

DESERET ALLIANCE

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

DESERET ALLIANCE KEY POINTS:

- Deseret Alliance is a Medicare supplement plan, meaning it provides additional benefits after Medicare has paid. Medicare is your primary plan provider and Deseret Alliance is your secondary plan. You must be properly enrolled in both Medicare Part A and Part B to have adequate benefits and to be eligible for Deseret Alliance.
- Your basic office visit copayments will be no more than \$15. Your out-of-pocket maximum is \$3,000 per person. Once you have met your out-of-pocket limit for the year, all eligible services are covered at 100 percent for the remainder of that calendar year, based on the plan's out-of-pocket maximum. (Some benefits do not apply to your out-of-pocket limit.)
- You must receive services from providers eligible to bill Medicare and who choose to accept you as a Medicare patient, otherwise your benefits will be denied unless you're traveling outside the United States.
- The plan partners with Granite Alliance Insurance Company, a subsidiary of VRx, to administer your prescription drug benefits. You can contact Granite Alliance Insurance Company toll free at 855-586-2573.

- The plan is not designed to pay all amounts not covered by Medicare.
- DMBA coordinates with Medicare to receive claims automatically. After your provider submits a claim to Medicare, your claim and Medicare's payment information is automatically sent to DMBA in a process known as crossover billing.
- New for 2019, Deseret Alliance provides a hearing aid benefit of \$325 annually per hearing aid per ear through TruHearing. You will be responsible for a copayment of \$399 or \$699 (depending on the model selected) per hearing aid per ear. This benefit is available only to Deseret Alliance participants in the United States. To use this benefit you must contact TruHearing at 866-929-5584.

ENROLLING IN MEDICARE

Medicare is the federal health insurance program that covers people 65 and older and certain disabled individuals. It is administered by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services.

Medicare benefits are divided into three parts:

- **Part A (hospital insurance)** helps pay for inpatient hospital care, inpatient care at a skilled nursing facility, some home healthcare, and hospice care.
- **Part B (medical insurance)** helps pay for doctors' services, outpatient hospital services, durable medical equipment, some home healthcare, and many other services not covered by Part A.
- **Part D (prescription drug insurance)** helps pay for your prescription medications.

Generally, you're automatically enrolled in Part A when you turn 65. It's up to you to enroll in Part B as soon as you're eligible. Go to www.medicare.gov for help or call 800-MEDICARE (800-633-4227).

Granite Alliance Insurance Company administers your Part D prescription drug benefits for you. You should not enroll in a separate Medicare

prescription plan. **If you do, you'll lose your Deseret Alliance medical and prescription drug benefits and won't be able to re-enroll later.**

MAXIMIZING YOUR BENEFITS

Make sure your providers will accept you as a Medicare patient.

If you use a provider who does not participate in Medicare, you may be "balance billed" 15 percent more than Medicare's allowable amount. Balance-billed amounts are not covered by the plan. You'll be responsible for paying any balance-billed amounts to non-participating providers.

Please be aware that sometimes you may not realize the services you're receiving or items you're buying are not covered because the provider is not Medicare eligible.

Here are some examples of expenses that aren't covered:

- Internet purchases of medical supplies and equipment
- Drugstore purchases of medical supplies and equipment
- Flu clinics from a non-Medicare participating entity (such as the convenient care clinics found in retail stores)

Key indicators that a provider does not participate with Medicare include:

- You are required to make full payment up front.
- The provider says he or she will not submit the claim to Medicare.
- The provider asks you to sign a form explaining he or she is not participating with Medicare.
- Providers who have completely opted out of the Medicare program, or who have been excluded for cause by Medicare, are not eligible to bill Medicare for services. Neither Medicare nor DMBA will pay for services performed by an "opted-out" or excluded provider. (Providers are obligated to inform

Medicare patients if they have opted out of or been excluded from Medicare.)

If you encounter any of these situations, we strongly encourage you to find a different provider who is participating with Medicare. For help finding a Medicare provider, go to www.medicare.gov.

IDENTIFICATION CARDS

Use your red, white, and blue Medicare card at your provider's office.

If you misplace or lose your card, call one of the following to get a replacement:

Medicare 800-MEDICARE
(800-633-4227)

Social Security
Administration 800-772-1213

You can also request a new card online at www.medicare.gov, www.socialsecurity.gov, or www.ssa.gov.

Use your Deseret Alliance card when you fill your prescription medications. If you misplace or lose your Deseret Alliance card, call DMBA Member Services and we'll send you a new one.

Salt Lake City area 801-578-5600
Toll free 800-777-3622

When you go to a doctor or hospital, tell them you're a participant of Deseret Alliance, a Medicare Supplement plan, **and show them both your Medicare card and your Deseret Alliance ID card.** This will let the provider know to submit claims directly to Medicare first, not DMBA. After Medicare has paid, your claim information will automatically be forwarded to DMBA.

If your providers have questions about DMBA as your benefits administrator, ask them to call us at 801-578-5600 or 800-777-3622.

If your providers have questions about Medicare's payment, they should call Medicare directly at 800-MEDICARE (800-633-4227).

IMPORTANT RULES AND GUIDELINES

If Medicare doesn't cover a specific service, neither will Deseret Alliance—except for a few supplemental services such as annual physical exams, routine eye exams, and hearing aids.

Except for a few medications, preauthorization is not required. (See [Preauthorization for specific medications](#).)

Deseret Alliance will only coordinate with Medicare Parts A, B, and C (Medicare Advantage plan without prescription drug benefits). If you're considering other Medicare supplement benefits, keep in mind that Deseret Alliance will not coordinate with them.

Please note, you cannot be enrolled in Deseret Alliance and another Medicare Part D Prescription Drug Plan (other than the Granite Alliance PDP) at the same time. It's your responsibility to inform DMBA of any other medical or prescription drug benefits you have or may get in the future.

As a Deseret Alliance participant, you have the right to appeal plan decisions about payments or services. If your appeal is related to Medicare's payment, you must appeal directly to Medicare. For information about appealing Deseret Alliance payment decisions, see [Claims Review and Appeal Procedures](#).

To disenroll or opt out from Deseret Alliance, call DMBA Member Services. If you drop your Deseret Alliance benefits, you cannot re-enroll later.

YOUR MEDICAL BENEFITS

To be eligible for payment, services must meet Medicare criteria. To maximize your benefits, confirm with your provider that he or she accepts Medicare assignment.

All benefits are subject to the allowable amounts determined by either Medicare or DMBA.

Medicare benefit limits also apply. See the *Medicare & You* handbook for more information. You can access a copy online at www.medicare.gov/medicare-and-you.

SERVICES NOT COVERED BY MEDICARE

ANNUAL ROUTINE EYE EXAM

Deseret Alliance pays: 100% of DMBA's allowable amount after your \$15 copayment

You pay: Up to a \$15 copayment

- One exam is covered per calendar year

ANNUAL ROUTINE PHYSICAL EXAM

Deseret Alliance pays: 100% of DMBA's allowable amount

You pay: Nothing

- One exam is covered per calendar year
- Labs and routine procedures are not eligible when associated with an ineligible physical exam.
- Some services may not be covered as part of a physical exam. Contact Member Services for information.

BENEFITS FOR FOREIGN MISSIONARIES

Deseret Alliance pays: 100% of DMBA's allowable amount after any applicable copayments and coinsurance

You pay: Applicable copayments and coinsurance

- Applies if you receive Medicare Part B services in the United States only while you're disenrolled from Part B because of voluntary foreign missionary service

BENEFITS DURING FOREIGN TRAVEL (WHEN YOU'RE OUTSIDE THE U.S.)

Medicare pays:

- Nothing, except in limited circumstances
- If covered, 80% of the Medicare-approved amount

Deseret Alliance pays:

- If covered by Medicare, 20% of the Medicare-approved amount minus any copayments and coinsurance

- If not covered by Medicare, 100% of all covered services up to the billed amount, minus any copayments and coinsurance (based on the type of service received)

You pay: Applicable copayments and coinsurance

EYE REFRACTION EXAMS

Deseret Alliance pays: 100% of DMBA's allowable amount

You pay: Nothing

HEARING AIDS

Deseret Alliance pays: 100% of DMBA's allowable amount after applicable copayments

You pay: Applicable copayments

- \$399 copayment per aid for Advanced model
- \$699 copayment per aid for Premium model

Eligible for one hearing aid per ear annually exclusively through TruHearing. Services from all other providers are excluded and are not a covered benefit.

IMMUNIZATIONS NOT COVERED BY MEDICARE

Deseret Alliance pays: 100% of DMBA's allowable amount for approved immunizations

You pay: Nothing

SERVICES COVERED BY MEDICARE PART A

HOME HEALTH SERVICES

Medicare pays: 100% of Medicare-approved amount

Deseret Alliance pays: Nothing

You pay: Nothing

HOSPICE CARE

Medicare pays: 100% of Medicare-approved amount

Deseret Alliance pays: Nothing

You pay: Nothing

HOSPITAL CARE—INPATIENT (INCLUDING MENTAL HEALTH INPATIENT CARE)

Days 1 to 60

Medicare pays: 100% after your Medicare Part A deductible (\$1,364 in 2019)

Deseret Alliance pays: 100% of the Medicare Part A deductible minus \$700

You pay: Up to \$700 copayment

Days 61 to 90

Medicare pays: 100% after your Medicare Part A daily coinsurance amount (\$341 per day in 2019)

Deseret Alliance pays: 100% of the Medicare Part A daily coinsurance amount

You pay: Nothing

After day 90 (per benefit period)

Medicare pays: Nothing, unless Medicare's lifetime reserve days are used

After day 90 (per benefit period when lifetime reserve days are exhausted)

Deseret Alliance pays: Nothing

You pay: 100% of charges for inpatient days that exceed Medicare's day limit

Lifetime reserve days

Medicare: 100% after your Medicare Part A daily coinsurance amount (\$682 per day in 2019) for days 91 to 150

Deseret Alliance: 100% of the Medicare Part A daily coinsurance amount

You pay: Nothing

SKILLED NURSING FACILITY CARE

Days 1 to 20

Medicare pays: 100%

Deseret Alliance pays: Nothing

You pay: Nothing

Days 21 to 100

Medicare pays: 100% after your Medicare Part A daily coinsurance amount (\$170.50 per day in 2019)

Deseret Alliance pays: 100% of the remaining Medicare-approved amount minus a \$100 copayment per day

You pay: Up to a \$100 copayment per day

After day 100 (per benefit period)

Medicare: Nothing

Deseret Alliance: Nothing

You pay: 100% of charges

SERVICES COVERED BY MEDICARE PART B

Medicare applies an annual Medicare Part B deductible (\$185 in 2019). No payment for charges is made until the deductible has been met.

Deseret Alliance covers the Medicare Part B deductible minus applicable copayments and coinsurance.

You pay the applicable copayment and coinsurance for the service provided.

AMBULANCE SERVICES

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus a \$75 copayment per day

You pay: Up to a \$75 copayment per day

AMBULATORY SURGICAL CENTER

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$250 copayment

You pay: Up to a \$250 copayment

CARDIAC REHABILITATION (OUTPATIENT)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

CHEMOTHERAPY

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

CHIROPRACTIC SERVICES (LIMITED)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

- Limited to 25 visits per calendar year

DIABETES SELF-MANAGEMENT TRAINING

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount

You pay: Nothing

DIABETIC SUPPLIES

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

- Supplies include blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, and therapeutic shoes (in some cases).

Some supplies will also be covered by your prescription benefits at Granite Alliance.

DIALYSIS

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

DOCTOR AND OTHER HEALTHCARE PROVIDER SERVICES—INPATIENT

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount

You pay: Nothing

- Includes some physician services you receive while admitted to the hospital

DOCTOR AND OTHER HEALTHCARE PROVIDER SERVICES—OUTPATIENT

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per day

You pay: Up to a \$15 copayment per day

DURABLE MEDICAL EQUIPMENT

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

EMERGENCY DEPARTMENT SERVICES

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus a \$50 copayment per day

You pay: Up to a \$50 copayment per day

- Copayment waived if the patient is admitted to the hospital from the emergency room

EYEWEAR—GLASSES

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

- Limited to glasses after cataract surgery

HEARING EXAMS

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

- Routine hearing exams not covered

IV THERAPY

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

MENTAL HEALTHCARE—OUTPATIENT

Office visit to diagnose

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

Counseling for outpatient treatment

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

OCCUPATIONAL THERAPY (LIMITED)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to a \$15 copayment per visit

- Limited to 25 visits per calendar year

OUTPATIENT HOSPITAL SERVICES

Clinic visits

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per day

You pay: Up to a \$15 copayment per day

Outpatient surgery

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$250 facility copayment per surgery

You pay: Up to a \$250 facility copayment

OUTPATIENT MEDICAL AND SURGICAL SERVICES OR SUPPLIES

Radiology, injections, and infusion services

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

Supplies

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount

You pay: Nothing

PARENTERAL NUTRITION SERVICES

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

PHYSICAL THERAPY (LIMITED)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to \$15 copayment per visit

- Limited to 25 visits per calendar year

PRESCRIPTION DRUGS (LIMITED TO THOSE COVERED BY MEDICARE PART B)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

PREVENTIVE SERVICES (SCREENING EXAMS)

Medicare pays: 100% of the Medicare-approved amount

Deseret Alliance pays: Nothing

You pay: Nothing

PROSTHETIC/ORTHOTIC ITEMS

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

SPEECH LANGUAGE PATHOLOGY SERVICES (LIMITED)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to \$15 copayment per visit

- Limited to 25 visits per calendar year

TESTS (LAB TESTS)

Medicare pays: 100% of the Medicare-approved amount

Deseret Alliance pays: Nothing

You pay: Nothing

- A1C, urinalysis, blood chemistry, glucose, lipid profile, etc.

TESTS, RADIOLOGY (OTHER THAN LAB TESTS)

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 10% of the Medicare-approved amount

You pay: 10% coinsurance

- X-ray, MRI, MRA, CT scan, PET, SPECT, etc.

URGENT CARE

Medicare pays: 80% of the Medicare-approved amount

Deseret Alliance pays: 20% of the Medicare-approved amount minus up to a \$15 copayment per visit

You pay: Up to \$15 copayment per visit

MEDICARE PART D PRESCRIPTION DRUG BENEFITS (FROM YOUR GRANITE ALLIANCE PDP)

Because Granite Alliance Insurance Company administers your prescription benefits, you should direct medication and prescription questions to them, toll free at 855-586-2573

TTY 711

You use Magellan Rx Home for your mail-order prescriptions.

Here's a summary of your prescription benefits from Granite Alliance Insurance Company. Please be aware, limitations, copayments, and restrictions may apply.

Prescription drug expenses don't count toward your out-of-pocket maximum. See [Out-of-pocket Maximum](#).

- Certain injections, oral cancer drugs, drugs used with durable medical equipment, and drugs given in a hospital setting are not covered by Granite Alliance.

Supplies used to administer diabetic medications

Deseret Alliance pays: 90% of the allowable amount

You pay: 10%

- Includes syringes, needles, alcohol swabs, gauze, and inhaled insulin devices

Prescription Category	From Your Local Retail Pharmacy for a 30-day Supply, You'll Pay	From Your Mail-order and Retail Pharmacy for a 90-day Supply, You'll Pay
Tier 1: Generic medications	25%, or at least \$5	25%, or at least \$10 but no more than \$200
Tier 2: Preferred brand-name medications	25%, or at least \$5	25%, or at least \$10 but no more than \$200
Tier 3: Non-preferred brand-name medications	50%, or at least \$5	50%, or at least \$10
Tier 4: Specialty medications	25%, at least \$150, but no more than \$200	Not covered
Catastrophic coverage: Brand-name medications	5%, or at least \$8.50	5%, or at least \$8.50
Catastrophic coverage: Generic medications	5%, or at least \$3.40	5%, or at least \$3.40
Excluded medications	100% (not covered)	100% (not covered)

Preauthorization for specific medications

Preauthorization means Granite Alliance is notified in advance about specific medications your doctor has prescribed. Then Granite Alliance can tell you what will be covered before you're faced with your share of the costs.

Preauthorization is only required for certain medications. The Granite Alliance formulary drug list includes information about which medications require preauthorization. If you have questions about your personal situation, please call Granite Alliance Customer Service. Otherwise, if you don't preauthorize when necessary, your benefits may be reduced or denied.

MEDICAL EMERGENCIES

A "medical emergency" is when you reasonably believe your health is in serious danger and every second counts. This includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency, get medical help as quickly as possible. **Call 911 or go to the nearest emergency room or urgent care center.**

OUT-OF-POCKET MAXIMUM

If your share of eligible medical expenses reaches \$3,000 per calendar year (your annual out-of-pocket maximum), your medical benefits for the remainder of the calendar year are paid at 100 percent for eligible charges, based on the out-of-pocket maximum of the plan.

Some benefits do not apply to your out-of-pocket limit, so they're not covered by the out-of-pocket maximum. These include prescription medications, except for drugs that are traditionally covered by Medicare Part B. (See [Medicare Part D prescription drug benefits](#).)

For information about the out-of-pocket limit for your prescription benefits from Granite Alliance, refer to your *Granite Alliance PDP Evidence of Coverage*.

TRUHEARING

DMBA participants have had access to special pricing on hearing aids through TruHearing. Now, Deseret Alliance is providing an annual benefit of \$325 per hearing aid per ear for devices obtained through TruHearing. Participants will be responsible to pay a copayment of \$399 or \$699 (depending on the model selected) per hearing aid per ear. To learn more or to schedule an appointment with a TruHearing contracted provider in your area, call TruHearing at 866-929-5584. For questions about the benefit, call DMBA Member Services at 801-578-5600 in the Salt Lake City area or toll free at 800-777-3622.

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.

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

SUBMITTING CLAIMS

For services from Medicare-eligible providers, you should not need to submit claims. These providers send bills directly to Medicare for processing. But you could receive a bill for services you receive when you're traveling outside the United States.

If you receive a bill for medical services, follow these steps to submit a claim:

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: Have the provider indicate the amount of payment already collected, if applicable.

Step 4: Fill out a claim form, which you can find in the *Forms Library* at www.dmba.com.

Step 5: Mail the claim to:

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

You must submit pharmacy claims to Granite Alliance, not DMBA. For more information, refer to your *Granite Alliance PDP Evidence of Coverage*.

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

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 insurer 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 coverage becomes 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 and applies the payable amount to unpaid covered charges after eligible benefits have been paid by the primary plan.

This amount includes deductibles, copayments, and coinsurance you may owe. DMBA will use its own deductible, copayments, and coinsurance 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.

Multiple health plans

As a participant in Deseret Alliance, you must immediately notify DMBA if you're enrolled in any other plan while you're concurrently enrolled in Deseret Alliance.

You're also prohibited from enrolling in certain types of plans while you're enrolled in this plan, as described below. If you're concurrently enrolled in any of the following plans, you will be involuntary disenrolled from Deseret Alliance:

- A Medicare Advantage Plan that includes drug benefits (Part D)
- Another Medicare Part D plan (other than your Granite Alliance PDP)
- An employer-based Medicare supplement plan that includes drug benefits

Order of payment

The primary payer pays up to the limits of its benefits. The secondary payer only pays if there are expenses the primary payer did not cover. The secondary payer may not pay all of the uncovered costs.

Coordination with other plans

Deseret Alliance will only coordinate with other plans as outlined here:

- Deseret Alliance and Medicare Parts A and B: Medicare pays first and Deseret Alliance pays second
- Deseret Alliance and a Medicare Advantage Plan without prescription drug benefits (known as Part C only): Medicare Advantage Plan pays first and Deseret Alliance pays second
- Deseret Alliance, Medicare Parts A and B, and a non-DMBA group health plan: The group health plan pays first, Medicare pays second, and Deseret Alliance pays third
- Deseret Alliance, Medicare Parts A and B, and TRI-CARE or Medicaid: Medicare pays first, Deseret Alliance pays second, and TRI-CARE or Medicaid pays third
- Deseret Alliance, Medicare Parts A and B, other third-party insurance (noted below): The third-party insurer pays first, Medicare pays second, and Deseret Alliance pays third
 - » No-fault insurance (including automobile insurance)
 - » Liability insurance (including automobile insurance)
 - » Black lung benefits
 - » Workers' compensation
 - » An active group health plan after the 30th month of end-stage renal disease-based eligibility

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. To be eligible for payment, services must meet Medicare's criteria. 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 treatment of the teeth, gums, or alveolar process; dentures, crowns, caps, permanent bridgework, and appliances; and supplies used in such care and treatment, except as provided for by the terms of the plan.

3. Diagnostic and experimental services

- 3.1 Care, service, 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, treatment, 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 service, 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 number 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 Services related to in vitro fertilization that do not meet plan guidelines.
- 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

- 6.1 Routine hearing exams and hearing exams related to the fitting of hearing aids.

7. Legal exclusions

- 7.1 Services that the individual is not, in the absence of this benefit, legally obligated to pay.
- 7.2 Care, treatment, operations, or prescription drugs incurred after termination of benefits.
- 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 covered as a benefit or a 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, 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 clearly a medical necessity 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 an abdominoplasty, lipectomy, panniculectomy (except when medical criteria has been met), skin furrow removal, or diastasis rectus repair.

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, and other therapy) that is not done in person. Family therapy is only covered when a family member has a diagnosed psychiatric disorder and that individual 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 treatment 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, treatment, 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 Acupuncture treatment and/or services.

11.6 Charges over and above the allowable amount (reasonable and customary) as determined by the plan administrator.

11.7 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, treatment, or operations in connection with obesity, unless the patient meets Medicare's current medical criteria.

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 Granite Alliance.

15. Testing

- 15.1 Some allergy tests, including but not limited to, 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 (intradermal, subcutaneous, or sublingual), Rebeck skin window test, and Rinkel test.

16. Transplants

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

17. Vision

- 17.1 Eye/visual training; purchase or fitting of glasses or contact lenses; and care, treatment, 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.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Deseret Alliance plan is a "retiree-only" plan. Under section 732(a) of ERISA and section 9831(a) of the Internal Revenue Code, "retiree-only" plans are exempt from certain health mandates in the Patient Protection and Affordable Care Act.

For information about which protections do or don't apply, please call us or 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*.

For information about how to file an appeal with Granite Alliance, refer to your *Granite Alliance PDP Evidence of Coverage*.

NOTIFICATION OF DISCRETIONARY AUTHORITY

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

NOTIFICATION OF BENEFIT CHANGES

DMBA reserves the right to amend or terminate the 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.

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