

DESERET PROTECT

This summary plan description (benefits handbook), or SPD, outlines the major provisions of Deseret Protect as of January 1, 2019.

DESERET PROTECT KEY POINTS:

- Generally, Deseret Protect covers contracted providers at 70 percent, leaving you responsible for the remaining 30 percent. Non-contracted providers are covered at 60 percent of DMBA's allowable amount and you are responsible for the remaining 40 percent, including any charges that exceed DMBA's allowable amount. Copayments apply to some benefits, including office visits. For specific benefits, see the information that follows.
- Certain preventive services—such as colonoscopies, mammograms, physical exams, and well-child care—from contracted providers are covered at 100 percent.
- Deseret Protect has an annual deductible of \$1,000 per person or \$2,000 per family for services from contracted providers and \$1,300 per person or \$2,600 per family for services from non-contracted providers.
- Your annual out-of-pocket maximum is \$4,000 per person or \$6,000 per family.
- Due to Deseret Protect's low premiums, some services are not covered, including acupuncture, allergy testing, injections, routine eye exams, and obesity surgery.
- Many of the medications covered by other DMBA plans may not be covered by Deseret Protect. The formulary does include a limited range of specialty drugs and brand-name drugs.

- To be eligible for benefits, you or your physician must preauthorize some services with DMBA, such as some surgeries and home healthcare.
- Deseret Protect offers a Virtual Visit benefit exclusively through the contracted Intermountain Connect Care network. A copayment applies.

MAXIMIZING YOUR BENEFITS

Contracted providers

All DMBA health plans are preferred provider organizations or PPOs, meaning your benefits are higher when you receive care from contracted providers (physicians, hospitals, etc.).

When you receive care from contracted providers, they accept your copayments and coinsurance along with what DMBA pays as payment in full for eligible services. They won't bill you for more than DMBA's allowable amounts.

When you receive care from providers not contracted with DMBA, they can bill you for the difference between the amount they charge and DMBA's allowable amount. Plus, your share of the expenses increases and you are responsible for all expenses that exceed allowable amounts.

Please note that different DMBA health plans can have different contracted providers. For information about contracted providers in your area for your specific plan, go to www.dmba.com. Our contracted organizations include:

Hawaii: MDX Hawaii Network	808-675-4873
Southeast Idaho and Utah: DMBA contracted providers	800-777-3622 or www.dmba.com
All other areas: UnitedHealthcare Options PPO Network	800-777-3622 or www.dmba.com

Access to certain medical services is available through our Virtual Visit benefit. A copayment applies. At this time, Intermountain Connect Care is the exclusive in-network provider for the Virtual Visit benefit. There is no benefit for out-of-network virtual provider visits, even if the medical provider is in your plan's network for in-person visits.

Preauthorization

You or your provider must preauthorize some services with DMBA.

When you preauthorize with DMBA, we verify that your care is medically necessary and tell you about any length-of-stay guidelines or other limitations.

If you don't preauthorize when required, your benefits may be reduced or denied. If you don't preauthorize, you're responsible for an initial charge (in addition to the appropriate coinsurance). Also, if DMBA ultimately denies benefits for the service, you're responsible for all charges.

For more information and a list of procedures requiring preauthorization, see [Preauthorization](#). Also see [Your Medical Benefits](#), which follows.

ANNUAL DEDUCTIBLE

When you receive care from contracted providers, the annual deductible of \$1,000 per person or \$2,000 per family applies. When you receive care from non-contracted providers, \$1,300 per person or \$2,600 per family applies.

This deductible is cumulative—you only need to satisfy the deductible once during the calendar year before normal benefits begin. Make sure to submit claims to DMBA while you're meeting the annual deductible. We'll keep tabs for you.

For information about how the annual deductible applies to your benefits, see the individual benefits in [Your Medical Benefits](#).

YOUR MEDICAL BENEFITS

To be eligible for benefits, all healthcare you receive must meet our medical criteria and be provided by a licensed practitioner of the healing arts. **All benefits are subject to the allowable amounts determined by DMBA.**

Your medical plan benefits follow alphabetically. (Please note that "PCP" refers to "primary care physician."):

AMBULANCE

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. The annual deductible applies.

- When services meet our medical criteria, the plan covers licensed ambulance services to the nearest medical facility equipped to furnish the appropriate care. This includes air ambulance services such as Life Flight.
- Certain services are not covered, including, but not limited to wheelchair van services, gurney van services, transportation not associated with emergency services, and repatriation from an international location back to the United States.
- Medical services and supplies provided during the transportation shall be covered at the appropriate benefit level for those services.

ANESTHESIA

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. The annual deductible applies.

APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY FOR AUTISM SPECTRUM DISORDER

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- The maximum annual benefit is:
 - \$25,000 for ages 1-5
 - \$15,000 for ages 6-12
 - \$10,000 for ages 13-15
- The ABA therapy must be provided through a board-certified behavior analyst (BCBA or BCBA-D) or licensed clinical psychologist.
- Not all ABA therapy is covered so you must preauthorize. The initial assessment does not require preauthorization.
- Please note that when an eligible dependent turns ages 6 or 13, the annual maximum benefit for that calendar year changes on

the dependent's birthday to the lower dollar amount.

For example, if a child turns 6 on July 15, the maximum benefit for that calendar year will be \$15,000, effective on his or her birthday. If that child used \$17,000 worth of services from January 1 through July 14, he or she will not have any benefit remaining through December 31 of that calendar year.

CARDIAC REHABILITATION

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

CHEMICAL DEPENDENCY—ALTERNATIVE CARE

In some cases, intensive outpatient treatment (more than two consecutive hours of treatment in a calendar day) may be an appropriate alternative to inpatient care.

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize alternative care.
- The benefit is for up to 60 days per calendar year.
- Chemical dependency alternative care days count toward your annual benefit limit for [Mental health—alternative care](#) days.

CHEMICAL DEPENDENCY—INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.

All benefits are subject to DMBA's allowable amounts.

CHEMICAL DEPENDENCY—OUTPATIENT EVALUATION, THERAPY, AND MEDICATION MANAGEMENT

Contracted provider: The plan pays 100% after your \$15 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

- Eligible services include individual therapy, group therapy, and family therapy. The patient must be present for family therapy.
- Some therapy is not eligible for benefits including educational groups and therapy over the telephone or internet.
- Services for more than two consecutive hours in a calendar day is considered part of the [Chemical dependency—alternative care](#) benefit.

CHEMICAL DEPENDENCY—OUTPATIENT TESTING

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Some mental health testing (such as standard diagnostic and personality testing) does not need to be preauthorized. But you must preauthorize more extensive testing, including psychological and neuropsychological testing. Call Member Services for more information.

CHEMOTHERAPY—PROVIDER-ADMINISTERED

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Preauthorization may be required. Call Member Services for more information.
- For oral chemotherapy agents or self-administered medications, see [Prescription drugs—specialty pharmacy](#).

- Investigational or experimental chemotherapy is not covered.

CHIROPRACTIC THERAPY

Contracted provider: The plan pays 100% after your \$30 copayment. The annual deductible applies.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$35 copayment. The annual deductible applies.

- You may have up to 15 visits per calendar year.
- Full-body X-rays are not eligible for benefits.
- Visits for chiropractic therapy do not count toward your annual benefit limit for physical therapy. (See [Physical and occupational therapy—outpatient](#).)
- If you're billed for an evaluation and for a therapy treatment in the same visit, you're responsible for both copayments.

COLORECTAL CANCER SCREENING OR COLONOSCOPY

Contracted provider: For preventive services, the plan pays 100%. For diagnostic services, the plan pays 70%; you pay 30%.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount for preventive and diagnostic services; you pay 40%.

- A preventive exam is covered once every five years.
- When the procedure is a preventive service, anesthesia is covered at 100% of DMBA's allowable amount. When the procedure is diagnostic, anesthesia is covered at its normal benefit amount.
- A virtual colonoscopy is not covered.

CONVENIENT CARE CLINIC

Contracted or non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$15 copayment.

- The office visit is covered at 100%. Other services such as lab work and X-rays are paid

All benefits are subject to DMBA's allowable amounts.

at the appropriate benefit levels for those services.

- If the visit results in an inpatient hospital stay, you must preauthorize within two business days of admission or as soon as reasonably possible. (See [Hospital—inpatient](#).)

DIABETIC EDUCATION

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- To be eligible for this benefit, you must be diagnosed with diabetes, gestational diabetes, or dysmetabolic syndrome X.
- This benefit does not extend to educational programs that are available to the general public without charge, are general health or lifestyle education programs unrelated to your diagnosis or condition, or consist of services that are not generally accepted as necessary and appropriate for management of the disease or injury.

DIABETIC SUPPLIES

Contracted provider:

- Covered supplies include syringes, lancets, and insulin pump supplies. For more information, see [Glucometers and test strips](#) and [Insulin pumps](#).
- Insulin is covered by the [Prescription drugs](#) benefit.
- When you use the [mail order pharmacy](#), supplies are covered at 50% of the contracted price for a 90-day supply.
- When you purchase supplies from your [local retail pharmacy](#), supplies are covered at 50% of the contracted price for a 30-day supply.

DIALYSIS

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

EMERGENCY ROOM

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30% after your \$75 copayment per visit. The annual deductible applies.

- If you receive follow-up care at the emergency room, you're responsible for another \$75 copayment plus your 30% coinsurance.
- If the visit results in an inpatient hospital stay, you must preauthorize within two business days of admission or as soon as reasonably possible. (For more information, see [Hospital—inpatient](#).)
- If your emergency is not life threatening, see [Urgent care](#) or [Virtual Visit](#) for a less expensive alternative.
- Other services you may receive in conjunction with a visit to the emergency room are paid at the appropriate benefit levels.

EMERGENCY ROOM PHYSICIAN

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. The annual deductible applies.

ENTERAL THERAPY

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. The annual deductible applies.

- You must preauthorize.
- Enteral therapy (formula) may be covered for participants with inborn errors of metabolism or inherited metabolic disorders (e.g. phenylketonuria (PKU), cystic fibrosis). Other conditions may also be covered when specific medical criteria is met.

EYEWEAR (GLASSES OR CONTACT LENSES)

Contracted or non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. The annual deductible applies.

- Generally, eyewear is not covered. But if eyewear is necessary because of eye surgery that is covered by the plan, expenses for one pair of glasses or contact lenses are covered—one pair per surgery. To be eligible for benefits, you must purchase the eyewear within one year of the surgery. Contact lenses are also covered with a diagnosis of keratoconus.

GENETIC COUNSELING

Contracted PCP: The plan pays 100% after your \$15 copayment.

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100% after your \$30 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- You must receive genetic counseling before genetic testing is done. You must preauthorize genetic testing.
- Only certain diagnoses are covered.

GENETIC TESTING

Contracted or non-contracted provider: The plan pays 100% of DMBA's allowable amount.

- Not all genetic testing is an eligible benefit so you must preauthorize.
- You must receive genetic counseling before genetic testing is done.

GLUCOMETERS AND TEST STRIPS

Abbott Diabetes Care: The plan pays 50%; you pay 50%.

Non-Abbott Diabetes Care: You pay the entire amount.

- For a free glucometer, call Abbott Diabetes Care at 866-224-8892.

HEARING AIDS

Contracted or non-contracted provider: The plan pays 50%; you pay 50%. The annual deductible applies.

- Only available for patients younger than 26.
- The maximum benefit is \$1,200 per ear once every three years.

HEARING EXAMS

Contracted PCP: The plan pays 100% after your \$15 copayment.

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100% after your \$30 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- For children from the day of birth through 3 months, audiometry (hearing testing) is covered at 100% when done by a contracted provider or 60% of DMBA's allowable amount when done by a non-contracted provider. The annual deductible applies.
- For patients older than 3 months, audiometry is covered at 70% when done by a contracted provider or 60% of DMBA's allowable amount when done by a non-contracted provider. The annual deductible applies.

HOME HEALTHCARE

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.
- To be eligible for benefits, services must be performed by a licensed registered nurse (RN) or a licensed practical nurse (LPN).

All benefits are subject to DMBA's allowable amounts.

- Custodial care, such as maintaining someone beyond the acute phase of injury or illness including room, meals, bathing, dressing, and home health aides, is not covered.

HOSPICE CARE

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- This benefit is available to patients who have a terminal illness and are expected to live less than six months.
- You must preauthorize.
- Hospice care usually includes:
 - » A coordinated team of hospice professionals
 - » Counseling services to patients and caregivers
 - » Medical equipment and supplies
 - » Medications related to the terminal illness and symptoms
 - » Nursing services for emergencies related to the terminal illness
 - » Primary caregiver respite care
 - » Bereavement services
- Regular plan benefits and requirements apply, depending on the service provided.

HOSPITAL-INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.

IMMUNIZATIONS

Contracted or non-contracted provider, including public/county health departments: The plan pays 100% of DMBA's allowable amount.

- Commonly covered immunizations include:
 - » Diphtheria/Pertussis/Tetanus (DPT)
 - » Diphtheria/Tetanus (DT)
 - » Haemophilus Influenzae (Hib) Hepatitis
 - » Human Papillomavirus (HPV) from ages 9 to 26
 - » Influenza
 - » Measles/Mumps/Rubella (MMR) Pneumococcal
 - » Polio
 - » Tetanus
 - » Tetramune

IN VITRO FERTILIZATION (IVF)

Contracted and non-contracted provider: Benefit coverage for IVF is dependent upon the type of services being rendered. Please refer to specific benefit sections for additional information on IVF-related services such as surgery, office visits, lab work, anesthesia, etc.

- You must preauthorize.
- The lifetime limit on the IVF benefit with respect to a contract is \$10,000 (whether utilized by the participant, a spouse, a dependent or a combination thereof).
- The benefit is restricted to services using only a spouse as the donor. This includes all tissue used for an IVF cycle including, but not limited to, eggs, sperm, and embryos.
- Subject to clinical guidelines.

INJECTIONS AND IV THERAPY

Contracted or non-contracted provider: The plan pays 50% of DMBA's allowable amount; you pay 50%. The annual deductible applies.

- Some injections and IV therapy services require preauthorization.
- Allergy injections are not covered.
- Coverage of high-cost specialty pharmacy injections is limited. Please contact DMBA for more information.

INSULIN PUMPS

Contracted or non-contracted provider: The plan pays 50% of DMBA's allowable amount; you pay 50%.

- You must preauthorize.
- Available every four years.

LABORATORY SERVICES—INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

LABORATORY SERVICES—OUTPATIENT

Contracted or non-contracted provider: The plan pays 100% of DMBA's allowable amount.

- Some laboratory services such as genetic profiling are not covered or may require preauthorization.

MAMMOGRAMS

Contracted provider: For preventive services, the plan pays 100%. For diagnostic services, the plan pays 70%; you pay 30%.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%.

- For participants 40 and older, a preventive mammogram is covered once a calendar year.
- Mammograms for medical reasons are covered as often as medically necessary. In these situations, the plan pays 70% and you pay 30% for services from a contracted provider. For services from a non-contracted provider, the plan pays 60% of DMBA's allowable amount and you pay 40%.

MATERNITY—INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- For extended hospital stays to be eligible, you must preauthorize after two days for a vaginal delivery or after four days for a cesarean section delivery.
- This benefit information also applies to newborn services.
- This benefit provides coverage for services rendered in an inpatient hospital setting. Other settings may not be eligible for benefits including, but not limited to, home birth (see [Exclusion 4.5](#)) and non-licensed birthing centers.

MATERNITY—PHYSICIAN SERVICES

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- This benefit provides coverage for services rendered by a medical professional such as a physician (MD), nurse practitioner (NP), or nurse midwife (NM, CNM, CRNM). The services of, including but not limited to, a licensed or non-licensed midwife (who is not also licensed as a nurse) is not an eligible benefit.

MEDICAL EQUIPMENT—DURABLE

Contracted or non-contracted provider: The plan pays 50% of DMBA's allowable amount; you pay 50%. The annual deductible applies.

- “Durable medical equipment” describes medical supplies or tools that are used repeatedly, serve a medical purpose, and are not useful to people in the absence of illness, injury, or congenital defect. See the *Definitions SPD* for more information.
- You must have a prescription from your healthcare provider.

Must be preauthorized	Do not need to be preauthorized	Are not covered
Apnea monitors/oximeters Bone-growth stimulators Hospital-grade breast pumps Communication devices (one per lifetime) CPAP/BiPAP machines Cranial remolding helmets (one per lifetime) Defibrillator vests Gait trainers/standers Hospital beds and all accessories such as: • Overhead trapeze • Special mattresses Hoyer lifts Implantable pain pumps Insulin pumps/continuous glucose monitors Joint stretching devices Lymph presses/compression pumps Oxygen/oxygen concentrators Respirators/ventilators Scooters Seasonal Affective Disorder lights (one per lifetime) Spinal cord stimulators Vest airway clearance systems Wheelchairs Wound vacs	Bilirubin lights Blood-pressure kits Breast prosthetics for cancer patients Breast pumps* Canes Commodes (bedside) (one per lifetime) Continuous passive motion machines (for knees only)** Crutches Erect-aids (one per lifetime) Hearing aids for younger than 26 Nebulizer/Pulmo-Aide (purchase only) Orthopedic braces Protective helmets Slant boards/transfer boards TENS units Walkers/knee walkers***	Air filtration systems Cold/heat applications Dehumidifiers Exercise equipment Hearing aids for 26 and older Hearing devices Humidifiers for home use Interferential stimulators Knee braces used solely for sports Learning devices Lift chairs Modifications associated with: • Activities of daily living • Homes • Vehicles Spa memberships Vision devices Whirlpools or hot tubs

* See [Preventive care services](#).

** Preauthorization is required after 30 days.

*** Preauthorization is required after 90 days.

- Certain equipment must be rented before it can be purchased. Also, certain equipment can only be replaced based on specific time intervals. A one-per-lifetime policy will apply to bedside commodes, communication devices, cranial remolding helmets, erectile dysfunction aids, and light boxes/SAD lights.
 - You must preauthorize certain medical equipment. For information about common equipment that must be preauthorized, please refer to the [medical equipment table](#). This table also includes a list of items you do not need to preauthorize and items that are not covered.
 - You are responsible for expenses associated with the maintenance, repair, and upkeep of your medical equipment.
 - In some instances, if you purchase the equipment after you rent it, the rental price may be applied to the purchase price.
- The table is not intended to be all-inclusive.

MEDICAL SUPPLIES

Contracted or non-contracted provider: The plan pays 50% of DMBA's allowable amount; you pay 50%. The annual deductible applies.

- Medical supplies are disposable, one-use-only medical items for immediate use. This includes dressings and compression stockings provided or prescribed by your healthcare provider.

MENTAL HEALTH–ALTERNATIVE CARE

In some cases, intensive outpatient treatment (more than two consecutive hours of treatment in a calendar day) may be an appropriate alternative to inpatient care.

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

All benefits are subject to DMBA's allowable amounts.

- You must preauthorize.
- The benefit is for up to 60 days per calendar year.
- Mental health alternative care days count toward your annual benefit limit for chemical dependency alternative care days. (See [Chemical dependency—alternative care.](#))

MENTAL HEALTH—INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.
- To be eligible for benefits, a manifest psychiatric disorder must be diagnosed. Some diagnoses are not covered. See [Mental health exclusions.](#)
- The benefit applies to all facility-based services; however, there may be additional charges for professional services billed separately (e.g. psychological testing, psychiatrist visits, etc.) and covered consistent with the corresponding benefit category.

MENTAL HEALTH—OUTPATIENT EVALUATION, THERAPY, AND MEDICATION MANAGEMENT

Contracted provider: The plan pays 100% after your \$15 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

- To be eligible for benefits, a manifest psychiatric disorder must be diagnosed. Some diagnoses are not covered. See [Mental health exclusions.](#)
- Eligible services include individual therapy and group therapy. Family therapy is eligible only if the patient is present for therapy.
- Some therapy is not covered including educational groups and therapy over the telephone or internet.
- Treatment for more than two consecutive

hours in a calendar day is considered alternative care. (See [Mental health—alternative care.](#))

MENTAL HEALTH—OUTPATIENT TESTING

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Some mental health testing (like standard diagnostic and personality testing) does not need to be preauthorized. But you must preauthorize more extensive testing, including psychological and neuropsychological testing.

NUTRITIONAL EDUCATION FOR EATING DISORDERS

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- For patients diagnosed with anorexia or bulimia.
- A certified or licensed dietician or nutritionist must provide the service.

OFFICE VISITS

Contracted PCP: The plan pays 100% after your \$15 copayment.

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100% after your \$30 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- You pay an additional \$5 for an after-hours visit.

All benefits are subject to DMBA's allowable amounts.

PAIN MANAGEMENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Normal plan benefits apply, depending on the service you receive. For example, if your physician prescribes oral medication to manage your pain, the medication will be covered based on the appropriate prescription drug benefit.
- You must preauthorize some physician services and items like implantable pain pumps and spinal cord stimulators. See [Medical equipment—durable](#).
- Certain outpatient procedures and durable medical equipment require preauthorization.

PHYSICAL EXAMS

Contracted PCP: The plan pays 100%. A copayment does not apply.

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100%. A copayment does not apply.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- You pay an additional \$5 for an after-hours visit.
- One exam is covered every calendar year.
- The physical exam benefit is for the office visit and for the recommended and related procedures and lab work. The related services, such as lab work and X-rays, are paid at the appropriate benefit levels for those services.
- Physical exams generally include:
 - » Blood count
 - » Cholesterol
 - » Pap smear once per calendar year
 - » PSA test
 - » Stool blood

- » TB test
- » Thyroid
- » Urinalysis and urine culture
- Labs and routine procedures are not eligible when associated with an ineligible physical exam.
- For information about screenings for women, see [Mammograms](#) and [Well-woman exams](#).
- Some services may not be covered as part of a physical exam.

PHYSICAL AND OCCUPATIONAL THERAPY—INPATIENT

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- The benefit covers an unlimited number of inpatient visits.

PHYSICAL AND OCCUPATIONAL THERAPY—OUTPATIENT

Contracted provider: The plan pays 100% after your \$30 copayment. The annual deductible applies.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$35 copayment. The annual deductible applies.

- The plan covers up to 15 visits per calendar year for physical and occupational therapy combined.
- Physical therapy visits do not count toward your annual benefit limit for chiropractic therapy. (See [Chiropractic therapy](#).)
- If you are billed for an evaluation and for a physical therapy services in the same visit, you are responsible for both copayments.

PRESCRIPTION DRUGS—LOCAL PHARMACY AND MAIL ORDER

If you take a prescription drug for the first time, if you need a small quantity, or if you need

All benefits are subject to DMBA's allowable amounts.

the prescription immediately, use a local retail pharmacy contracted with VRx. To learn about VRx and participating pharmacies, visit www.dmba.com or call 877-879-9722.

Contracted or non-contracted provider:

- The plan pays 80% of DMBA's allowable amount for formulary generic drugs at participating pharmacies; you pay 20%.
- The plan pays 50% of DMBA's allowable amount for a limited number of covered brand-name drugs at participating pharmacies; you pay 50%.
- For all other drugs, you pay 100%.
- The plan covers up to a 30-day supply or 90 doses, whichever is greater.
- If you take prescription drugs on a regular basis or for an extended period, you may save money by ordering them through our mail-order pharmacy, Magellan Rx Home. To learn more about Magellan Rx Home, or register for mail order, call 801-417-9722 or 877-879-9722.
- For certain classes of drugs, the benefit is limited by quantity per prescription in accordance with federal, state, and manufacturer guidelines.
- If you purchase prescription drugs from non-participating pharmacies, you must pay the pharmacy's retail price and then submit your claims for reimbursement directly to VRx.
- You must preauthorize some medications. These may include long-term maintenance or large-quantity medications. If you do not preauthorize, you may be responsible for all charges. For specific information, please call VRx.
- Some items that can be prescribed but are not covered include:
 - » Contraceptives and family planning devices that do not meet current medical criteria.
 - » Dietary or nutritional products, including special diets for medical problems.
 - » Medications used for sexual dysfunction.
 - » Products used to stimulate hair growth.
 - » Vitamins, except prescribed prenatal and infant vitamins.
 - » Weight-reduction aids.

- Over-the-counter medications are not eligible for benefits.
- Expenses do not count toward the plan's out-of-pocket maximum. (See [Out-of-pocket Maximum](#).)
- Prescription drugs that are not covered by the plan may be eligible for reimbursement through Flexible Spending.

PRESCRIPTION DRUGS—PREVENTIVE

Contracted provider: For some preventive care prescription drugs, the plan pays 100% of DMBA's allowable amount when filled at the pharmacy with a valid prescription. For a list of prescription drugs considered to be preventive, see the [preventive care services](#) table.

PRESCRIPTION DRUGS—PROVIDER-ADMINISTERED OR OPTIONAL ADMINISTRATION

Some medications may be either self-administered or administered by your provider. These medications may be purchased either directly by you, through a participating pharmacy, or for you by your provider. Depending on the medication and the place of purchase, your benefit may vary. Some provider-administered medication may not be covered by the plan.

You must preauthorize some provider-administered medications. These may include high-cost or specialty medications administered in a physician's office, outpatient facility, or in home. If you do not preauthorize, you may be responsible for all charges.

PRESCRIPTION DRUGS—SPECIALTY PHARMACY

Some expensive medications (generally greater than \$600 per month) that require special handling and are used to treat complex or rare conditions may be covered by the specialty pharmacy benefit.

All benefits are subject to DMBA's allowable amounts.

Contracted or non-contracted provider:

- Specialty tier 1: The plan pays 75% of DMBA's allowable amount for eligible drugs; you pay 25%.
- Specialty tier 2: The plan pays 50% of DMBA's allowable amount for eligible drugs; you pay 50%.
- For all other specialty drugs, you pay 100%.
- For medications from the specialty pharmacy, the plan covers up to a 30-day supply per prescription.
- You must purchase eligible specialty medications through a participating specialty pharmacy. For more information, call VRx at 801-417-9722 or 877-879-9722.
- Expenses do not count toward the plan's out-of-pocket maximum. (See [Out-of-pocket Maximum](#).)

PREVENTIVE CARE SERVICES

When you receive specific preventive care services from contracted providers, these services will be covered at 100% of DMBA's allowable amount. You won't have to pay any copayments or coinsurance. For information about which services will be covered at 100% of DMBA's allowable amount, see the [preventive care services](#) table.

When a service is considered preventive:

Preventive care relates to the evaluation of your current health status when no symptoms of illness exist. It includes immunizations and services that attempt to diagnose disease early and help you avoid serious health problems. It also includes services like screening tests, routine exams, and some types of counseling. These services help your doctor discover issues early and give you a better chance of recovery.

Preventive care does NOT include any service or benefit related to an illness, injury, or medical condition that you already have. Services that are used to manage an existing medical condition or health issue are considered diagnostic care or treatment. When services are diagnostic rather than preventive, you'll be responsible for any copayments and coinsurance.

Review your online personal preventive care report:

Preventive care services are designed to help you stay healthy—to prevent illness and disease before it starts. We encourage you to take advantage of these critical benefits.

To help you keep track of the services you may need, review your personal preventive care report by clicking on the *Routine Care* tile after logging into www.dmba.com.

Adults (Men and Women)	Women	Children
Any provider: The plan pays 100% of DMBA's allowable amount		
Aspirin (ages 45 to 79, generic OTC 81 mg and 325 mg strengths when filled at a pharmacy with a valid Rx)*	Anemia screening	Cervical dysplasia screening
Blood-pressure screening	Cervical cancer screening	Dyslipidemia screening
Cholesterol screening	Chlamydia infection screening	Hematocrit or hemoglobin screening
Diabetes (type 2) screening	Domestic and interpersonal violence screening and counseling (as part of a routine exam)	Hemoglobinopathies or sickle cell screening
HIV screening	Folic acid (ages 12 to 59, generic OTC when filled at a pharmacy with a valid prescription)*	HIV screening
Immunization vaccines	Gestational diabetes screening	Hypothyroidism screening
Syphilis screening	Gonorrhea screening	Immunization vaccines
Prostate cancer screening	Hepatitis B screening	Iron supplements (ages 6 to 12 months, generic OTC when filled at a pharmacy with a valid prescription)*
Vitamin D (ages 65 and older, generic OTC when filled at a pharmacy with a valid prescription)*	Human papillomavirus (HPV) DNA test	Lead screening
	Rh incompatibility screening	Oral fluoride (ages 6 months to 16 years when deficient in water and with a valid prescription)*
	Urinary tract or other infection screening	Phenylketonuria (PKU) screening
		Vision screening (ages 0 to 4)
Contracted provider: The plan pays 100%.		
Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.		
Abdominal aortic aneurysm (ages 65 or older; one screening per lifetime); annual deductible does NOT apply	Breast cancer mammography screenings (annually for ages 40 and older); annual deductible does NOT apply	Autism and developmental screenings (ages 18 months to 10 years; two per lifetime)
Alcohol misuse screening	Breastfeeding comprehensive support and counseling and breast pumps (breast pumps are eligible every three years)	Hearing screening (ages 0 to 90 days)
Colorectal cancer screening (one every five calendar years)	Osteoporosis screening (one per lifetime); annual deductible does NOT apply	Obesity screening and counseling (one per calendar year)
Diet counseling (three per calendar year)		Sexually transmitted infection (STI) prevention counseling
Obesity screening and counseling (one per calendar year)		
Sexually transmitted infection (STI) prevention counseling		
Tobacco use counseling and intervention*		
Contracted provider: The plan pays 100%.		
Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$20 copayment to a PCP or \$35 copayment to a specialist.		
Alcohol misuse counseling	Breast cancer chemoprevention counseling	Depression screening
Depression screening (always a \$20 copayment)	Breast cancer genetic test counseling	Tuberculin testing
Routine physical exam (annual)	Well-woman visits (one per calendar year)	Well-child visits (includes blood-pressure screening, height, weight and body mass index measurements, medical history, and oral health risk assessment)

* When you purchase medications from a non-contracted pharmacy, you may have to pay the over-allowable amount.

All benefits are subject to DMBA's allowable amounts.

PROSTHETICS

Contracted or non-contracted provider: The plan pays 50% of DMBA's allowable amount; you pay 50%. The annual deductible applies.

- You must preauthorize.
- Includes prosthetics such as artificial arms, legs, or eyes.
- Repair for wear and tear is covered, but replacement of a lost prosthesis is not covered.
- Some prosthetics have time limits for replacement.

RADIATION THERAPY

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Certain types of radiation therapy must be preauthorized.

RADIOLOGY—MRIS, MRAS, PET, AND SPECT SCANS

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize all services except MRIs and SPECT scans.

RADIOLOGY—X-RAYS AND CT SCANS

Contracted provider: The plan pays 70%; you pay 30%.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%.

- Bone density scans are covered every five years or once per year for patients diagnosed with osteoporosis or osteopenia.
- A preventive screening for osteoporosis is covered at 100% once per lifetime.

RESPIRATORY EDUCATION

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- Covers evaluation and education for patients with asthma or cystic fibrosis.
- Only available for patients younger than 26.
- A licensed respiratory therapist must provide the service.

SKILLED NURSING FACILITY

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.
- Time in an extended-care facility must occur after an inpatient hospitalization.
- If the care is for recuperating or convalescing from an acute injury or illness, the maximum benefit is 50 days per calendar year.
- Custodial care (such as maintaining someone beyond the acute phase of injury or illness, including room, meals, bathing, and dressing) is not covered.

SURGERY—INPATIENT AND PHYSICIAN SERVICES

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.
- In case of an emergency, call DMBA within two business days after the surgery or as soon as reasonably possible.

SURGERY—OUTPATIENT AND PHYSICIAN SERVICES

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- If outpatient services result in an inpatient hospital stay, you must preauthorize within two business days of admission or as soon as reasonably possible. (See [Hospital—inpatient](#).)
- You must preauthorize some procedures.

TRANSPLANTS

Contracted provider: The plan pays 70%; you pay 30%. The annual deductible applies.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

- You must preauthorize.
- If you meet DMBA eligibility requirements, these transplants are covered:
 - » Bone marrow
 - » Cornea (preauthorization not required)
 - » Heart
 - » Heart/lung
 - » Intestine
 - » Kidney
 - » Liver
 - » Lung
 - » Pancreas/kidney
- Other transplants are not eligible for benefits.
- Limitations apply to donor benefits.
- For prescription drugs associated with a covered transplant, see [Prescription drugs](#).

URGENT CARE

Contracted or non-contracted provider: The plan pays 100% of DMBA's allowable amount after your \$40 copayment per visit.

- The office visit is covered at 100% of the allowable amount. Other services, such as lab work and X-rays, are paid at the appropriate benefit levels for those services.

- If the visit results in an inpatient hospital stay, you must preauthorize within two business days of admission or as soon as reasonably possible. (See [Hospital—inpatient](#).)
- For a less expensive alternative, see *Virtual Visit*, which follows.

VIRTUAL VISIT

Intermountain Connect Care: The plan pays 100% after your \$10 copayment.

Non-Intermountain Connect Care: No benefit; you pay 100%

- If your medical need is not treatable in a virtual setting, you will be advised to visit a provider in person and will not be charged for the Virtual Visit.
- You must visit a provider in person to obtain certain prescription medications.

WELL-CHILD CARE

Contracted PCP: The plan pays 100%. No copays apply

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100%. No copays apply

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- Available to dependents younger than 19.
- You pay an additional \$5 for an after-hours visit.
- The office visit is covered at the percentages listed above. Other services, such as lab work and X-rays, are paid at the appropriate benefit levels for those services.

WELL-NEWBORN CARE—PHYSICIAN SERVICES

Contracted provider: The plan pays 100%.

Non-contracted provider: The plan pays 60% of DMBA's allowable amount; you pay 40%. The annual deductible applies.

All benefits are subject to DMBA's allowable amounts.

WELL-WOMAN EXAMS

Contracted PCP: The plan pays 100%. A copayment does not apply.

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your \$20 copayment.

Contracted specialist: The plan pays 100%. A copayment does not apply.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your \$35 copayment.

- You pay an additional \$5 for an after-hours visit.
- One exam is covered every calendar year.
- The office visit is covered at the percentages listed above. Other services, such as lab work and X-rays, are paid at the appropriate benefit levels for those services.
- Generally, well-woman exams include:
 - » Office visit
 - » Breast and pelvic exam
 - » Hematocrit
 - » HPV screening
 - » Lipid profile
 - » Pap smear, covered once per calendar year
 - » Urinalysis
- Labs and routine procedures are not eligible when associated with an ineligible exam.
- For more information, see [Mammograms](#) and [Physical exams](#).

MEDICAL EMERGENCIES

Emergency care is medical services needed immediately because of an injury or sudden illness. Because the time required to reach DMBA could risk permanent damage to your health in an emergency, you don't need to preauthorize medical services in emergency situations.

If you have an emergency, go to the nearest emergency room or call 911 for help.

If you are admitted to the hospital because of the emergency, please contact DMBA within two business days or as soon as reasonably possible.

PREAUTHORIZATION

Preauthorization is an important step in making sure your care meets our medical criteria and helps you know what services are covered before you commit to the costs.

To preauthorize, you or your physician must call DMBA at least two business days before your anticipated services. In an emergency situation when you or your physician cannot contact DMBA beforehand, you or your physician must call DMBA within two business days after the emergency or as soon as reasonably possible.

Provide the following information when you call to preauthorize:

- Patient's name
- Participant's DMBA ID number
- Diagnosis (explanation of the medical problem) and, if possible, diagnostic code
- Pertinent medical history, including:
 - » Previous treatment
 - » Symptoms
 - » Test results
- Name of physician or surgeon
- Treatment or surgery planned and, if possible, procedure codes and costs for each procedure
- Where and when the treatment or surgery is planned

Registered nurses and a consulting physician review the case when necessary. When the review is complete, DMBA will send you a letter to confirm the preauthorization.

Please note, preauthorize as soon as you have compiled the needed information so that you can get a written confirmation of the preauthorization before receiving the services.

If you don't preauthorize with DMBA when necessary, your benefits may be reduced or denied. Also, you become responsible for an initial charge, usually \$200, in addition to your coinsurance. (See the [preauthorization table](#).)

Remember, all procedures, services, therapies, devices, etc., must meet our medical criteria to be eligible for benefits. If your situation doesn't meet

our medical guidelines and DMBA ultimately denies benefits for the service, you're responsible for all charges.

Even though your physician provides much of the needed information and may even make the call to DMBA, you're responsible to make sure your care is preauthorized.

Some provider-administered medications must be preauthorized by Magellan Rx Management.

Magellan Rx Management can be reached at 800-424-8269. For more information about the medications that require preauthorization by Magellan Rx Management, please call DMBA.

The following services must be preauthorized. Additional services also require preauthorization.

Plan benefit	If you don't preauthorize, you pay a penalty of
Applied Behavior Analysis (ABA) therapy	All charges until authorized
Chemical dependency—alternative care	\$200 per calendar year
Chemical dependency—inpatient	\$200 per admission
Chemical dependency—outpatient testing (certain services)	All charges until authorized
Chemotherapy	All charges until authorized
Enteral therapy	All charges until authorized
Genetic testing	\$200 per test
Home healthcare	\$200 per episode of care
Hospice care	All charges until authorized
Hospital—inpatient	\$200 per admission
In vitro fertilization	All charges until authorized
Insulin pumps/continuous glucose monitors	\$200 per pump/monitor
Laboratory services—outpatient (certain services)	All charges until authorized
Maternity—inpatient (extended stays)*	\$200 per admission
Medical equipment (certain devices)	\$200 per device per calendar year
Mental health—alternative care	\$200 per calendar year
Mental health—inpatient	\$200 per admission
Mental health—outpatient testing	\$200 per testing episode
Pain management (certain services)	\$200 per service
Prescription drugs (certain medications)	All charges until authorized
Prescription drugs administered by a provider (certain medications)	All charges until authorized
Prosthetics	\$200 per calendar year
Radiation therapy (certain types)	\$200 per episode of treatment
Radiology (certain types of scan)	\$200 per service
Skilled nursing facility	\$200 per admission
Surgery—inpatient and physician services	\$200 per surgery
Transplants	All charges (no benefit)

* For maternity hospitalization, the \$200 per admission applies if the stay exceeds two days for vaginal delivery or four days for cesarean section delivery.

OUT-OF-POCKET MAXIMUM

If your share of eligible expenses reaches a certain limit per calendar year (your annual maximum out-of-pocket cost), your benefits for the remainder of the calendar year are paid according to the plan's out-of-pocket maximum.

The out-of-pocket maximum may be calculated on an individual or family basis and includes services from both contracted and non-contracted providers.

For individuals (participants or dependents): After your share of eligible expenses reaches \$4,000, benefits increase to 100 percent for eligible charges, after any copayments, based on allowable amounts.

For families: After your share of eligible expenses reaches \$6,000, benefits increase to 100 percent for eligible charges, after any copayments, based on allowable amounts.

You continue to be responsible for copayments on these benefits:

- Chiropractic therapy
- Convenient care clinics
- Hospital emergency room
- Mental health—outpatient care
- Office visits
- Therapy (such as physical therapy)
- Urgent care facility
- Virtual Visit

These medical expenses do not apply to your annual out-of-pocket maximum and will continue to have associated copayments and coinsurance once the annual out-of-pocket maximum has been met:

- Prescription drugs
- Specialty pharmacy

Also, these expenses do not apply to your eligible expenses and will not apply to your out-of-pocket maximum:

- Amounts that exceed the allowable amounts
- Annual deductible
- Ineligible amounts
- Initial charge for not preauthorizing
- Premium payments
- Any other expenses not covered by the plan

ERRORS ON BILLS OR EOB STATEMENTS

If you see services listed on an *Explanation of Benefits* (EOB) statement that were not performed or could be considered fraudulent, call 801-578-5600 or toll free at 800-777-3622. For more information, see the [Fraud Policy Statement](#).

If you find a provider billing error on any of your medical bills after your claims are 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
Attn: Audit Reimbursement
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 \$500 per incident, as defined by DMBA.

Because the error usually means the provider was overpaid, we must first 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 medical 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 (ERISA). We are obligated to maintain the integrity of our medical plans based on ERISA guidelines and regulations.

SUBMITTING CLAIMS

For services from contracted providers, you should not need to submit claims. These providers send bills directly to DMBA for processing. But you could mistakenly receive a bill for services covered by the plan, a bill from a non-contracted provider, or a bill for care you received in an emergency situation.

If you need to submit a claim for benefits, please follow these steps:

Step 1: Get an itemized bill from the provider or facility that includes:

- Patient's name
- Provider's name, address, phone number, and tax identification number
- Diagnosis and diagnosis code(s)
- Procedure and procedure code(s)
- Place and date of service(s)
- Amount charged for service(s)

Step 2: Write your name and DMBA ID number on the bill.

Step 3: Complete a *Medical Claim Form* (available at www.dmba.com in the *Forms Library*).

Step 4: Mail the claim and bill to:

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

You must submit pharmacy claims to VRx, not DMBA. To contact VRx, call 877-879-9722.

To be eligible for benefits, medical claims must be submitted by you or your provider within 12 months from the service date. It is your responsibility to ensure this happens. DMBA sends you an EOB statement when your claims are processed. Please review all your EOBs for accuracy.

FINANCIAL DISCLOSURE

DMBA health plan providers are under contract with DMBA to provide quality, cost-effective medical care. The financial arrangements in our contracts may include discounts from the normal fees charged by healthcare providers and incentive arrangements that reward quality, cost-effective medical care through the prudent use of healthcare resources.

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

When you or your dependents have medical or dental benefits from more than one health plan, your benefits are coordinated between the different plans. This is to avoid duplication of payments.

Coordination of benefits 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 or your dependents must inform DMBA of other medical and/or dental benefits in force when you enroll 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, 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 the claim.

Please note, we generally coordinate benefits between all DMBA group health plans (Deseret Choice Hawaii, Deseret Premier, Deseret Protect, Deseret Select, and Deseret Value).

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. All procedures or treatments are excluded until specifically included in the plan. In addition, the following services and their associated costs are excluded from benefits.

1. Custodial care

- 1.1 Custodial care, education, training, or rest cures, except as provided for by the terms of the plan. Custodial or long-term care is defined as maintaining a patient beyond the acute phase of injury or sickness and includes room, meals, bed, or skilled medical care at any hospital, care facility, or home to help the patient with feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, ambulation, etc. The patient's impairment, regardless of the severity, requires such support to continue for more than two weeks after establishing a pattern of this type of care.
- 1.2 Inpatient hospitalization or residential treatment for the primary purpose of providing shelter or safe residence.

2. Dental care

- 2.1 Dental services, including care and services performed on the teeth, gums, or alveolar process; dentures, crowns, caps, permanent bridgework, and appliances; and supplies used in such care and services, except as provided for by the terms of the plan.

3. Diagnostic and experimental services

- 3.1 Care, services, diagnostic procedures, or operations for diagnostic purposes not related to an injury or sickness, except as provided for by the terms of the plan.
- 3.2 Care, services, diagnostic procedures, or operations that are:
 - Considered medical research
 - Investigative/experimental technology (unproven care, treatment, procedures, or operations)
 - Not recognized by the U.S. medical profession as usual and/or common
 - Determined by DMBA not to be usual and/or common medical practice
 - Illegal

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

Investigative/experimental technology means 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:

- It must have final approval from all appropriate governmental regulatory bodies, if applicable.
- It must be available in significant numbers outside the clinical trial or research setting.
- Available research about the technology must be substantial. For plan purposes, substantial means sufficient to allow DMBA to conclude the technology is:
 - » Both medically necessary and appropriate for the covered person's treatment
 - » Safe and efficacious
 - » More likely than not to be beneficial to the covered person's health
 - » Generally recognized as appropriate by the regional medical community as a whole

Procedures, care, treatment, or operations falling in the categories described herein will continue to be excluded until actual experience clearly defines them as non-experimental and they are specifically included in the plan by DMBA.

4. Fertility, infertility, family planning, home delivery, surrogate pregnancy, and adoption

- 4.1 Family planning, including contraception, birth control devices, and/or sterilization procedures, unless the patient meets DMBA's current medical criteria.
- 4.2 Abortion or abortion pills, except in cases of rape, incest, or when the life of the mother

and/or fetus would be seriously endangered if the fetus was carried to term.

- 4.3 Care, services, diagnostic procedures, or operations in relation to the following infertility services: collection and storage of sperm; direct intra-peritoneal insemination (DIPI); donor sperm; fallopian tubal sperm perfusion (FSP); intra-follicular insemination (IFI); the GIFT procedure.
- 4.4 Reversal of sterilization procedures.
- 4.5 Planned home delivery for childbirth and all associated costs.
- 4.6 All services and expenses related to a surrogate pregnancy and/or gestational carrier including but not limited to care, treatment, delivery, diagnostic procedures, or operations, as well as maternity care for the surrogate mother and prenatal/postnatal care for the newborn child are excluded. All services and expenses for complications related to a surrogate pregnancy are also excluded.
- 4.7 All services and expenses related to a pregnancy resulting in an adoption including but not limited to care, treatment, delivery, diagnostic procedures, or operations, as well as maternity care and prenatal/postnatal care for the newborn child are excluded. All services and expenses for complications related to a pregnancy resulting in adoption are also excluded.

5. Government/war

- 5.1 Services required as a result of war, act of war, or service in the military forces of any country at war, declared or undeclared. The term "war" includes, but is not limited to, 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.
- 5.2 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 to recover the cost had the services been provided by the United States.

- 5.3 Services and supplies that school systems are legally required to provide.

6. Hearing/speech

- 6.1 The purchase or fitting of hearing aids, except for children younger than 26.
- 6.2 Speech therapy
- 6.3 Hearing devices or services unless expressly designated as eligible under the plan.

7. Legal exclusions

- 7.1 Services that the individual is not, in the absence of this benefit, legally obligated to pay.
- 7.2 Care, services, operations, or prescription drugs incurred after termination of coverage under the plan.
- 7.3 Injury arising from participation in or attempt at committing a crime.
- 7.4 Complications resulting from excluded services.
- 7.5 Services provided as a result of a court order or for other legal proceedings.
- 7.6 Services not expressly specified as a benefit or covered expense.
- 7.7 Care, treatment, diagnostic procedures, or operations for diagnostic purposes that are not related to an injury or illness except as provided for by the terms of the plan.
- 7.8 Mandated state service charges and taxes.

8. Medical equipment

- 8.1 Multipurpose equipment or facilities, including related appurtenances, controls, accessories, or modifications thereof. This includes, but is not limited to buildings, motor vehicles, air conditioning, air filtration

units, exercise equipment or machines, and vibrating chairs and beds. This also includes certain medical equipment, including air filtration systems, dehumidifiers, hearing aids for anyone 26 or older, hearing devices, humidifiers, nonprescription braces or orthotics, learning devices, spa and gym memberships, vision devices, or modifications associated with activities of daily living, homes, or vehicles.

- 8.2 Upgrade or replacement of medical equipment when the existing equipment is still functional, unless otherwise specified by the plan.
- 8.3 Replacement of a device when damage is due to the covered individual's abuse or neglect.

9. Medical necessity

- 9.1 Care, services, or operations performed primarily for cosmetic purposes, except for expenses incurred as a result of injury suffered while covered by the plan or as otherwise provided for by the terms of the plan.
- 9.2 Care, services, or operations that are not medically necessary as defined by the plan. Covered individuals will receive benefits under this plan only for services that are determined to be medically necessary and not investigative/experimental technology. The fact that a provider has prescribed, ordered, recommended, or approved services, or has informed the covered individual of its availability, does not in itself make it medically necessary or a covered expense. The plan administrator will make the final determination of whether any services are medically necessary or considered investigative/experimental technology. If a particular service is not medically necessary as defined by this plan and determined by the plan administrator, the plan will not pay for any charges related to such services, and any such charges will not be counted toward the out-of-pocket maximum. The charges will be outside the plan and will be the covered individual's financial responsibility.

- 9.3 Care, services, or operations for convenience, contentment, or other non-therapeutic purposes.
- 9.4 Cardiopulmonary fitness training or conditioning either as a preventive or therapeutic measure, except as provided for by the terms of the plan.
- 9.5 Care, services, diagnostic procedures, or other expenses, which include, but are not limited to, abdominoplasty, lipectomy, panniculectomy (except when medical criteria has been met), skin furrow removal, or diastasis rectus repair.
- 9.6 Care, services, or operations in conjunction with disturbances for the temporomandibular joint (TMJ).
- 9.7 Care, services, or operations for functional/ cosmetic surgery.

10. Mental health, counseling, chemical dependency

- 10.1 Mental or emotional conditions without manifest psychiatric disorder or with non-specific symptoms.
- 10.2 Counseling (including but not limited to marriage and family counseling, recreational therapy, or other therapy) that is not done in person. Family therapy is only covered when a family member has a diagnosed psychiatric disorder and that person is present during the therapy.
- 10.3 Services and materials in connection with surgical procedures undertaken to remedy a condition diagnosed as psychological.
- 10.4 Care and services for the abuse of or addiction to alcohol or drugs, except as provided for by the terms of the plan.
- 10.5 Care and services for learning disabilities or physical or mental developmental delay, including pervasive developmental disorders or cognitive dysfunctions, except as provided for by the terms of the plan.
- 10.6 Mental health services provided in a day treatment program or residential care facility,

unless the individual receiving such services meets the requirements for the mental health alternative care benefit, as defined by DMBA, and as otherwise provided for by the terms of the plan.

- 10.7 Custodial and supportive care of participants or dependents with mental illness.

11. Miscellaneous

- 11.1 Services of any practitioner of the healing arts 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.
- 11.2 Care, services, diagnostic procedures, or other expenses when it has been determined that brain death has occurred.
- 11.3 Sex reassignment surgery, including all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.).
- 11.4 Reproductive organ prosthesis.
- 11.5 Charges over and above the allowable amount (reasonable and customary) as determined by the plan administrator.
- 11.6 Education and training: Education available to the general public without charge; educational evaluation and therapy, testing, consultation, rehabilitation, remedial education, services, supplies or treatment for developmental disabilities, communication disorders, or learning disabilities; educational treatment, including reading or math clinics or special schools for the intellectually disabled or behaviorally impaired individuals; therapy that is part of a special educational program.

12. Obesity

- 12.1 Care, services, or operations in connection with obesity.

13. Other insurance/workers' compensation

- 13.1 Services covered or that could have been covered by applicable workers' compensation statutes.
- 13.2 Services covered or that could have been covered by insurance required or provided by any statute had the participant complied with the statutory requirements, including but not limited to no-fault insurance.
- 13.3 Services for which a third party, the liability insurance of the third party, underinsured motorist, or uninsured motorist insurance pays or is obligated to pay.
- 13.4 Physical examination for the purpose of obtaining insurance, employment, government licensing, or as needed for volunteer work except as provided for by the terms of the plan.

14. Prescription drugs

- 14.1 Medications such as contraceptives for purposes of family planning, dietary or nutritional products or supplements (including special diets for medical problems), herbal remedies, holistic or homeopathic treatments, products used to stimulate hair growth, medications used for sexual dysfunction, medications whose use is for cosmetic purposes, over-the-counter products, vitamins (except prenatal vitamins and prescribed infant vitamins), weight-reduction aids, and non-legend drugs, except to the extent specifically provided in the plan (including any requirements regarding preauthorization).
- 14.2 Specific medications, unless specifically authorized by DMBA.

15. Testing

- 15.1 Allergy tests, including but not limited to, ALCAT testing/food intolerance testing, leukocyte histamine release test (LHRT), cytotoxic food testing (Bryan's

test, ACT), conjunctival challenge test, electroacupuncture, passive transfer (P-X) or Prausnitz-Küstner (P-K) test, provocative nasal test, provocative food and chemical testing (intra dermal, subcutaneous, or sublingual), Rebeck skin window test, and Rinkel test.

16. Transplants

- 16.1 Care, services, diagnostic procedures, or operations in relation to organ transplants (donor or artificial), unless the patient characteristics and transplant procedures are preauthorized and meet DMBA's current medical criteria.

17. Vision

- 17.1 Eye/visual training; purchase or fitting of glasses or contact lenses; and care, services, diagnostic procedures, or other expenses for elective surgeries to correct vision, including radial keratotomy or LASIK surgery, except as provided for by the terms of the plan.
- 17.2 Routine eye exams.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

As part of the Patient Protection and Affordable Care Act (healthcare reform), health plans are classified as either "grandfathered" or "non-grandfathered." Because DMBA has maintained the benefit structure that was in place at the time the law passed, our health plans are grandfathered.

As a grandfathered plan, your benefits may not include certain consumer protections included in the law that apply to other plans. But grandfathered plans must still comply with other consumer protections included in the Affordable Care Act—like eliminating lifetime limits on essential benefits, which DMBA has already done.

For information about which protections do or don't apply, as well as information about what could cause a plan to change from grandfathered to non-grandfathered status, please contact the

Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform.

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.** For more information about how to appeal a claim, please refer to your *General Information 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 NON-COMPLIANCE AND ABUSE OF BENEFITS

If a participant seeks to either bypass or ignore appropriate medical advice in an attempt to abuse the healthcare system (which may include, but is not limited to, jumping from physician to physician or emergency room to emergency room or seeking medications from multiple sources), DMBA has the right to place the participant on a “medical compliance plan.”

The participant will then be instructed to receive care from certain providers and facilities that are specifically named in the compliance plan, as determined by DMBA.

If the participant then chooses to receive care from providers or facilities that are not included in the compliance plan, benefits will be denied and the participant will be responsible for paying all costs associated with this care, including repaying DMBA for any amounts it may have paid.

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.