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YOUR DESERET VALUE

Summary of Benefits and Coverage

September 2023

Dear Deseret Value Participant:

Enclosed please find your 2024 Deseret Value plan Summary of Benefits and Coverage. The Affordable Care Act of 2010 requires that this summary of your medical benefits be sent to you each year. It does not include information about dental benefits for which you may be eligible.

You can review online summaries of all medical plans for which you're eligible at www.dmba.com, where a glossary of terms is also available for your reference. If you'd prefer a printed copy, please call us and we'll send it at no cost to you.

As you review this summary, remember open enrollment is just around the corner. We encourage you to carefully review the open enrollment materials coming your way as you consider your healthcare needs for next year.

If you have questions about the contents of this document, call Member Services at 801-578-5600 or toll free at 800-777-3622.

Sincerely,

DMBA

This document provides a brief description of benefits offered under the Deseret Healthcare Employee Benefits Plan ("Plan"). *Full details are in the summary plan description (benefits handbook) and official* Plan *documents. 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 the summary plan description and* Plan *documents and the information in this document, the terms outlined in the summary plan description and* Plan *documents will control. You can view the summary plan description by logging into www.dmba.com.*

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.dmba.com or call 1-800-777-3622. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-777-3622 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/individual or $800/family for non-contracted providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes; services from all contracted providers, outpatient labs, behavioral health outpatient therapy and initial evaluation, and some preventive, primary, and urgent/emergent care from non-contracted providers	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,600/individual or $8,400/family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, healthcare this plan doesn't cover, lifestyle screenings, prescription drugs, specialty pharmacy, temporomandibular joint (TMJ) dysfunction, the annual deductible, and the initial charge for not preauthorizing	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.dmba.com or call 1-800-777-3622 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	$25 copayment	You pay an additional $5 for after-hours visits. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$35 copayment	$40 copayment	
	Preventive care/screening/ immunization	No charge	$25 copayment for primary care; $40 for specialist	
If you have a test	Diagnostic test (x-ray, blood work)	No charge for outpatient lab work; 30% coinsurance on X-rays	No charge for outpatient lab work; 40% coinsurance on X-rays	You may be required to preauthorize; failure to preauthorize results in denial or $200 penalty.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	40% coinsurance	You may be required to preauthorize; failure to preauthorize results in $200 penalty.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.dmba.com	Generic drugs	50% coinsurance	Not covered; you pay 100%	Submit claims from non-contracted providers for possible reimbursement.
	Preferred brand drugs	50% coinsurance	Not covered; you pay 100%	Submit claims from non-contracted providers for possible reimbursement.
	Non-preferred brand drugs	Not covered; you pay 100%	Not covered; you pay 100%	—None—
	Specialty drugs	45% coinsurance; mail order capped at $195 per prescription	Not covered; you pay 100%	Some specialty drugs aren't covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	40% coinsurance	—None—
	Physician/surgeon fees	30% coinsurance	40% coinsurance	You may be required to preauthorize; failure to preauthorize results in $200 penalty.
If you need immediate medical attention	Emergency room care	$100 copayment plus 30% coinsurance	$100 copayment plus 30% coinsurance	—None—
	Emergency medical transportation	30% coinsurance for ambulance	30% coinsurance for ambulance	—None—
	Urgent care	$45 copayment	$45 copayment	—None—
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	40% coinsurance	Failure to preauthorize results in $200 penalty.
	Physician/surgeon fees	30% coinsurance	40% coinsurance	You may be required to preauthorize; failure to preauthorize results in $200 penalty. Cosmetic surgery is not covered.

[* For more information about limitations and exceptions, see the plan or policy document at www.dmba.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment	$25 copayment	—None—
	Inpatient services	30% coinsurance	40% coinsurance	Failure to preauthorize results in $200 penalty.
If you are pregnant	Office visits	30% coinsurance	40% coinsurance	—None—
	Childbirth/delivery professional services	30% coinsurance	40% coinsurance	Planned home birth is not covered.
	Childbirth/delivery facility services	30% coinsurance	40% coinsurance	You must preauthorize hospital stays of more than two days for a vaginal delivery or four days for a cesarean section delivery. Non-licensed birthing centers are not covered.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	40% coinsurance	Failure to preauthorize results in $200 penalty.
	Rehabilitation services	$35 copayment	$40 copayment	25 visit limit per year for physical therapy and 25 visit limit per year for occupational therapy (additional visits may be available with preauthorization)
	Habilitation services	$35 copayment	$40 copayment	25 visit limit per year for physical therapy and 25 visit limit per year for occupational therapy (additional visits may be available with preauthorization)
	Skilled nursing care	30% coinsurance	40% coinsurance	Failure to preauthorize results in $200 penalty; covers up to 50 days
	Durable medical equipment	30% coinsurance	40% coinsurance	You may be required to preauthorize; failure to preauthorize results in denial or $200 penalty.
	Hospice services	30% coinsurance	40% coinsurance	Failure to preauthorize results in $200 penalty.
If your child needs dental or eye care	Children's eye exam	$35 copayment	$40 copayment	One routine exam per calendar year
	Children's glasses	Not covered; you pay 100%	Not covered; you pay 100%	—None—
	Children's dental check-up	Not covered; dental plan is available	Not covered; dental plan is available	—None—

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Any treatment not medically necessary
- Cosmetic surgery
- Custodial care unless medically necessary
- Dental care (adult)
- Eyewear (except after surgery)
- Long-term care
- Non-formulary drugs
- Private-duty nursing unless preauthorized
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery (eligibility based on strict medical criteria)
- Chiropractic care
- Emergency and non-emergency care when traveling outside the U.S.
- Hearing aids
- Routine eye care (adult)
- Routine foot care
- Some infertility treatments

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Administration, 1-888-444-3272 or www.dol.gov/ebsa/healthreform; or the U.S. Department of Health and Human Services, 1-877-267-2323, ext. 61565, or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: DMBA, 1-800-777-3622 or www.dmba.com, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-(EBSA) 3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-777-3622.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-777-3622.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-777-3622.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-777-3622.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at www.dmba.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,480**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The plan would be responsible for the other costs of these EXAMPLE covered services.