GENERAL INFORMATION

To help you become familiar with your benefits, your summary plan descriptions (benefit handbooks) include a complete description of each of the plans in your benefit program as of January 1, 2019. This summary plan description, or SPD, outlines general information.

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 24 hours a day, seven days a week for access to personalized benefit information. Our telephone numbers and website address are:

Salt Lake City area..... 801-578-5600
Toll free..... 800-777-3622
Website ..... www.dmba.com

If you're hearing-impaired, please contact us using a relay service.

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

DMBA

If you want to visit us in person, our offices are located at 150 Social Hall Avenue, Suite 170, in downtown Salt Lake City. You can make an appointment or drop by during office hours.

Our mailing address is:

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

DMBA'S PARTICIPATING EMPLOYERS

- AgReserves, Inc.
- Beneficial Life Insurance Company
- Bonneville International Corporation
- Brigham Young University
- Brigham Young University-Hawaii
- Brigham Young University-Idaho
- Brigham Young University-Pathway
- City Creek Reserve, Inc.
- Corporation of the President
- Corporation of the Presiding Bishop
- Deseret Book Company
- Deseret Digital Media
- Deseret Management Corporation
- Deseret Mutual Benefit Administrators
- Deseret News
- Deseret Trust Company
- East Central Florida Services
- Ensign Peak
- Hawaii Reserves, Inc.
- LDS Business College
- LDS Family Services
- Polynesian Cultural Center
- Property Reserve, Inc.
- 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, including the Living Healthy Wellness Program
- Dental
- Group Term Life (GTL)
- Occupational Accidental Death & Dismemberment (OAD&D)
- Deseret Healthcare Disability Income Plan

Supplemental benefits

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

Retirement benefits

- Deseret 401(k) Plan
- Retirement *PLUS* Plan

Flexible benefits

- Flexible Spending program
- Premium Only Plan (POP)

Value-added benefits

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

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 enroll within 60 days of a HIPAA qualifying event.
	GTL **OAD&D** **DISABILITY PLAN**	GTL: Employee and eligible dependents OAD&D and Disability: Employee only	Enroll within 30 days after your eligibility date. If you 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 or you may enroll later if you meet our health standards. Enroll newly acquired dependents within 60 days of their eligibility date or enroll within 60 days of a HIPAA qualifying event.
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	**RETIREMENT *PLUS* 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.	Enrollment is automatic.
	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.	We encourage you to enroll within 30 days of your eligibility date. If you don't, we'll automatically enroll you at 6% before-tax and in the Long-term Preset Mix Asset Allocation Model.
FLEXIBLE BENEFITS	**FLEXIBLE SPENDING**	Employee only	You must meet your employer's eligibility requirements, determine your election, and then enroll.	Enroll within 30 days after your eligibility date and each annual open enrollment thereafter. Or enroll within 60 days of a HIPAA qualifying event.
	PREMIUM ONLY PLAN (POP)	Employee only	Same requirements as for medical and dental coverage.	Enrollment is automatic unless you waive participation within 30 days of your eligibility date or during open enrollment.

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.
BASIC BENEFITS	**GTL** **OAD&D** **DISABILITY PLAN**	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. At any time thereafter, coverage begins the first day of the month after we approve your application.	
SUPPLEMENTAL BENEFITS	**SGTL**	You pay the entire premium.	Coverage begins the first day of the month after we approve your application.	
SUPPLEMENTAL BENEFITS	**24-HOUR AD&D**	You pay the entire premium.	Coverage begins the first day of the month after we approve your application.	
RETIREMENT BENEFITS	**RETIREMENT *PLUS* PLAN**	Your employer makes all of the contributions to your account.	Vesting is immediate. See the RPP SPD, for information about when benefits are available.	
RETIREMENT BENEFITS	**DESERET 401(K) PLAN**	You determine your contribution amount and your employer makes a matching contribution to your account.	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.	
FLEXIBLE BENEFITS	**PREMIUM ONLY PLAN (POP)**	Not applicable.	If you enroll during open enrollment, benefits begin the first day of the following year.	

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 nearly all the benefit programs on our website, www.dmba.com. For help, work with your employer directly or call DMBA Member Services at 801-578-5600 or 800-777-3622.

Basic benefits

Enrolling in the basic benefit 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.)

Also, if you enroll after 30 days, you must meet DMBA's health standards for GTL, OAD&D, and Disability.

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. (See 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)
- To waive all benefits

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

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

Please note that 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 online at www.dmba.com. Also, 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

Each eligible employee is automatically enrolled in the Retirement *PLUS* Plan. (See the *Retirement* PLUS *Plan* SPD.) The Retirement *PLUS* Plan is a defined contribution plan to which your employer makes regular contributions.

The Deseret 401(k) Plan is a defined contribution plan to which you can elect to make contributions and your employer will make matching contributions. (See the *Deseret 401(k) Plan* SPD.)

You're also automatically enrolled in the Deseret 401(k) Plan if you don't enroll 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.

Visit www.dmba.com to see the value-added benefits currently available to you.

Eligible dependents

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

- Natural children, stepchildren, and legally adopted children who are younger than 26.
- A grandchild who is the child of your covered, unmarried, dependent child. The unmarried dependent child and grandchild must live in your home and depend primarily on you for support. For the grandchild to be included in benefits, a direct lineal relationship must exist between you and the grandchild (or a direct line created through adoption). The grandchild may be covered as long as the unmarried dependent child is also covered on the plan.
- Dependents who are added because of a full and complete guardianship. These dependents may be included up to age 18.
- A child placed with you under the direction of a licensed child placement agency while awaiting adoption. The child may be included up to age 18.
- Your unmarried child who is 26 or older and incapable of self-support because of mental or physical incapacity that existed before the child reached 26, and who is primarily dependent on you for support and resides in your home. The child must be an eligible dependent according to IRS guidelines and must have been included in your DMBA plan before age 26.
  To apply for inclusion, submit proof of these circumstances within 60 days from the end of the month when the child reaches 26. Any requests made more than 60 days after the end of the month when coverage ended 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 are effective and the dependent is in the hospital on the date benefits become effective, medical benefits do not begin for the dependent until the day after he or she is discharged from the hospital. If the 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/her employer-sponsored health plan, you must notify DMBA of the coverage. That coverage will be the dependent's primary coverage.

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

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

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

Guidelines for stepchildren

You may enroll your stepchild as an eligible dependent at 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. However, if your stepchild is covered under his/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 purposes of coordinating benefits.

Guidelines for employees at high risk

If you apply for GTL, SGTL, and Disability after 30 days from your eligibility date and you do not meet our health standards, you may be classified as high risk. This applies to your spouse, too. In this situation, benefits may be reduced or unavailable:

- GTL: $25,000 (or 50 percent of benefits)
- SGTL: 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 our website or contact us for a *Declaration of Insurability* form.

Qualifying events

Major family events may qualify you to enroll at times other than during open enrollment or as a new employee. These include:

- Marriage
- Birth
- Adoption
- Change in employment status (such as going from part-time to full-time employment)
- Involuntary loss of eligibility for other medical benefits
- Change of spouse's employment status and ineligibility for health benefits through his or her employer

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when you or your dependents have medical or dental benefits from more than one health 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 must pay as the secondary payer, and so on.

You must inform DMBA of other medical 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 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.

Please note, we coordinate benefits between all DMBA health plans (Deseret Choice Hawaii, Deseret Premier, Deseret Protect, Deseret Select, and Deseret Value). We also coordinate benefits between our group dental plans (Deseret Dental and Deseret Dental *PLUS*).

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

PREMIUMS

Basic benefits

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.

For the basic benefits, monthly premiums are divided into three categories. These include benefits for:

- 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. Your employer makes regular contributions to the Retirement *PLUS* Plan. For the Deseret 401(k) Plan, you determine your contribution amount and your employer makes a matching contribution.

Premium adjustments

Please be aware that premium adjustments because of enrollment changes or errors are limited to 12 months immediately preceding the date DMBA receives evidence that such adjustments should be made. These adjustments can be either returned premium dollars 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
- Adoption
- Birth
- Death
- Dependent status
- Divorce
- Marriage (for you and/or your dependent children)
- Name change
- Permanent guardianship
- You or any of your dependents qualify for Medicare
- You or any of your dependents acquire other medical or dental benefits
- Any other situation that may affect your participation in the benefit program

BENEFITS DURING LEAVES OF ABSENCE

Depending on the type of leave, benefits may continue to an employee on a leave of absence. Please contact DMBA for more information. 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. But limitations apply as to how long your benefits may continue and how long your employer continues to contribute to the premium. 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 if you keep basic GTL. You may also continue your 24-Hour AD&D.

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
- 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 to the Deseret 401(k) Plan and your employer will continue to make contributions to your Retirement *PLUS* Plan account. You may also participate in the Flexible Spending program.

If you are on unpaid leave, you cannot make contributions to the Deseret 401(k) Plan and your employer will not make contributions to your Retirement *PLUS* Plan account. If you're enrolled in Flexible Spending, you may be able to contribute on an after-tax basis. Please contact DMBA Member Services 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 you 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.)
- 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. (Your spouse's and stepchildren's coverage ends but your dependent children's—natural or adopted—coverage may not end.)
- 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.)

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

Retirement *PLUS* Plan: If you end employment for any reason, including retirement, your employer will not make further contributions to your Retirement *PLUS* Plan account. But you may be able to roll over your account to another qualified plan. See the *Retirement* PLUS *Plan* SPD.

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. 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.

CONTINUING MEDICAL AND DENTAL BENEFITS (COBRA)

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act. It allows individuals and their dependents to continue group medical and dental benefits for a limited time after a qualifying event causes them to lose benefits. With COBRA, you pay or your dependent pays 102 percent of the monthly premium (all of the premium plus 2 percent for administrative costs).

To be eligible for COBRA, you and your dependents must be enrolled in a DMBA medical or dental plan when a qualifying event occurs as listed:

- If your employment with a participating employer ends (for reasons other than gross misconduct on your part) or you lose eligibility for benefits, you and your dependents may be covered for up to 18 months. If you acquire new dependents, they may be added to your COBRA benefits. You must enroll them within 60 days after marriage, birth, or adoption.
- You may also be able to continue participating in Flexible Spending on an after-tax basis.
- If you get divorced, your former spouse (and any stepchildren, if applicable) may be covered for up to 36 months. You must notify us of the divorce.
- If a dependent child exceeds the maximum age for benefits as your dependent, your dependent may be covered for up to 36 months.

If you lose eligibility or end employment and qualify for COBRA benefits, your employer notifies DMBA. We then send you a notice of your COBRA eligibility and information on how to enroll. You have 60 days from the date DMBA sends you notification to enroll in COBRA benefits.

COBRA benefits may end for any of the following reasons:

- Failure to make timely payment of COBRA premiums.
- The employer stops providing group health benefits to any of its employees.
- Another group health plan begins to cover the qualified beneficiary.
- Medicare begins to cover the qualified beneficiary.
- A disabled qualified beneficiary whose disability extends the maximum coverage period to 29 months is determined not to be disabled before the end of the extended period.
- The qualified beneficiary's COBRA benefit is terminated for cause (for example, for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA beneficiary in the plan.

CONTINUING LIFE BENEFITS

If 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 31 days from the time your group coverage ends. Please contact DMBA Member Services for an application.

FAMILY SURVIVOR BENEFIT

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

After one year, your dependents may continue to receive their medical and dental benefits depending on your length of service before your death.

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

If your surviving dependents choose to continue coverage, they must notify DMBA within 60 days of your death.

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* 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. So although we use your Social Security number when communicating financial information to the federal government, generally we do not use your Social Security number to identify you. We use your personal DMBA ID number.

  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. The following HIPAA regulations apply to your DMBA medical and dental benefits:

- **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 Qualifying 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. But special enrollment in DMBA's medical plans is only allowed if:

» You had other insurance and you subsequently lost eligibility for the other benefits. In this case, you and your dependents may enroll within 60 days after losing the other benefits. This also applies to your eligible dependents who had and lost other benefits.
» You gain a newly eligible dependent. You may also enroll within 60 days after acquiring the dependent. In this case, you may enroll any other eligible dependents who are not currently enrolled.

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 and/or employer's offices—all program documents, including plan contracts, 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. (DMBA is the program administrator.)
- Obtain copies of all program documents and other program information upon written request to DMBA, which may charge a reasonable fee for the copies.
- Receive a summary of the program's annual financial report. DMBA is required by law to furnish each participant with a copy of this summary financial report.

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 $100 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 program fiduciaries misuse the program'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 what's called a medical compliance plan. That person will then be instructed to receive care from certain providers and facilities that are specifically named in the compliance plan (except in an emergency), as determined by DMBA. In other words, the participant must comply with medically necessary advice and care.

If the participant then chooses to receive care from providers and facilities that are 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
- 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.

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. **You must submit your appeal in writing within 12 months from the date we send your adverse benefit decision.**

- **What if I need help understanding a denial?** Call us at 801-578-5600 or 800-777-3622.
- **How do I file an appeal?** When you log in at www.dmba.com, go to the *My Health* tab at the top of the page and click on *Claims* under *Medical* or *Dental* and click on a claim number to view an *Explanation of Benefits* (EOB). Below the benefit details, you'll see the statement, "You have the right to appeal this claim within 12 months from the date paid shown above. Click here for more details…" Click to get the appeal form. Complete your appeal form and send it to DMBA's appeals coordinator at the address listed below.
- **What if my situation is urgent?** If your situation meets the definition of urgent by law, your review will typically be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also checking the boxes requesting an urgent appeal. Urgent appeals aren't available for disputes involving services you've already received.
- **Who may file an appeal?** You, or someone you name to act for you as your authorized representative, may file an appeal. 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 listed hereafter.
- **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 listed below, requesting a second level of appeal. You are also entitled to bring a civil action under ERISA Section 502(a) to appeal an adverse benefit determination based on the review of an earlier determination.
- **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.
- **Submit all claims review or appeal communications to:**

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

Claims Review Procedures					
	Urgent Care Health Claims	**Pre-service Health Claims**	**Post-service Health Claims**	**Disability Claim**	**Other Non-health Claim**
Notice of Initial Benefit Determination	72 hours after receiving your claim, if it was properly completed	15 days after receiving your initial claim 15-day extension with notice	30 days after receiving your initial claim 15-day extension with notice	45 days after receiving your initial claim Two 30-day extension with notice	90 days after receiving your initial claim 90-day extension with notice
Incorrectly filed claim notice	24 hours after receiving your claim	Five days after receiving your claim	Claim will be denied	45 days after receiving your claim, extended 30 days from the date we receive the required information	Not applicable
You must complete the claim within ...	Not applicable	45 days after receiving the notice to provide information	Not applicable	45 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 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 days after your request for review	30 days after receiving your request for review	45 days after your request for review 45-day extension with notice of special circumstances	60 days after your request for review 60-day extension with notice of special circumstances
Notification of Benefit Determination on second level of appeal	72 hours after receipt of the appeal	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at their scheduled meeting (at least quarterly)	Five calendar days after the Claims Review Committee (CRC) makes the benefit determination at their 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 their 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 their scheduled meeting (at least quarterly) If special circumstances require a further extension of time, a benefit determination may be rendered no later than the third CRC meeting.

DEFINITIONS AND EXCLUSIONS

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

NOTIFICATION OF DISCRETIONARY AUTHORITY

DMBA has full discretionary authority and the sole right to interpret the plans and to determine benefit eligibility. All DMBA decisions relating to plan terms or eligibility for benefits 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.*