal.

If your appeal is denied, you may request an external review through Navitus within four months after receiving notice of the appeal denial. The external review will be handled by an independent review organization (IRO). The IRO's response time will be no later than 45 days from receipt of your request, subject to any applicable extensions under ERISA. For prescription drug appeal time limits, see the *Prescription drug appeal time limits* table. You must complete the internal appeal and external review 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.

If you have questions related to the prescription drug program, including how to file a prescription drug appeal, call Navitus at 833-354-2226 or visit memberportal.navitus.com/landing.

Send prescription drug appeals to Navitus:

Navitus Health Solutions
Attn: Appeals Department
P.O. Box 999
Appleton, WI 54912-1039

Table: Prescription drug appeal time limits

	Urgent care prescription drugs	Pre-service prescription drugs	Post-service prescription drugs
You must file an appeal within . . .	180 days after receiving the claim denial notice		
Navitus must provide notice of appeal decision . . .	Not later than 72 hours after receiving an appeal	Not later than 15 days after receiving an appeal	Not later than 30 days after receiving an appeal
You must request an external review within . . .	Four months after receiving the appeal denial notice		
IRO must provide notice of external review decision . . .	Not later than 72 hours after receiving the request for external review	Not later than 45 days after receiving the request for external review	

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; 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.

DMBA may allocate or delegate its duties and responsibilities under this plan and may designate any person or entity to carry out any of its duties or responsibilities with respect to administration of this plan, including the appointment of one or more claims administrators to evaluate benefit claims under this plan. In the case of such allocation or delegation, all references to "DMBA" or "plan administrator" shall be deemed to refer to such person or entity to the extent of such allocation or delegation. However, DMBA has a continuing duty to monitor the performance of any of its delegates or designees.

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.