DESCHH5HBA0920

2020

# DESERET CHOICE HAWAII

This summary plan description (benefits handbook), or SPD, outlines the major provisions of Deseret Choice Hawaii as of June 1, 2020.

## DESERET CHOICE HAWAII KEY POINTS:

- Generally, Deseret Choice Hawaii covers contracted providers at 90%, leaving you responsible for the remaining 10%. Non-contracted providers are covered at 70% of DMBA's allowable amount and you are responsible for the remaining 30%, 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%.
- Your annual out-of-pocket maximum is $2,000 per person or $3,500 per family for services from contracted providers and $3,000 per person or $7,000 per family from non-contracted providers.
- To be eligible for benefits, you or your physician must preauthorize some services with DMBA, such as some surgeries and home healthcare.

DMBA

# 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 your plan's 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 | 808-466-4077 |
| 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 |

## 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, see Preauthorization. Also see *Your Medical Benefits*, which follows.

# 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.")

Each page listing these benefits needs a footer

### ACUPUNCTURE

**Contracted provider:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $30 copayment.

- Up to 12 visits are covered per calendar year.
- You may receive more than one service in a single visit. But only 12 visits are covered a year.

### ALLERGY TESTING

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- Some testing, such as ALCAT and LHRT, is not covered. See Exclusion 15.1.
- For information about injections for allergies, see Injections.

### AMBULANCE

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

- 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 are covered at the appropriate benefit level for those services.
- For more information on other transportation services, see the Transportation benefit.

## ANESTHESIA

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

## APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY FOR AUTISM SPECTRUM DISORDER

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- The ABA therapy must be provided through a board-certified behavior analyst (BCBA) or a board-certified behavior analyst–doctorate (BCBA-D).
- Not all ABA therapy is covered so you must preauthorize before the initial functional behavior assessment.

## CARDIAC REHABILITATION

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

## CHEMICAL DEPENDENCY–ALTERNATIVE CARE

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- Includes residential treatment centers (inpatient), partial hospitalization programs (outpatient), and intensive outpatient programs (outpatient).
- You must preauthorize.
- To be eligible for benefits, a manifest psychiatric disorder must be diagnosed.

## CHEMICAL DEPENDENCY–INPATIENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

You must preauthorize.

## 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 covered individual must be present for family therapy.
- Some therapy is not eligible for benefits. See Exclusion 10.2.
- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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 preauthorization requirements.
- Lab testing is covered under the laboratory services benefit.

## CHEMOTHERAPY–PROVIDER-ADMINISTERED

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- Preauthorization may be required.
- For oral chemotherapy agents or self-administered medications, see Prescription drugs—specialty pharmacy.
- Investigational or experimental chemotherapy is not covered.

## CHIROPRACTIC THERAPY

**Contracted or non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $20 copayment.

- You may have up to 30 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount for preventive and diagnostic services; you pay 30%.

- 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.

## DIABETES EDUCATION

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- To be eligible for this benefit, you must be diagnosed with diabetes, gestational diabetes, 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.

## 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 90% of the contracted price for a 90-day supply.

- When you purchase supplies from your local retail pharmacy, supplies are covered at 90% of the contracted price for a 30-day supply.

## DIALYSIS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

## EMERGENCY ROOM

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10% after your $75 copayment per visit.

- If you receive follow-up care at the emergency room, you're responsible for another $75 copayment plus your 10% 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 90% of DMBA's allowable amount; you pay 10%.

## ENTERAL THERAPY

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

- You must preauthorize.
- Enteral formula must be for inborn errors of metabolism (e.g., PKU, cystic fibrosis) or the sole source of nutrition delivered by means of feeding tube as defined by DMBA.

## EYE EXAMS

**Contracted specialist:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 80% of DMBA's allowable amount after your $20 copayment.

- One routine eye exam is eligible for benefits each calendar year.
- Eye exams for medical conditions, such as glaucoma, may be eligible for benefits more often.

## EYEWEAR (GLASSES OR CONTACT LENSES)

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

- 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.

## FUNCTIONAL COSMETIC SURGERY

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize.
- If you meet DMBA eligibility requirements, these procedures may be eligible for benefits:
  - » Certain breast surgeries, such as reduction mammoplasty and gynecomastia excision
  - » Certain nasal surgeries
  - » Congenital defects, such as a missing ear, extra finger, or some facial disfigurements

  - » Eyelid surgery, such as blepharoplasty
  - » Jaw surgery (maxillary and mandibular osteotomy)
  - » Scar revisions
- Other surgeries with a cosmetic component are not eligible for benefits. (See Exclusion 9.1.)

## GENETIC COUNSELING

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

**Contracted specialist:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment.

Genetic counseling is required before genetic testing. You must preauthorize genetic testing.

## 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.
- Genetic counseling is required before genetic testing.

## GLUCOMETERS AND TEST STRIPS

**Abbott Diabetes Care:** The plan pays 90%; you pay 10%.

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

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

## HEARING AIDS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

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

## HEARING EXAMS

**Contracted provider:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 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 70% of DMBA's allowable amount when done by a non-contracted provider.
- For covered individuals older than 3 months, audiometry is covered at 90% when done by a contracted provider or 70% of DMBA's allowable amount when done by a non-contracted provider.

## HOME HEALTHCARE

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize.
- To be eligible for benefits, services must be performed by a licensed registered nurse (RN) or a licensed practical nurse (LPN).
- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- This benefit is available to covered individuals 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 covered individuals 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

You must preauthorize.

## IMMUNIZATIONS

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

Commonly covered immunizations include:

- Diphtheria/Pertussis/Tetanus (DTaP, Tdap)
- Diphtheria/Tetanus (DT)
- Haemophilus Influenzae (Hib)
- Hepatitis A and B
- Human Papillomavirus (HPV) from ages 9 to 26
- Influenza
- Measles/Mumps/Rubella (MMR)
- Meningococcal (MenACWY, MenB)
- Pneumococcal
- Polio
- Shingles from ages 50 to 99
- Tetanus
- Tetramune
- Varicella/chicken pox (VAR)

## 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.
- In vitro fertilization is eligible for benefits for one time only.
- 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 provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable limit; you pay 30%.

Some injections and IV therapy require preauthorization.

## INSULIN PUMPS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize.
- Available every four years.

## LABORATORY SERVICES–INPATIENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

## 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.

## LIFESTYLE SCREENINGS

**Contracted or non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $20 copayment, up to $100 per screening.

- One screening is eligible for benefits every three calendar years.
- Limited to the employee and spouse; benefits are not available for dependent children.
- Lifestyle screenings usually include:
  - » Blood-pressure check
  - » Blood test for cholesterol levels
  - » Body fat evaluation
  - » Cardiopulmonary fitness
  - » Flexibility test
  - » Medical history
  - » Strength test
  - » Weight analysis
- Expenses do not count toward the plan's out-of-pocket maximum. (See Out-of-pocket Maximum.)

## MAMMOGRAMS

**Contracted provider:** For preventive services, the plan pays 100%. For diagnostic services, the plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- For participants 40 and older, a preventive mammogram is covered each calendar year.
- Mammograms for medical reasons are covered as often as medically necessary. In these situations, the plan pays 90% and you pay 10% for services from a contracted provider. For services from a non-contracted provider, the plan pays 70% of DMBA's allowable amount and you pay 30%.
- 3D mammograms are eligible for benefits.

## MATERNITY–INPATIENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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 4.7) and non-licensed birthing centers.

## MATERNITY–PHYSICIAN SERVICES

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

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 other types of care providers including, but not limited to, a licensed or non-licensed midwife (who is not also licensed as a nurse) are not eligible benefits.

## MEDICAL EQUIPMENT–DURABLE

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- "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.
- 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, 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.

| MUST BE PREAUTHORIZED | DO NOT NEED TO BE PREAUTHORIZED | ARE NOT COVERED |
|---|---|---|
| Apnea monitors for infants | Bilirubin lights | Air filtration systems |
| Bone-growth stimulators | Blood-pressure kits | Breast pumps, manual |
| Breast pumps, hospital grade | Breast prosthetics (external) for covered individuals with cancer | Cold/heat applications |
| Communication devices (one per lifetime) | Breast pumps, electric* | Dehumidifiers |
| CPAP/BiPAP machines | Canes | Exercise equipment |
| Cranial remolding helmets | Commodes (bedside) (one per lifetime) | Hearing aids for 26 and older |
| Defibrillator vests | Continuous passive motion machines (for knees only)** | Hearing devices |
| Gait trainers | Crutches | Humidifiers for home use |
| Hospital beds, mattresses, overlays, and accessories (e.g., overhead trapeze) | External erectile vacuum device (e.g., Erect-aid) (one per lifetime) | Interferential stimulators |
| Hoyer lifts | Hearing aids for younger than 26 | Knee braces used solely for sports |
| Implantable pain pumps | Nebulizer/Pulmo-Aide (purchase only) | Learning devices |
| Insulin pumps/continuous glucose monitors | Orthopedic braces | Lift chairs |
| Joint stretching devices | Oxygen, stationary** | Modifications associated with:<br>• Activities of daily living<br>• Homes<br>• Vehicles |
| Lymph presses/compression pumps | Protective helmets | Spa memberships |
| Oxygen concentrators | Scooter, knee (knee walker)*** | Vision devices |
| Respirators/ventilators | Slant boards/transfer boards | Whirlpools or hot tubs |
| Scooters, mobility | TENS units | |
| Seasonal Affective Disorder lights (one per lifetime) | Walkers | |
| Spinal cord stimulators | | |
| Vest airway clearance systems | | |
| Wheelchairs | | |
| Wound vacs | | |

* See the Preventive care services benefit.
** Preauthorization is required after 30 days.
*** Preauthorization is required after 90 days.

## MEDICAL SUPPLIES

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

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

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- Includes residential treatment centers (inpatient), partial hospitalization programs (outpatient), and intensive outpatient programs (outpatient).
- You must preauthorize.
- To be eligible for benefits, a manifest psychiatric disorder must be diagnosed.

## MENTAL HEALTH–INPATIENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize.

- To be eligible for benefits, a manifest psychiatric disorder must be diagnosed. Some diagnoses are not covered. See Exclusion 10.1.
- 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 Exclusion 10.1.
- Eligible services include individual therapy and group therapy. Family therapy is eligible only if the covered individual is present for therapy.
- Some therapy is not eligible for benefits. See Exclusion 10.2.
- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

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.

## NUTRITIONAL EDUCATION FOR EATING DISORDERS

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

- The nutritional education benefit is eligible for covered individuals diagnosed with eating disorders, such as anorexia or bulimia.
- A certified or licensed dietician or nutritionist must provide the service.

## OBESITY SURGERY

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize. Before DMBA will authorize this surgery, your provider must provide documentation showing the covered individual has been compliant with their prescribed treatment plan for at least one year.
- One surgery is covered per lifetime.
- Procedures eligible for benefits include: Roux-en-Y gastric bypass, vertical gastrectomy with duodenal switch, and gastric sleeve. All other surgical procedures are excluded.
- You must be at least 18 to be eligible.

## OFFICE VISITS

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

**Contracted specialist:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment.

- 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.

## PAIN MANAGEMENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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, such as 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.

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

**Non-contracted provider:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 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.
- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

Inpatient visits do not apply to your maximum annual outpatient benefit limit.

## PHYSICAL AND OCCUPATIONAL THERAPY–OUTPATIENT

**Contracted provider:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $30 copayment.

- The plan covers up to 30 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 therapy treatment in the same visit, you are responsible for both copayments.

## PRESCRIPTION DRUGS–LOCAL PHARMACY

If you take a prescription drug for the first time, if you need a small quantity, or if you need the prescription immediately, use a local retail pharmacy contracted with MRx. To learn about MRx and participating pharmacies, visit www.dmba.com or call 877-879-9722.

**Contracted or non-contracted provider:**

- The plan pays 70% of DMBA's allowable amount for formulary drugs at participating pharmacies; you pay 30%.
- Non-formulary medications are excluded.
- Non-preferred medications are not included on the formulary or preferred drug list; you pay 100%.

- For prescriptions that cost more than $5, you pay at least $5 or your coinsurance amount, whichever is greater.
- You must have a prescription from your healthcare provider. Prescription drugs must be approved by the FDA and provided by a licensed pharmacist.
- The plan covers up to a 30-day supply or 90 doses, whichever is greater.
- If you need more than a 30-day supply or 90 doses, you may save money by purchasing the medication from the contracted mail-order pharmacy.
- 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 MRx.
- 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 MRx.
- 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.)
- Medications that are not covered by the plan may be eligible for reimbursement through Flexible Spending.

## PRESCRIPTION DRUGS–MAIL-ORDER PHARMACY

If you take prescription drugs for an extended period, you may save money by ordering them through our mail-order pharmacy, Magellan Rx Pharmacy. First-time users of new medications should purchase their first prescription from a local retail pharmacy (30-day supply). To learn more about Magellan Rx Pharmacy and order your prescriptions, visit www.dmba.com.

**Contracted or non-contracted provider:**

- The plan pays 75% of DMBA's allowable amount for formulary medications; you pay 25%, but no more than $85 per prescription or refill, up to a 90-day supply.
- Non-formulary medications are excluded.
- Non-preferred medications are not included on the formulary or preferred drug list; you pay 100%.
- For prescriptions that cost more than $10, you pay at least $10 or your coinsurance amount, whichever is greater.
- For certain classes of drugs, the benefit is limited by quantity per prescription in accordance with federal, state, and manufacturer guidelines.
- You must preauthorize some medications. These may include long-term maintenance or large-quantity medications. If you don't preauthorize, you may be responsible for all charges. For specific information, please call MRx at 877-879-9722.
- Some items that can be prescribed but are not eligible for benefits 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.

- Expenses do not count toward the plan's out-of-pocket maximum. (See Out-of-pocket Maximum.)

## PRESCRIPTION DRUGS–PREFERRED DRUG STEP THERAPY

**Contracted or non-contracted provider:** In some situations, you must use a generic medication to treat a newly diagnosed condition before moving to a preferred brand-name medication.

## 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.

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

**Contracted provider or non-contracted provider:**

- The plan pays 90% of DMBA's allowable amount for formulary medication; you pay 10%, but no more than $85 per prescription.
- Non-formulary medications are excluded.
- Non-preferred medications are not included on the formulary or preferred drug list; you pay 100%.
- For medications from the specialty pharmacy, the plan covers a 30-day supply per prescription.
- For more information, call MRx at 877-879-9722.
- Expenses do not count toward the plan's out-of-pocket maximum. (See Out-of-pocket Maximum.)

## PREVENTIVE CARE SERVICES

Preventive care services are designed to help you stay healthy—to prevent illness and disease before it starts. They include immunizations and services that attempt to diagnose disease early to help you avoid serious health problems. Also included are services, such as 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.

When you receive specific preventive care services from contracted providers, most preventive services will be covered at 100% of DMBA's allowable amount. You won't have to pay any copayments or coinsurance.

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.

For information about which services are considered preventive and covered at 100% of DMBA's allowable amount, please see the tables that follow.

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

| PREVENTIVE CARE SERVICE | MEN | WOMEN | CHILDREN | AGE | FREQUENCY |
|---|---|---|---|---|---|
| Anemia screening | | • | | | |
| Aspirin to prevent cardiovascular disease (generic over-the-counter 81 mg and 325 mg strengths when filled at a pharmacy with a valid prescription)* | • | • | | 45 to 79 | |
| Bacteriuria screening (urinary tract infection) | | • | | | |
| Bilirubin screening (as part of delivery or routine exam) | | | • | | |
| Blood pressure screening | • | • | | | |
| Breast cancer chemoprevention | | • | | | |
| Breast cancer (BRCA) genetic testing (requires preauthorization) | | • | | | |
| Bowel preparation medications for colorectal cancer screening* | • | • | | | |
| Cervical cancer screening (PAP smear) | | • | | | |
| Chlamydia infection screening | | • | • | | |
| Cholesterol screening | • | • | • | | |
| Diabetes Type 2 screening | • | • | | | |
| Domestic and interpersonal violence screening and counseling (as part of a routine exam) | | • | | | |
| Dyslipidemia screening | | | • | | |
| Folic acid (generic over-the-counter when filled at a pharmacy with a valid prescription)* | | • | | 12 to 59 | |
| Gestational diabetes screening | | • | | | |
| Gonorrhea prophylactic medications | | | • | Newborn | |
| Gonorrhea screening | | • | • | | |
| Hemoglobinopathies (sickle cell screening) | | | • | | |
| Hepatitis B screening | | • | | | |
| HIV screening | • | • | • | | |
| Human papillomavirus (HPV) DNA test (cervical dysplasia screening) | | • | • | | |
| Hypothyroidism screening | | | • | | |
| Immunizations | • | • | • | | |
| Iron deficiency anemia prevention, hematocrit, or hemoglobin screening | | • | • | | |
| Iron supplements (generic over-the-counter when filled at a pharmacy with a valid prescription)* | | | • | 6 to 12 months | |
| Lead screening | | | • | | |
| Oral fluoride (when deficient in water and with a valid prescription)* | | | • | 6 months to 16 years | |
| Phenylketonuria (PKU) screening | | | • | | |
| Prostate cancer screening | • | | | | |
| Rh incompatibility screening | | • | | | |
| Rubella screening | | • | | | |
| Syphilis screening | • | • | | | |
| Tobacco use interventions* | • | • | | | |
| Tuberculosis (TB) testing | • | • | • | | |
| Vision screening | | | • | 0 to 4 | |
| Vitamin D (generic over-the-counter when filled at a pharmacy with a valid prescription)* | • | • | | 65 and older | |

* Purchased at a contracted pharmacy. 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.**

| Contracted provider: The plan pays 100% of DMBA's allowable amount.<br>Non-contracted provider: The plan pays 70% of DMBA's allowable amount; you pay 30%. | | | | | |
|---|---|---|---|---|---|
| **PREVENTIVE CARE SERVICE** | **MEN** | **WOMEN** | **CHILDREN** | **AGE** | **FREQUENCY** |
| Abdominal aortic aneurysm screening | • | • | | 65 and older | One per lifetime |
| Alcohol misuse screening | • | • | | | |
| Autism and developmental screenings | | | • | 18 months to 10 years | Two per lifetime |
| Breast cancer mammography screening | | • | | 40 and older | Annually |
| Breastfeeding comprehensive support and counseling | | • | | | |
| Breast pump, electric | | • | | | One every three years |
| Colorectal cancer screening | • | • | | | One every five years |
| Diet counseling for cardiovascular disease | • | • | | | One per calendar year |
| Hearing loss screening | | | • | 0 to 90 days | |
| HIV counseling | | • | | | |
| Obesity screening and counseling | • | • | • | | Three per calendar year |
| Osteoporosis screening | | • | | | One per lifetime |
| Sexually transmitted infection (STI) prevention counseling | • | • | • | | |
| Tobacco use counseling | • | • | | | |
| Topical fluoride application by physician to prevent dental caries | | | • | | |

| Contracted provider: The plan pays 100% of DMBA's allowable amount.<br>Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment. | | | | | |
|---|---|---|---|---|---|
| **PREVENTIVE CARE SERVICE** | **MEN** | **WOMEN** | **CHILDREN** | **AGE** | **FREQUENCY** |
| Alcohol misuse counseling | • | • | | | |
| Breast cancer chemoprevention counseling | | • | | | |
| Breast cancer (BRCA) risk assessment and genetic counseling | | • | | | |
| Tuberculosis (TB) risk assessment (as part of a routine exam) | • | • | • | | |
| Routine physical exam | • | • | | | One per calendar year |
| Well-woman exam | | • | | | One per calendar year |
| Well-child visits | | | • | | |

| Contracted provider: The plan pays 100% of DMBA's allowable amount.<br>Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $20 copayment. | | | | | |
|---|---|---|---|---|---|
| **PREVENTIVE CARE SERVICE** | **MEN** | **WOMEN** | **CHILDREN** | **AGE** | **FREQUENCY** |
| Depression screening | • | • | • | | |

**Review your online personal preventive care report:**

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 choosing the *Routine Care* tile after logging into www.dmba.com.

## PROSTHETICS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

Certain types of radiation therapy must be preauthorized.

## RADIOLOGY–MRIS, MRAS, PET, AND SPECT SCANS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

You must preauthorize all services except MRIs and SPECT scans.

## RADIOLOGY–X-RAYS AND CT SCANS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

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

## RESPIRATORY EDUCATION

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

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

## SKILLED NURSING FACILITY

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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 100 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.

## SPEECH THERAPY–INITIAL EVALUATION

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

The initial evaluation does not require preauthorization.

## SPEECH THERAPY–INPATIENT

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

Inpatient visits do not apply to your maximum annual outpatient benefit limit.

## SPEECH THERAPY–OUTPATIENT

**Contracted provider:** The plan pays 100% after your $20 copayment.

**Non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $30 copayment.

- Preauthorization is required.
- The plan covers up to 30 outpatient visits per calendar year.

## SURGERY–INPATIENT AND PHYSICIAN SERVICES

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- 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.

## TELEMEDICINE

**Contracted provider visit:** The plan pays 100% of DMBA's allowable amount after your $15 copayment per visit or your $20 copayment per visit for a specialist.

**Non-contracted provider visit:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment per visit.

**Contracted and non-contracted provider urgent care:** The plan pays 100% of DMBA's allowable amount after your $25 copayment per visit.

- All telemedicine services are paid at the applicable plan benefit.
- Telemedicine is available for appropriate services if such services would have been covered under the plan if provided in person.

## TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- The lifetime maximum benefit is $1,000. This limit does not apply to MRIs, anesthesia, or surgery for TMJ dysfunction.
- Night guards (occlusal guards) for grinding teeth are not eligible for benefits.
- Orthognathic surgery is not eligible for benefits when it is used to treat TMJ dysfunction.
- Expenses do not count toward the plan's out-of-pocket maximum. (See Out-of-pocket Maximum.)

## TRANSPLANTS

**Contracted provider:** The plan pays 90%; you pay 10%.

**Non-contracted provider:** The plan pays 70% of DMBA's allowable amount; you pay 30%.

- You must preauthorize.
- If you meet DMBA eligibility requirements, these transplants are covered:
  - » Blood or bone marrow stem cell
  - » Combined heart/lung

  - » Combined pancreas/kidney
  - » Cornea (preauthorization not required)
  - » Heart
  - » Intestine
  - » Kidney
    - Renal auto-transplantation may be available for the treatment of loin pain hematuria syndrome
  - » Liver
  - » Lung
- Other transplants are not eligible for benefits.
- Limitations apply to donor benefits.
- For prescription drugs associated with a covered transplant, see Prescription drugs.

## TRANSPORTATION

**Contracted or non-contracted provider:** The plan pays 90% of DMBA's allowable amount; you pay 10%.

- You must preauthorize.
- When services meet our medical criteria, the plan covers transportation services to the nearest medical facility equipped to furnish the appropriate care.
- Generally, this benefit covers transportation for the covered individual only. But in some situations, it may cover transportation for one parent or guardian to accompany a child younger than 19.
- If you travel by automobile, the benefit is based on the IRS standard mileage rate—after the first 200 miles per round trip.
- If you travel by airplane or train, contact DMBA for more information.
- This benefit does not cover hotels, meals, or any other personal expenses.
- For more information on other transportation services, see the Ambulance benefit.

## URGENT CARE

**Contracted or non-contracted provider:** The plan pays 100% of DMBA's allowable amount after your $25 copayment per visit.

- The office visit is covered at 100% of DMBA's 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.

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.

## WELL-CHILD CARE

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

**Non-contracted PCP:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment.

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

**Non-contracted specialist:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 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 70% of DMBA's allowable limit; you pay 30%.

### WELL-WOMAN EXAMS

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

**Non-contracted PCP:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 copayment.

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

**Non-contracted specialist:** The plan pays 80% of DMBA's allowable amount; you pay 20% after your $20 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

## LEAVING THE SERVICE AREA TEMPORARILY

If you leave the Deseret Choice Hawaii service area temporarily (90 days or less), you can remain enrolled in the plan. Your benefits will be based on benefits from non-Deseret Choice Hawaii providers. Your family members who stay in the service area will still be covered by regular plan benefits.

If the majority of your family members leave the service area for more than 90 days, you cannot remain enrolled in the plan. Contact DMBA for help in switching to another plan available in your area.

## DEPENDENTS WHO LIVE AWAY FROM HOME

### Within the plan service area

You and each of your eligible dependents can live in different areas. But if you are enrolled in Deseret Choice Hawaii, your entire family must be enrolled in Deseret Choice Hawaii.

If you have eligible dependents who live away from home but within the Deseret Choice Hawaii service area, encourage them to coordinate their medical care with their own PCPs.

### Outside the plan service area

If any of your dependents live away from home and outside the plan service area, benefits for non-Deseret Choice Hawaii providers apply, as well as other Deseret Choice Hawaii guidelines and limitations, such as preauthorization.

## 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, please have your physician complete the online *Provider Preauthorization Request* form on www.dmba.com at least 7 to 10 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.

Failure to preauthorize, when necessary, will result in a denial of your claim. If you appeal a claim for benefits that was denied for failure to preauthorize, the denied claim may be approved by DMBA on post-service review, subject to a penalty (usually $200), which is payable by you, in addition to your coinsurance.

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.

## 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 $2,000 from contracted providers or $3,000 for services from non-contracted providers, benefits increase to 100% for eligible charges, after any copayments, based on allowable amounts.

**For families:** After your share of eligible expenses reaches $3,500 for services from contracted providers or $7,000 from non-contracted providers, benefits increase to 100% for eligible charges, after any copayments, based on allowable amounts.

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:

- Lifestyle screenings
- Prescription drugs
- Specialty pharmacy
- TMJ dysfunction

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
- 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% 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 & Dental 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 MRx, not DMBA. To contact MRx, 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.

## MEDICAL BENEFITS DURING DISABILITY

If you become disabled and unable to work, your medical coverage will continue for at least three months after the month in which you became disabled. Benefits are not limited to expenses you incur solely for treating the sickness that caused your disability. Benefits will continue on the same basis as they were before you became disabled.

Also, the continuation of your medical coverage is not contingent on you receiving Deseret Healthcare Disability Income Plan benefits because the requirements for both benefits may differ based on Hawaii state law.

## 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 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 the person to whom you are legally married.

# 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 covered individual beyond the acute phase of injury or sickness and includes room, meals, bed, or skilled or unskilled medical care at any hospital, care facility, or home to assist the covered individual with activities of daily living including, but not limited to, feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, or ambulation. The covered individual'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; or
- 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, meet all of the following criteria:

- It must have final approval from all appropriate governmental regulatory

bodies, if applicable. (Federal Drug Administration approval does not necessarily mean a service is not investigational/experimental.)

- 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

A service, care, treatment, or operation falling in the categories described herein will continue to be excluded until the plan administrator determines that it meets all such criteria and specifically includes it as a covered service in the plan.

## 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 covered individual meets DMBA's current medical criteria.

**4.2** Abortion and medications to induce abortion, except in cases of rape, incest, or when the life of the mother and/or fetus would be seriously endangered if the fetus were carried to term.

**4.3** Care, services, diagnostic procedures, or operations in relation to the following infertility services: direct intraperitoneal insemination (DIPI), fallopian tubal sperm perfusion (FSP), intra-follicular insemination (IFI), and the GIFT procedure.

**4.4** Donor eggs, sperm, or embryos (including services related to procurement of donor material) used in assisted reproductive technologies.

**4.5** Cryopreservation (freezing), storage, and thawing of sperm, eggs, embryos, and ovarian and/or testicular tissue.

**4.6** Reversal of sterilization procedures.

**4.7** Planned home delivery for childbirth and all associated costs.

**4.8** All pregnancy- and birth-related expenses (prenatal and postnatal) of an individual (including a covered individual) acting as a surrogate or gestational carrier. An infant born to a surrogate or gestational carrier is eligible for coverage from the date on which the infant became a dependent of the participant.

**4.9** Services, drugs, or supplies to treat sexual dysfunction, erectile dysfunction, enhance sexual performance, or increase sexual desire. This exclusion does not apply to the external erectile vacuum erection device under the durable medical equipment benefit.

## 5. Government/war

**5.1** Services and supplies received as a result of a covered individual's participation in insurrection, terrorism, war or act of war (declared or undeclared), or due to an injury or illness sustained in the armed services of any country.

**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 The purchase or fitting of hearing aids, except for covered individuals younger than age 26.

6.2 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 Services and supplies for an illness or injury sustained while committing or attempting to commit an assault or felony, whether or not criminal charges are filed or a conviction results. Subject to the nondiscrimination provisions of HIPAA, this exclusion does not apply if the injury resulted from a medical condition (including both physical and mental health conditions) or from being the victim of an act of domestic violence.

7.4 Complications resulting from excluded services.

7.5 Court-ordered treatment unless such services are medically necessary and are otherwise covered under the plan.

7.6 Services and supplies provided to a covered individual while incarcerated in a federal, state, or local correctional facility; in the custody of federal, state, or local law enforcement authorities; required as a condition of parole; or participating in a work release program.

7.7 Court-ordered testing, such as drug screening and confirmatory drug testing.

7.8 Reports, evaluations, or examinations not required for health reasons, such as employment or insurance, or for legal purposes, such as custodial rights, paternity suits, sports physicals, legal defenses or disputes, etc.

7.9 Services not expressly specified as a benefit or covered expense.

7.10 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.

7.11 Mandated state service charges and taxes.

## 8. Medical equipment

8.1 General/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 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.

8.4 Maintenance, repair, and upkeep of durable medical equipment.

## 9. Medical necessity

9.1 Care, services, or supplies primarily for cosmetic purposes (whether or not for psychological or emotional reasons), to improve or change appearance or to correct a deformity without restoring a physical bodily function, except for injuries suffered while covered by the plan or as otherwise provided for by the terms of the plan.

9.2 Care, services, or supplies 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. 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 supplies 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.

## 10. Mental health, counseling, chemical dependency

**10.1** Mental or emotional conditions without manifest psychiatric disorder as described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM),or non-specific symptoms.

**10.2** Counseling (including, but not limited to, marriage and family counseling, recreational therapy, or other therapy). Counseling for a covered individual's diagnosed psychiatric disorder is not considered family or marriage therapy even though the family or spouse is present.

**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 covered individuals with mental illness.

## 11. Miscellaneous

**11.1** Services of any practitioner of the healing arts who:

- ordinarily resides in the same household with the covered individual, or
- has legal responsibility for financial support and maintenance of the covered individual.

**11.2** Care, services, supplies, or other expenses when it has been determined that brain death has occurred.

**11.3** Gender reassignment surgery, including all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.) used to facilitate gender transition.

**11.4** Reproductive organ prosthesis.

**11.5** Charges over and above the allowable amount or reasonable and customary amount 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 supplies in connection with obesity, unless the covered individual meets DMBA'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 whose use is for cosmetic purposes, over-the-counter (non-legend) products, vitamins (except prenatal vitamins and prescribed infant vitamins), weight-reduction aids, and non-formulary drugs, except to the extent specifically provided in the plan (including any requirements regarding preauthorization).

## 15. Testing

15.1 Some 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 (intradermal, subcutaneous, or sublingual), Rebuck skin window test, and Rinkel test.

## 16. Transplants

16.1 Care, services, medications, or supplies in relation to organ transplants (donor or artificial), unless the covered individual 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.

# 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—such as 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.*