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2019

DESERET DENTAL *PLUS*

administered by MetLife

This summary plan description (benefits handbook), or SPD, outlines the major provisions of DMBA's Deseret Dental *PLUS* Plan as of January 1, 2019.

KEY POINTS OF THE PLAN

- After your $25 per person annual deductible, the plan pays 100 percent of the cost for routine diagnostic exams and cleanings twice a year.
- The plan pays 80 percent of the cost for most other services, such as restorative procedures (including fillings), up to an annual maximum of $1,500 per person.
- The plan pays 50 percent for orthodontic procedures, up to a lifetime maximum of $2,000 per person.
- Use contracted providers to maximize your benefits and minimize your out-of-pocket costs. (Visit www.dmba.com to link to a current list of MetLife providers.)
- Most benefits in this plan are administered by MetLife. A few specific benefits are administered by DMBA. If you have questions about benefits, please contact the appropriate administrator.

DMBA

ELIGIBILITY

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

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

MAXIMUM BENEFITS

The annual maximum benefit is $1,500 per person for you and each of your eligible dependents. For orthodontic benefits, the lifetime maximum benefit is $2,000 per person. (See Orthodontic procedures.)

For information about other maximum benefits, see Supplemental Accident Benefit.

DEDUCTIBLE

For your first exam, you pay a $25 deductible per person per calendar year.

METLIFE'S DENTAL NETWORK

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

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

But please be aware, **you are still responsible** for charges that are ineligible or not covered by the plan.

MetLife's nationwide network has nearly 69,000 dentists and specialists. For information about participating MetLife dentists in your area, please contact MetLife:

Toll free 800-942-0854

Website www.metlife.com/dental

YOUR DENTAL BENEFITS

All benefits are based on medical or dental necessity and are subject to the allowable amounts determined by MetLife (or DMBA, if DMBA administers the benefit). Charges are considered incurred on the date of service, which is generally the date your treatment begins. One exception is for dentures; this service date is the date you receive the dentures.

Your dental plan benefits follow alphabetically:

ANESTHESIA

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

- General anesthesia expenses are covered when used as a part of oral surgery or in a case approved for the outpatient hospitalization benefit. (See Outpatient hospitalization.)
- Anesthesia shall also be considered for benefit payment for services performed on a child under (but not including) the age of 5, or services performed on a person who has a mental or sensory disability.
- Generally, local anesthesia or relative analgesia is included in the cost of a complete procedure. If they are billed separately, they are not covered.
- When general anesthesia is administered as part of an eligible outpatient hospitalization, expenses do not count toward your annual maximum benefit.

ENDODONTIC PROCEDURES

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

- Pulpal and root canal therapy is covered.

- Pulp caps are covered.
- Generally, bases are included in the cost of a restorative or a prosthodontic procedure. If they're billed separately, they aren't covered.

ORAL SURGERY

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

- Extractions and other oral surgeries are covered, including:
  - » Reimplanting knocked out teeth
  - » Single-tooth implants, replacing an implant once every five years (to the date)
- Generally, routine post-operative visits are included in the cost of the total surgical procedure. If they're billed separately, they're not covered. For tooth transplants, oral surgery expenses and other related expenses are not covered.

ORTHODONTIC PROCEDURES

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

- The lifetime maximum benefit is $2,000 per person.
- Benefits are paid on a monthly basis for the duration of the treatment. MetLife makes an initial payment of 20% of the total eligible charges. To determine the monthly payment amount, they 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 are considered part of the treatment and are included in the benefit maximum.
- Habit-control appliances, such as night guards and finger-sucking appliances, are not covered.

OUTPATIENT HOSPITALIZATION

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

- This outpatient hospitalization benefit is provided by DMBA, which determines the allowable amounts.
- Submit a doctor's statement to DMBA, including the treatment plan, fees, and a description of medical necessity.
- 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.
  - » 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.
- Eligible outpatient hospitalization expenses do not count toward your annual $1,500 maximum benefit.

PERIODONTAL PROCEDURES

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

- Periodontal maintenance is covered twice each calendar year.
- For the following procedures, a consultant reviews and determines benefits on a case-by-case basis:
  - » Non-surgical procedures, including deep scaling, root planing, full mouth debridement, chemotherapeutic agents, and post-operative care
  - » Surgical procedures including gingivectomy, osseous surgery, grafting, mucogingival surgery, and subgingival curettage
- Before payment can be made, you must submit periapical X-rays.

PREVENTIVE/DIAGNOSTIC PROCEDURES

The plan pays 100% of MetLife's allowable amount after your deductible ($25 per person per calendar year applied to the first examination).

- Preventive care does not count toward your annual maximum benefit.

- Cleaning (prophylaxis) is covered twice each calendar year.
- Exams are covered twice each calendar year. Specialist and emergency exams are covered at 100% of the allowable amount after your deductible ($25 per person per calendar year applied to the first examination) and count toward the maximum of two visits per calendar year.
- Fluoride treatment topical application is covered twice each calendar year.
- Sealants are covered based on plan guidelines (See Sealants.)
- Space maintainers are covered only for dependents younger than 19. Charges to replace lost or stolen space maintainers are not covered.
- X-rays are covered as follows:
  - » Complete mouth X-rays or panoramic X-rays once every three years (to the date)
  - » A series of bitewing X-rays twice each calendar year
  - » Periapical X-rays as necessary

PROSTHODONTIC PROCEDURES

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

- For most services, the service date is the date treatment begins. For dentures, the service date is the date you receive the dentures.
- Crowns, veneers, bridges, onlays, inlays, and partial and complete dentures are covered based on these guidelines:
  - » Bridges, onlays, inlays, and partial and complete dentures are covered once every five years (to the date).
  - » Crowns and veneers are covered once every seven years (to the date). A replacement may be covered sooner when it's justified by either a medical or dental problem that results in an unavoidably damaged crown or veneer. But all exceptions must be preapproved and meet MetLife's specific dental criteria.
  - » Charges for relining or rebasing dentures are covered once every three years (to the date).
  - » Separate payment is not made for tooth preparation, temporary restorations, impressions, analgesia, or local anesthesia. These procedures are normally included in the cost of the complete prosthodontic procedure.
  - » Replacement of removable dentures with fixed bridgework is covered.
- Charges to replace lost or stolen dentures are not covered.
- Before payment can be made, you must submit periapical X-rays for all crowns, veneers, onlays, and bridges.

RESTORATIVE PROCEDURES

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

- Amalgam, porcelain, composite or resin, and metal restorations are covered. But separate payment is not made for tooth preparation, temporary restorations, cement bases, impressions, analgesia, or local anesthesia. These procedures are normally included in the cost of a complete restorative procedure.
- Changing restorations from amalgam to composite fillings because of amalgam/mercury sensitivity is not covered.

RIDGE AUGMENTATION/EXTENSION

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

- This benefit includes procedures to restore the alveolar ridge to accommodate dentures.
- These expenses do not apply toward your annual maximum benefit.

SEALANTS

The plan pays 100% of MetLife's allowable amount based on these guidelines:

- Only patients younger than 16 are eligible for this benefit.
- The benefit covers permanent molars only.
- A molar sealant is covered twice per tooth per lifetime.

TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

Not covered.

- Benefits for temporomandibular joint (TMJ) dysfunction are covered by most of DMBA's medical plans, not by the dental plan.
- For more information, please see your medical plan's SPD or call Member Services. If you're enrolled in a contracted HMO, please contact your HMO representative for more information.

OTHER BENEFITS

These benefits are paid at the following percentages:

- Eligible application of desensitizing medications (subject to review): 80% of the allowable amount
- Eligible drugs or medications: 80% of the allowable amount
- Eligible treatment for pain: 80% of the allowable amount
- Eligible therapeutic drug injections (subject to review): 80% of the allowable amount
- Recementing space maintainers: 100% of the allowable amount

SPECIAL MEDICAL/DENTAL BENEFIT

The plan pays 90% of DMBA's allowable amount; you pay 10%.

This benefit is provided by DMBA. It may pay for eligible dental services needed because of specific medical conditions or the treatment of specific medical conditions, as defined by the plan.

Example of conditions that may be covered include:

- Cleft palate
- Jaw tumors
- Radiation therapy

Before treatment, submit a doctor's statement to DMBA, including the treatment plan, fees, and medical necessity. Then, benefits are based on these guidelines:

- The plan pays 90% of DMBA's allowable amount and you pay 10%.
- The lifetime maximum benefit is $10,000 per person.
- Expenses covered by this benefit do not apply to your annual maximum dental benefit.
- Orthodontic expenses are not covered by the special medical/dental benefit.

For more information about this unique benefit, please call DMBA.

SUPPLEMENTAL ACCIDENT BENEFIT

This benefit is administered by DMBA. If you need dental services because of an accident, eligible charges will be covered according to regular dental plan benefits, based on the services performed. The allowable amount is determined by DMBA. Benefits are based on the following guidelines:

- The injury must occur while the patient is covered by DMBA's dental plan administered by MetLife.
- The cause of the condition must meet the definition of an accident as defined by the plan.
- Benefits are determined by the date of the accident. Eligible expenses must be incurred within two years of the accident and while the patient remains covered by the plan. Some additional benefits may be available beyond two years. Contact DMBA for more information.
- Orthodontic expenses are not covered by the supplemental accident benefit.
- The first $2,000 paid per accident does not count toward the annual maximum benefit.
- If five or more teeth are involved, additional benefits may be available up to $5,000 per accident. They do not count toward your annual maximum benefit.

For more information about this benefit, please call DMBA.

SUBMITTING CLAIMS

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

Step 1: Request a *Dental Expense Claim Form* from MetLife.

Step 2: Complete the information in the Employee section of the claim form. Sign the form.

Step 3: Take the claim form to your dental appointment. (Each patient needs a separate form.)

Step 4: Ask the dentist to complete the form. Also, for most prosthodontics procedures, the dentist must provide periapical X-rays.

Step 5: Send the completed claim form and X-rays, if applicable, to MetLife at the following address:

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

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

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

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

ERRORS ON BILLS OR EOBS

If you see services listed on a MetLife EOB statement that were not performed or could be considered fraudulent, call MetLife at 800-942-0854.

Benefits administered by DMBA

If you see services listed on an 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 at the following address:

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 percent 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. So 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 your claim was denied in error, you have the right to file an appeal with MetLife or with DMBA, depending on who administers the benefit. As discussed previously, most benefits in this plan are administered by MetLife.

If you submit an appeal to MetLife, you must submit your appeal in writing within 180 days of the date of the *Explanation of Benefits* (EOB) denying your claim.

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

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

Send your appeal to:

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

If you are still unsatisfied with the benefits decision after the second-level appeal, you may have rights under ERISA to bring a civil action.

If you submit an appeal regarding a claim administered by DMBA, 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 the 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

The Coordination of Benefits provision applies when you or your dependents have medical or dental benefits from more than one health benefit plan.

The purpose of coordinating benefits is to avoid 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 and MetLife of other medical and/or dental benefits in force at the time of enrollment or when any other benefits become effective after your initial enrollment. If applicable, you may be required to submit court orders or decrees. You must also keep DMBA and MetLife informed of any changes in the status of the other benefits.

Coordination of benefits rules

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

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

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

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 defined as a person of the opposite sex who is your legal husband or wife.

EXCLUSIONS

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

1. Cosmetic

1.1 Surgery or dentistry done for cosmetic reasons.

1.2 Services for primarily non-therapeutic purposes.

2. Diagnostic and Experimental Services

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

- Considered dental research
- Investigative/experimental technology
- Not recognized by the U.S. dental profession as usual and/or common
- Determined by DMBA or MetLife not to be usual and/or common dental practice
- Illegal

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

Investigative/experimental technology means a treatment, procedure, facility, equipment, drug, device, or supply that does not, as determined by DMBA or MetLife on a case-by-case basis, meet all of these 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.
  - » The technology is safe and efficacious.
  - » More likely than not, the technology will be beneficial to the covered person's health.
  - » The technology is generally recognized as appropriate by the regional dental community as a whole.

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

3. Education

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

4. Government/War

4.1 Services that would have been covered by any governmental plan had the participant complied with the requirements of the plan, including but not limited to Medicare. This exclusion does not apply when a veteran is furnished medical services by the United States for a non-service-connected condition

if the veteran would be eligible from the plan to recover the cost had the services not been provided by the United States.

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 patient is not charged or is not legally obligated to pay.

5.2 Services that began before the patient 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 Charges that exceed MetLife's allowable amounts (or DMBA's allowable amounts for the special medical/dental or supplemental accident benefits).

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. 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 Replacing dentures or bridges less than 5 years old (to the date), or crowns or veneers less than 7 years old (to the date) unless otherwise covered by the plan.

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 by the patient.

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.

DEFINITIONS

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

NOTIFICATION OF DISCRETIONARY AUTHORITY

DMBA has full discretionary authority and the sole right to interpret the plan and to determine eligibility. All DMBA decisions relating to plan terms or eligibility are binding and conclusive.

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. If benefits change, we will notify you at least 30 days before the effective date of change.

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 Legal Plan Document *will govern.*