DESERET DENTAL *PLUS*

This summary plan description, or SPD, outlines the major provisions of DMBA's Deseret Dental *PLUS* 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 80% of the cost for most other services, such as restorative procedures (including fillings), up to an annual maximum of $2,000 per person.
- The plan pays 50% for orthodontic procedures, up to a lifetime maximum of $2,000 per person.
- Using contracted providers will maximize your benefits and minimize your out-of-pocket costs.

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 Maximum

The annual dental benefit maximum is $2,000 per person for you and each of your eligible dependents. For orthodontic services (a separate benefit), the lifetime benefit maximum is $2,000 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.

DMBA's Dental Network

It's in your best interest financially to receive care from our contracted dental network. Contracted dentists accept what you pay (your copayments and coinsurance) and what DMBA 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 contracted dentists in your area, please visit www.dmba.com (for Utah and Idaho providers and all other states) or call DMBA Member Services.

Your Dental Benefits

All benefits are based on medical or dental necessity and are subject to the allowable amounts determined by 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 80% of DMBA's allowable amount; you pay 20%.

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 80% of DMBA's allowable amount; you pay 20%.

Covered services:

- Pulp therapy
- Root canal treatment
- Pulp capping

Bases billed separately from a restorative or prosthodontic procedure are not covered.

Oral surgery

The plan pays 80% of DMBA's allowable amount; you pay 20%.

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 DMBA's allowable amount; you pay 50%. The lifetime benefit maximum is $2,000 per person.

DMBA makes an initial payment of 50% of the down payment, up to $400, and then benefits are paid monthly for the duration of the treatment.

To determine the monthly payment amount, we divide 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 80% of DMBA's allowable amount; you pay 20%.

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 80% of DMBA's allowable amount; you pay 20%.

Services covered twice each calendar year:

- Periodontal maintenance
- Periodontal exams

Services covered once every six months to the date:

- Deep scaling
- Root planing
- Full mouth debridement
- Chemotherapeutic agents

Covered surgical procedures:

All benefits are subject to the allowable amounts.

- Gingivectomy
- Osseous surgery
- Grafting

Preventive/diagnostic procedures

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

Services covered twice each calendar year:

- Cleaning (prophylaxis)
- Initial and routine exams by a general or pediatric dentist
- 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
- 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 80% of DMBA's allowable amount; you pay 20%.

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 meets DMBA's specific dental criteria
- Stainless steel crowns on permanent teeth, once every two years to the date
- Stainless steel crowns on primary teeth, once every five years to the date
- Relining or rebasing dentures, once every three years to the date

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 for review of veneers to determine eligibility. Cosmetic veneers are not covered (see Exclusion 1.1).

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 80% of DMBA's allowable amount; you pay 20%.

Covered services:

- One amalgam, porcelain, composite, or resin restoration per tooth surface, every two years to the date
- One gold restoration per tooth surface, every five years to the date

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 80% of DMBA's allowable amount; you pay 20%.

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 DMBA's allowable amount.

Up to one sealant on each permanent molar once every five years (to the date) for individuals younger than 16 is 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.

Other benefits

These benefits are covered at the following percentages:

- Eligible application of desensitizing medications (subject to review): 80% of the allowable amount
- Examinations provided on an emergency basis (such as after regular office hours): 80% of the allowable amount

All benefits are subject to the allowable amounts.

- Exams or consultations by specialty dentists: 80% of the allowable amount
- Space maintainers: 100% of the allowable amount
- Recementing space maintainers: 100% of the allowable amount
- Repairs to space maintainers: 80% of the allowable amount
- Eligible therapeutic drug injections (subject to review): 80% of the allowable amount
- Eligible cone-beam X-rays (subject to review): 100% of the allowable amount

All benefits are subject to the allowable amounts.

Special Medical/Dental Benefit

The plan pays 90% of DMBA's allowable amount; you pay 10%. The lifetime benefit maximum is $10,000 per person.

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

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.
- 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.

You or your dentist completes a dental claim form and sends it to DMBA. If veneers are done, the dentist must also submit periapical X-rays.

After your claim has been processed, DMBA 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.

Errors on Bills or EOBs

If you see services listed on an *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.

Because the error usually means the provider was overpaid, we must recover the money from the provider before we can return the savings to you. Please be patient while we correct the error.

If DMBA detects an error on a bill before you do, we cannot forward the savings to you because this would violate our obligations based on the Employee Retirement Income Security Act of 1974 (ERISA).

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. **You must submit your appeal 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 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 us 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 Kaiser 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 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 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 until they are specifically included in the dental 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 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:

- fillings less than two years old to the date
- 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.