DESERET PREMIER

This summary plan description, or SPD, outlines the major provisions of Deseret Premier as of January 1, 2024.

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Deseret Premier Key Points

- Generally, Deseret Premier covers contracted providers at 90% and non-contracted providers at 80% of DMBA's allowable amount.
- Certain preventive services—such as colonoscopies, mammograms, physical exams, and well-child care—from contracted providers are covered at 100%.
- Deseret Premier has an annual deductible of $400 per person or $800 per family for services from non-contracted providers.
- Your annual out-of-pocket maximum is $2,800 per person or $5,600 per family.
- Copayments apply to some benefits, including office visits. Copayments for most benefits are not required after your annual out-of-pocket maximum is reached.
- You or your physician must preauthorize some services with DMBA, such as some surgeries and home healthcare.

Maximizing Your Benefits

Contracted providers

All DMBA health plans are preferred provider organizations, or PPOs, meaning you pay less out of pocket 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 amount.

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. Your share of the expenses increases and you are responsible for all expenses that exceed allowable amounts.

Services from non-contracted providers will apply to your annual deductible.

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 and select *Find a Provider*. Our contracted organizations include the following:

Hawaii	MDX Hawaii Network	808-466-4077
Southeast Idaho and Utah	DMBA contracted providers	800-777-3622 or www.dmba.com
Other areas	UnitedHealthcare Options PPO Network	800-777-3622 or www.dmba.com

Preauthorize when needed

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. You may be responsible for a preauthorization penalty (usually $200) in addition to the appropriate coinsurance. If DMBA ultimately denies benefits for the service, you will be responsible for all charges.

For more information, see *Preauthorization* and *Your Medical Benefits*.

Annual Deductible

When you receive care from non-contracted providers, the annual deductible is $400 per person or $800 per family. This deductible is cumulative—you only need to satisfy the deductible once during the calendar year before normal benefits begin.

Submit claims to DMBA while you're meeting the annual deductible. Through standard claims submission, we track the amounts applied to your deductible. You can see how much has been applied by logging in to www.dmba.com and checking the *Deseret Premier* tile on your dashboard.

For information about how the annual deductible applies to your benefits, see the individual benefits in *Your Medical Benefits*, which follows.

Your Medical Benefits

To be a covered service, the healthcare you receive must be medically necessary, meet the plan's guidelines and medical criteria, and be provided by a licensed practitioner of the healing arts. **All benefits are subject to the allowable amounts determined by DMBA.**

Acupuncture

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment. The annual deductible applies.

Up to 12 visits are covered per calendar year.

You may receive more than one service in a single visit.

Allergy testing

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Some testing, such as ALCAT and LHRT, is not covered. See *Exclusion 15.1*.

For information about injections for allergies, see *Injections*.

Ambulance—emergency

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

Covered services when DMBA's medical criteria are met:

- Licensed ambulance services to the nearest medical facility equipped to furnish the appropriate care
- Air ambulance services

Medical services and supplies provided during the transportation are covered at the appropriate benefit levels for those services.

Examples of services not covered:

- Wheelchair van services
- Gurney van services
- Transportation not associated with emergency services
- Repatriation from an international location back to the United States

For more information about 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

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

To be covered, a board-certified behavior analyst (BCBA or BCBA-D) must provide therapy for an individual with a confirmed autism spectrum disorder diagnosis by a qualified provider (i.e., psychiatrist, psychologist, neurologist, or developmental pediatrician).

You must preauthorize, including the initial assessment.

Behavioral (mental) health and substance use disorders

To be covered, an individual must be diagnosed with and treated for a mental disorder included in the current *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient

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

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

Covered services:

- Individual therapy
- Group therapy

Some therapies, such as educational groups, are not covered. See *Exclusion 10.2*.

Inpatient, partial hospital, and intensive outpatient treatment, and outpatient testing

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered services:

- Acute inpatient hospitalization
- Residential treatment services
- Partial hospitalization programs (PHP)
- Intensive outpatient programs (IOP)
- Psychological and neuropsychological testing

Preauthorization is required. In case of emergency, call DMBA within two business days after the admission or as soon as reasonably possible.

Cardiac rehabilitation

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Chemotherapy—provider-administered

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You may have to preauthorize.

Oral chemotherapy agents and self-administered medications may be covered by the *Prescription drugs—specialty pharmacy* benefit.

Chiropractic therapy

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment. The annual deductible applies.

Up to 25 visits per calendar year are covered.

If you're billed for an evaluation and for a therapy treatment in the same visit, you're responsible for both copayments.

Full-body X-rays are not covered.

Colorectal cancer screening or colonoscopy

Screenings can be preventive or diagnostic. A preventive screening that results in a diagnosis is considered diagnostic and services will be paid under the diagnostic benefit.

Preventive

Contracted provider: The plan pays 100%.

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

A preventive exam once every five years is covered for individuals age 45–75.

Anesthesia for preventive procedures is covered at 100% of DMBA's allowable amount.

Virtual colonoscopies are not covered.

Diagnostic

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Anesthesia for diagnostic procedures is covered at the appropriate benefit level for that service.

Virtual colonoscopies are not covered.

Contraceptive products

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered products:

- Oral hormonal contraceptive pills, contraceptive patches, and vaginal rings listed on the prescription drug formulary
- Intrauterine devices (IUDs)
- Injectable medroxyprogesterone acetate (e.g., Depo-Provera)

Not covered:

- Over-the-counter contraceptives
- Contraceptive products not listed on the prescription drug formulary
- Implantable rods, contraceptive sponges, cervical caps, male and female condoms, spermicides, and emergency contraceptive products (e.g., levonorgestrel and ulipristal acetate)
- Sterilization procedures, unless DMBA's medical criteria are met

Convenient care clinic

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

Services provided during the visit, such as lab work and X-rays, are covered 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.

Diabetes

Education

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

To be covered, an individual must be diagnosed with diabetes, gestational diabetes, or dysmetabolic syndrome X.

Programs and services not covered:

- Educational programs available to the general public without charge
- General health or lifestyle education programs unrelated to the diagnosis or condition
- Services not generally accepted as necessary and appropriate for management of the disease

Glucometers

For a glucometer, call Navitus at 833-354-2226.

Insulin pumps

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

One pump every four years is covered.

You must preauthorize.

Supplies

Contracted provider: The plan pays 90% for a 90-day supply from the mail-order pharmacy or a 30-day supply from a retail pharmacy; you pay 10%.

Covered supplies:

- Syringes
- Lancets
- Insulin pump supplies

Insulin is covered by the *Prescription drugs* benefit.

Test strips

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

Non-contracted pharmacy: You pay 100%.

Test strips compatible with covered glucometers are covered.

For equipment that costs more than $5, you pay $5 or your coinsurance amount, whichever is greater.

Dialysis

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Durable medical equipment

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered equipment:

- Medical equipment or tools prescribed by your healthcare provider that are used repeatedly, serve a medical purpose, and are not useful to people in the absence of illness, injury, or congenital defect
- Bedside commodes, communication devices, external erectile vacuum devices (e.g., ErecAid), and light boxes/SAD lights, once per lifetime
- Replacement of some equipment, at specific intervals

You must preauthorize some medical equipment. The medical equipment table that follows lists common equipment that must be preauthorized, items you do not need to preauthorize, and items that are not covered. **The table is not intended to be all-inclusive.**

Some equipment must be rented before it can be purchased. In some instances, if you purchase the equipment after you rent it, the rental price may be applied to the purchase price.

Maintenance, repair, and upkeep of medical equipment are not covered.

Table: Medical equipment

	Must be preauthorized	No preauthorization needed	Not covered
Air filtration system			•
Apnea monitor for infants	•		
Bilirubin light		•	
Blood pressure kit		•	
Bone growth stimulator	•		
Breast prosthetics, external, for individuals with cancer		•	
Breast pump, electric*		•	
Breast pump, hospital grade	•		
Breast pump, manual			•
Cane		•	
Cold/heat application			•

All benefits are subject to the allowable amounts.

	Must be preauthorized	No preauthorization needed	Not covered
Commode, bedside (one per lifetime)		•	
Communication device (one per lifetime)	•		
Continuous passive motion machine (for knees only)**		•	
CPAP/BiPAP machine	•		
Cranial remolding helmet	•		
Crutches		•	
Defibrillator vest	•		
Dehumidifier			•
Exercise equipment			•
External erectile vacuum device (e.g., ErecAid) (one per lifetime)		•	
Gait trainer	•		
Hearing aids		•	
Hearing device			•
Hospital bed, mattress, overlay, and accessories (e.g., overhead trapeze)	•		
Hoyer lift	•		
Humidifier for home use			•
Implantable pain pump	•		
Insulin pump/continuous glucose monitor	•		
Interferential stimulator			•
Joint stretching device	•		
Knee brace used solely for sports			•
Learning device			•
Lift chair			•
Lymph press/compression pump	•		
Modification for home, vehicle, or activities of daily living			•
Nebulizer/Pulmo-Aide (purchase only)		•	
Orthopedic brace		•	
Oxygen concentrator	•		
Oxygen, stationary**		•	
Protective helmet		•	
Respirator/ventilator	•		
Scooter, knee/knee walker***		•	
Scooter, mobility (purchase)	•		
Scooter, mobility (rental)***		•	
Seasonal Affective Disorder light (one per lifetime)	•		
Slant board/transfer board		•	

All benefits are subject to the allowable amounts.

	Must be preauthorized	No preauthorization needed	Not covered
Spinal cord stimulator	•		
TENS unit		•	
Vest airway clearance system	•		
Vision device			•
Walker		•	
Wheelchair (purchase)	•		
Wheelchair (rental)***		•	
Whirlpool or hot tub			•
Wound vac	•		

* See the preventive care services table for information about benefit frequency.
** Preauthorization is required after 30 days.
*** Preauthorization is required after 90 days.

Emergency room

Contracted or non-contracted provider: The plan pays 90% of DMBA's allowable amount; you pay 10% after your $100 copayment per visit.

If you receive follow-up care at the emergency room, you're responsible for another $100 copayment plus your 10% coinsurance.

If your emergency is not life threatening, see *Urgent care* for a less expensive alternative.

Other services you receive during an emergency room visit that are billed separately are covered 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.

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%.

Covered services:

- Enteral formula for inborn errors of metabolism (e.g., PKU)
- Feeding tube delivering the sole source of nutrition as defined by DMBA's medical criteria

You must preauthorize.

Eye exams

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Covered services:

- One routine eye exam each calendar year
- Eye exams for medical conditions, such as glaucoma, as needed

Eyewear (glasses or contact lenses)

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

Covered supplies:

- One pair of glasses or contact lenses needed as a result of a covered eye surgery and purchased within one year of the surgery
- Contact lenses for individuals with a diagnosis of keratoconus

All other eyewear is not covered.

Functional cosmetic surgery

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered procedures when DMBA's medical criteria are met:

- 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

You must preauthorize.

Other surgeries with a cosmetic component are not covered. (See *Exclusion 9.1*.)

Genetic counseling

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Contracted specialist: The plan pays 100% after your $35 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Genetic counseling must be provided by a certified genetic counselor or board-certified medical geneticist.

Genetic testing

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

You must preauthorize.

Not all genetic testing is covered.

Hearing aids

Contracted provider: The plan pays 90%, up to $1,200 per ear once every three years; you pay 10%.

Non-contracted provider: The plan pays 80% of DMBA's allowable amount, up to $1,200 per ear once every three years; you pay 20%. The annual deductible applies.

Prescription hearing aids prescribed by a licensed audiologist are covered.

Over-the-counter (OTC) hearing aids, hearing aids not prescribed by an audiologist, and other personal sound amplification products are not covered.

Hearing exams

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Contracted specialist: The plan pays 100% after your $35 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Hearing testing (audiometry)

Contracted provider: The plan pays 100% for individuals from birth through 90 days. For individuals older than 90 days, the plan pays 90%; you pay 10%.

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

One test per lifetime is covered for individuals from birth through 90 days.

Home healthcare

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

To be covered, a licensed registered nurse (RN) or a licensed practical nurse (LPN) must provide the services.

You must preauthorize.

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. See *Exclusion 1*.

Hospice care

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered services for individuals who have a terminal illness and are expected to live less than six months:

- A coordinated team of hospice professionals
- Bereavement services
- Counseling services for 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

You must preauthorize.

Hospice care services are covered at the appropriate benefit levels for those services.

Hospital—inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You must preauthorize.

Imaging services (radiology)

Diagnostic

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

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

Examples of covered services:

- X-rays
- Computed tomography (CT) scans
- Ultrasounds

Advanced

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Examples of covered services:

- Electrocardiograms (EKG)
- Echocardiograms
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET) scans
- Single-photon emission computed tomography (SPECT) scans

You must preauthorize all services except MRIs and SPECT scans.

Immunizations

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

Commonly covered immunizations/vaccines:

- COVID-19
- Diphtheria/Pertussis/Tetanus (DTaP, Tdap)
- Diphtheria/Tetanus (DT)
- Haemophilus Influenzae (Hib)
- Hepatitis A and B
- Human Papillomavirus (HPV), for individuals aged 9–26
- Influenza
- Measles/Mumps/Rubella (MMR)
- Meningococcal (MenACWY, MenB)
- Pneumococcal
- Polio
- Rotavirus
- Shingles (zoster, Shingrix), for individuals aged 50–99
- Tetanus
- Tetramune
- Varicella/chicken pox (VAR)
- Yellow fever

Infertility services

Artificial insemination

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

In vitro fertilization (IVF)

Contracted or non-contracted provider: The plan pays up to $10,000 per lifetime for a participant, whether used by the participant, a spouse, a dependent, or a combination thereof.

To be covered, the patient's spouse must be the donor for all tissue used for an IVF cycle, including but not limited to eggs, sperm, and embryos, and DMBA's medical criteria must be met.

You must preauthorize.

Services you receive with IVF, such as surgery, office visits, lab work, and anesthesia, are covered at the appropriate benefit levels for those services and apply to the IVF lifetime benefit limit.

Injections and IV therapy

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You may need to preauthorize.

Laboratory services

Outpatient

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

You may need to preauthorize.

Inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Lifestyle screenings

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

All benefits are subject to the allowable amounts.

Covered once every three calendar years for the employee and spouse:

- 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.

Services for dependent children are not covered.

Mammograms

Screenings can be preventive or diagnostic. A preventive screening that results in a diagnosis is considered diagnostic and services will be paid under the diagnostic benefit.

Preventive

Contracted provider: The plan pays 100%.

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

Covered services:

- One mammogram each calendar year for women 40 and older
- 3D mammograms

Diagnostic

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

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

Covered services:

- Mammograms as often as medically necessary
- 3D mammograms

Maternity

Physician services

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

All benefits are subject to the allowable amounts.

To be covered, a licensed medical professional, such as a physician (MD), nurse practitioner (NP), or certified nurse midwife (CNM) must provide the services.

Inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered services:

- Services provided in an inpatient hospital setting
- Newborn services
- Extended hospital stays with preauthorization after two days for a vaginal delivery or after four days for a cesarean section delivery

Services received in other settings may not be covered, including but not limited to home birth (see *Exclusion 4.8*) and non-licensed birthing centers.

Medical supplies

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered supplies:

- Disposable, one-use-only medical items for immediate use
- Dressings
- Compression stockings provided or prescribed by your healthcare provider

Nutritional education

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

To be covered, a certified or licensed dietician or nutritionist must provide education for an individual diagnosed with an eating disorder, such as anorexia or bulimia, or with Celiac disease.

Obesity surgery

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

One procedure per lifetime for individuals at least 18 years old is covered:

- Roux-en-Y gastric bypass

All benefits are subject to the allowable amounts.

- Vertical gastrectomy with duodenal switch
- Gastric sleeve

You must preauthorize with provider documentation that the patient has complied with his or her prescribed treatment plan for at least one year.

All other surgical procedures are not covered.

Occupational therapy

Outpatient

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment. The annual deductible applies.

Up to 25 visits per calendar year are covered.

You must preauthorize additional visits.

You must preauthorize cognitive rehabilitation therapy.

If you are billed for both evaluation and treatment in the same visit, you are responsible for both copayments. Multiple copayments also apply if you receive more than one type of therapy in the same visit.

Inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

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

Office visits

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Contracted specialist: The plan pays 100% after your $35 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

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

Other services, such as lab work and X-rays, are covered at the appropriate benefit levels for those services.

Osteoporosis screening

Screenings can be preventive or diagnostic. A preventive screening that results in a diagnosis is considered diagnostic and services will be paid under the diagnostic benefit.

Preventive

Contracted provider: The plan pays 100%.

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

One screening per lifetime for women is covered.

Diagnostic

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

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

Covered services:

- Bone density scans, once every five years
- Bone density scans, once per year for individuals diagnosed with osteoporosis or osteopenia

Pain management

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You must preauthorize inpatient services, some physician services, outpatient procedures, and durable medical equipment, such as implantable pain pumps and spinal cord stimulators.

Services you receive with pain management are covered at the appropriate benefit levels for those services.

Physical exams

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Covered services:

- One office visit with exam every calendar year
- Recommended and related procedures and lab work

All benefits are subject to the allowable amounts.

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

Related services, such as lab work and X-rays, are covered at the appropriate benefit levels for those services.

Some services may not be covered as part of a physical exam.

Labs and routine procedures are not covered when associated with an exam that is not covered.

For information about screenings for women, see *Mammograms* and *Well-woman exams*.

Physical therapy

Outpatient

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment. The annual deductible applies.

Up to 25 visits per calendar year are covered.

You must preauthorize additional visits.

You must preauthorize cognitive rehabilitation therapy.

If you are billed for both evaluation and treatment in the same visit, you are responsible for both copayments. Multiple copayments also apply if you receive more than one type of therapy in the same visit.

Inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

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

Prescription drugs

The prescription drug benefit is administered by Navitus Health Solutions. As the administrator for the prescription drug program, Navitus processes payments for claims, answers questions, and reviews appeals according to the plan's provisions. Navitus has been delegated authority to, in its sole discretion, interpret plan provisions as well as facts and other information for claims and appeals for the prescription drug benefit. Navitus's decisions on claims and appeals are final and binding. For the time limits on prescription drug benefit appeals administered by Navitus see the *General Information SPD*.

Navitus has a network of retail pharmacies, a mail-order pharmacy program, and a specialty pharmacy. To find out whether a pharmacy is in this network, call Navitus at 833-354-2226 or visit memberportal.navitus.com/landing. If you buy prescription drugs from a non-network pharmacy, you must pay the non-network pharmacy's price and then

submit a claim form for reimbursement directly to Navitus. The claim will be reimbursed according to plan guidelines based on the plan's allowable amount for that medication (not at the price paid at the non-network pharmacy) minus the applicable coinsurance that you would have paid. This means you will not be reimbursed for the difference between the discounted network pharmacy price and the non-network pharmacy price for a prescription.

You must preauthorize certain medications, including but not limited to long-term maintenance or large-quantity medications, and some provider-administered medications, including high-cost or specialty medications administered in a physician's office, outpatient facility, or home.

Certain medications require step therapy, which means you must use a preferred alternative medication to treat a condition before moving to another formulary medication.

For some classes of drugs, the benefit is limited by quantity per prescription in accordance with federal, state, and manufacturer guidelines. In addition, certain medications may be subject to age or gender limits.

Expenses do not count toward the plan's out-of-pocket maximum.

If this is your first time using a medication, purchase a 30-day supply from a retail pharmacy.

If you need more than a 30-day supply, you may save money by purchasing the medication from the mail-order pharmacy.

Medications not covered:

- Drugs not approved by the Federal Drug Administration (FDA)
- Drugs to prevent or delay pregnancy that do not meet current medical criteria
- Dietary or nutritional products, including special diets for medical problems
- Medications used for sexual dysfunction
- Non-formulary medications
- Over-the-counter medications, except as provided for by the terms of the plan
- Products used to stimulate hair growth
- Vitamins, except prescribed prenatal and infant vitamins
- Weight-reduction aids

Medications that are not covered by the plan may be eligible for reimbursement through Flexible Spending.

For more information about the prescription drug benefit, call Navitus at 833-354-2226 or visit memberportal.navitus.com/landing.

Mail-order pharmacy

Costco Mail Order Pharmacy: The plan pays 75%; you pay 25%, but no more than $115 per prescription or refill, up to a 90-day supply.

Other mail-order pharmacy: You pay 100%.

All benefits are subject to the allowable amounts.

For prescriptions that cost more than $5, you pay $5 or your coinsurance amount, whichever is greater.

Preventive

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

See the preventive care services table.

Retail pharmacy

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

Non-contracted pharmacy: The plan reimburses you 70% of DMBA's allowable amount after you pay the full price and submit a claim to Navitus.

Up to a 30-day supply is covered.

For prescriptions that cost more than $5, you pay $5 or your coinsurance amount, whichever is greater.

90-day retail pharmacy

Contracted 90-day retail pharmacy: The plan pays 70%; you pay 30%, but no more than $150 per prescription.

Non-contracted 90-day retail pharmacy: You pay 100%.

Up to a 90-day supply is covered, unless adjusted based on the drug manufacturer's packaging size or any additional supply limits adopted by Navitus.

For prescriptions that cost more than $5, you pay $5 or your coinsurance amount, whichever is greater.

Specialty pharmacy

Contracted specialty pharmacy: The plan pays 90%; you pay 10%, but no more than $115 per prescription.

Non-contracted specialty pharmacy: You pay 100%.

Up to a 30-day supply per prescription of some expensive formulary medications that require special handling and treat complex or rare conditions is covered.

Preventive care services

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

Non-contracted provider: Varies by service.

See the preventive care services table.

Preventive care services are designed to help you stay healthy—to prevent illness and disease before they start. They include services that attempt to diagnose disease early, discover issues early, and give you a better chance of recovery.

Examples of covered services:

- Immunizations/vaccines
- Screening tests
- Routine exams
- Some types of counseling

Services not covered:

- Any service or benefit related to an illness, injury, or medical condition you already have
- Services billed as diagnostic
- Services considered by DMBA to be an integral part of a routine exam*

For information about services that are considered preventive, see the following table.

Table: Preventive care services

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
Routine exams							
• Newborn (inpatient hospital)			•			100%	80%; annual deductible applies
• Ages 0–4 years			•	Birth to 4 years (ends on fifth birthday)		100%	100% after copayment ($25 for PCP; $40 for specialist)
• Ages 5 and older	•	•	•	5 years and older	Once per calendar year	100%	100% after copayment ($25 for PCP; $40 for specialist)
• Well-woman exam (routine and gynecological)		•			Once per calendar year	100%	100% after copayment ($25 for PCP; $40 for specialist)

All benefits are subject to the allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
Abdominal aortic aneurysm (AAA) screening	•			65–75	Once per lifetime	100%	90% for professional services; 80% for facility
BRCA-related cancer: genetic counseling		•				100%	100% after $40 copayment
BRCA-related cancer: genetic testing (requires preauthorization)		•			Once per lifetime	100%	100%
Breast cancer (mammography) screening		•		40 and older	Once per calendar year	100%	90% for professional services; 80% for facility
Breast pump, electric		•			Once every three years	100%	80%; annual deductible applies
Breastfeeding counseling		•			Six times per calendar year	100%	80%; annual deductible applies
Cervical cancer screening (human papillomavirus (HPV) DNA test and PAP smear)		•		21–65	Once per calendar year	100%	100%
Colorectal cancer screening (Fecal occult blood [FOBT], FIT)	•	•		45–75	Once per calendar year	100%	100%
Colorectal cancer screening (FIT-DNA)	•	•		45–75	Once every three years	100%	100%
Colorectal cancer screening (colonoscopy or sigmoidoscopy)	•	•		45–75	Once every five years	100%	90% for professional services; 80% for facility; annual deductible applies

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
Depression screening	•	•	•	11 years and older	Once per calendar year	100%	100% after $25 copayment
Developmental screening/autism screening			•	3 years and younger	Four times per lifetime	100%	80%; annual deductible applies
Diet counseling for cardiovascular disease prevention	•	•			Three times per calendar year	100%	80%; annual deductible applies
Fluoride: topical varnish for dental caries prevention			•	5 years and younger	Twice per calendar year	100%	80%; annual deductible applies
Hearing loss screening			•	Birth to 90 days	Once per lifetime	100%	80%; annual deductible applies
High blood pressure screening (outside the clinical setting)	•	•		18 years and older	Once per calendar year	100%	80%; annual deductible applies
Laboratory tests							
• Abnormal blood glucose and type 2 diabetes mellitus screening	•	•			Once per calendar year	100%	100%
• Asymptomatic bacteriuria screening (urinary tract infection)		•			Twice per calendar year	100%	100%
• Chlamydia infection screening		•			Once per calendar year	100%	100%
• Cholesterol screening	•	•	•		Once per calendar year	100%	100%
• Diabetes mellitus after pregnancy screening		•			Once per calendar year	100%	100%

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
• Dyslipidemia screening			•		Once between age 9 and 11 years, and once between age 17 and 21 years	100%	100%
• Gestational diabetes screening		•			Once per calendar year (during pregnancy)	100%	100%
• Gonorrhea screening		•			Once per calendar year	100%	100%
• Hematocrit or hemoglobin screening		•	•		Once per calendar year	100%	100%
• Hepatitis B virus infection screening	•	•	•		Once per calendar year	100%	100%
• Hepatitis C virus infection screening	•	•	•		Once per calendar year	100%	100%
• HIV screening	•	•	•		Once per calendar year	100%	100%
• Newborn bilirubin screening			•	Birth to 1 year	Twice per calendar year	100%	100%
• Newborn blood screening			•		Once per lifetime	100%	100%
• Rh incompatibility screening		•			Twice per calendar year (during pregnancy)	100%	100%
• Syphilis screening	•	•			Once per calendar year	100%	100%
• Tuberculosis (TB) testing	•	•	•		Once per calendar year	100%	100%
Lung cancer screening	•	•		55–80	Once per calendar year	100%	90% for professional services; 80% for facility

All benefits are subject to the allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
Medications (retail pharmacy) when filled at a pharmacy with a valid prescription**							
• Aspirin to prevent cardiovascular disease or colorectal cancer	•	•		Younger than 60		100%	100%
• Aspirin to prevent preeclampsia after 12 weeks' gestation		•		Younger than 60		100%	100%
• Bowel preparation medications for colorectal cancer screening	•	•		45–75		100%	100%
• Breast cancer preventive medications (chemoprevention)		•		35 and older		100%	100%
• Fluoride supplements to prevent cavities			•	5 years and younger		100%	100%
• Folic acid supplements		•		55 and younger		100%	100%
• Statin use to prevent cardiovascular disease	•	•		40–75		100%	100%
• Tobacco cessation medications	•	•				100%	100%
• Vaccines (routine)	•	•	•		As recommended by the CDC	100%	100%
Obesity screening and behavioral interventions	•	•	•		Three times per calendar year	100%	80%; annual deductible applies
Osteoporosis screening		•			Once per lifetime	100%	90% for professional services; 80% for facility

All benefits are subject to the allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						Contracted provider	*Non-contracted provider (based on DMBA's allowable amount)*
Tobacco use prevention counseling and interventions	•	•			Eight times per calendar year	100%	80%; annual deductible applies
Tuberculosis (TB) screening	•	•	•		Once per calendar year	100%	100%
Unhealthy alcohol use counseling	•	•	•	11 years and older	Three times per calendar year	100%	100% after copayment ($25 for PCP; $40 for specialist)
Vaccines (routine)	•	•	•		As recommended by the CDC	100%	100%

* DMBA considers the following services to be integral to a routine exam and not eligible for separate reimbursement:

- Administration/interpretation of health risk
- Anxiety screening
- Autism screening
- Blood pressure measurement for high blood pressure screening/preeclampsia screening
- Breast cancer chemoprevention counseling for women at risk for breast cancer
- Breastfeeding primary care interventions
- Counseling related to sexual behavior/sexually transmitted infection (STI) prevention
- Counseling to prevent initiation of tobacco use
- Counseling/education to minimize exposure to ultraviolet radiation (skin cancer prevention)
- Critical congenital heart disease screening
- Discussion of aspirin prophylaxis
- Discussion/referral for genetic counseling/evaluation for BRCA testing
- Falls prevention risk assessment
- Hearing (other than newborn) and vision screening
- Intimate partner/interpersonal and domestic violence screening/referral to support services
- Maternal depression screening
- Obesity screening
- Ocular prophylaxis (newborn gonorrhea prophylactic medications)
- Oral health assessment/discussion of water fluoridation
- Tobacco use screening
- Tuberculosis (TB) risk assessment
- Unhealthy alcohol use and substance abuse screening
- Urinary incontinence screening

** 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 the allowable amounts.

Review your online personal preventive care report

We encourage you to take advantage of these critical benefits. See which services you may need by logging in to www.dmba.com and on the *Routine Care* tile selecting *View Details*.

Prosthetics

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered services:

- Prosthetics, such as artificial arms, legs, or eyes
- Repair for normal wear and tear
- Replacement of some prosthetics, at specific intervals

You must preauthorize.

Replacement of a lost prosthesis is not covered.

Radiation therapy

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You must preauthorize some types of radiation therapy, such as proton beam therapy, IMRT, and brachytherapy.

Respiratory education

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

To be covered, a licensed respiratory therapist must provide evaluation and education for an individual younger than 26 with asthma or cystic fibrosis.

Skilled nursing facility

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered services:

- Time in an extended-care facility after an inpatient hospitalization
- Up to 50 days per calendar year for an individual recuperating or convalescing from an acute injury or illness

All benefits are subject to the allowable amounts.

You must preauthorize.

Custodial care, such as maintaining someone beyond the acute phase of injury or illness, including room, meals, bathing, and dressing, is not covered. See *Exclusion 1*.

Speech therapy

Initial evaluation

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You do not need to preauthorize the initial evaluation.

If you are billed for both evaluation and treatment in the same visit, you are responsible for both copayments. Multiple copayments also apply if you receive more than one type of therapy in the same visit.

Outpatient

Contracted provider: The plan pays 100% after your $35 copayment.

Non-contracted provider: The plan pays 100% of DMBA's allowable amount after your $40 copayment. The annual deductible applies.

You must preauthorize.

If you are billed for both evaluation and treatment in the same visit, you are responsible for both copayments. Multiple copayments also apply if you receive more than one type of therapy in the same visit.

Inpatient

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Surgery

Outpatient and physician services

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

You must preauthorize some procedures. If outpatient services result in an inpatient hospital stay, preauthorize within two business days of admission or as soon as reasonably possible.

Inpatient and physician services

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

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

Telemedicine

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Contracted specialist: The plan pays 100% after your $35 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Contracted or non-contracted urgent care: The plan pays 100% of DMBA's allowable amount after your $45 copayment.

Covered services include office visits and certain other health services furnished through an interactive multimedia communications system that provides for two-way, real-time audio and video communication between an individual and a distant site provider.

Appropriate services provided via telemedicine that would be covered if provided in person are covered.

Temporomandibular joint (TMJ) dysfunction

Contracted provider: The plan pays 90%, up to $1,000 per lifetime; you pay 10%.

Non-contracted provider: The plan pays 80% of DMBA's allowable amount, up to $1,000 per lifetime; you pay 20%. The annual deductible applies.

The $1,000 limit does not apply to MRIs, anesthesia, or surgery for TMJ dysfunction.

Expenses do not count toward the plan's out-of-pocket maximum.

Services not covered:

- Night guards (occlusal guards) for grinding teeth
- Orthognathic surgery to treat TMJ dysfunction

Transplants

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

Non-contracted provider: The plan pays 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Covered transplants when DMBA's medical criteria are met:

All benefits are subject to the allowable amounts.

- Blood or bone marrow stem cell
- Combined heart/lung
- Combined pancreas/kidney
- Cornea (preauthorization not required)
- Heart
- Intestine
- Kidney
- Liver
- Lung

You must preauthorize.

Limitations apply to donor benefits.

Prescription drugs associated with a transplant are covered by the *Prescription drugs* benefit.

Other transplants are not covered.

Transportation

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

Covered services when DMBA's medical criteria are met:

- Transportation services for the covered individual to the nearest medical facility equipped to furnish the appropriate care
- Transportation for one parent or guardian to accompany a child younger than 19

You must preauthorize.

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.

Hotels, meals, and other personal expenses are not covered.

For more information about 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 $45 copayment per visit.

For a less expensive alternative, consider using Intermountain Connect Care, a telemedicine service. The plan pays 100% after your $20 copayment. If your medical need is not treatable in a virtual setting, you will not be charged for the Connect Care telemedicine visit.

Other services you receive during an urgent care visit are covered at 90% of DMBA's allowable amount or the appropriate benefit level, whichever is higher.

All benefits are subject to the allowable amounts.

If the visit results in an inpatient hospital stay, you must preauthorize within two business days of admission or as soon as reasonably possible.

Well-child care

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Office visits for dependents younger than 19 are covered.

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

Other services, such as lab work and X-rays, are covered 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 80% of DMBA's allowable amount; you pay 20%. The annual deductible applies.

Well-woman exams

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

Non-contracted PCP: The plan pays 100% of DMBA's allowable amount after your $25 copayment.

Non-contracted specialist: The plan pays 100% of DMBA's allowable amount after your $40 copayment.

Covered services:

- One office visit with exam every calendar year
- Breast and pelvic exam
- Hematocrit
- HPV screening
- Lipid profile
- Pap smear, once per calendar year
- Urinalysis

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

Other services, such as lab work and X-rays, are covered at the appropriate benefit levels for those services.

Labs and routine procedures are not covered when associated with an exam that is not covered.

All benefits are subject to the allowable amounts.

For more information, see *Mammograms* and *Physical exams*.

Medical Emergencies

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

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

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

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 seven 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 preauthorize as soon as you have compiled the needed information so 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 per

occurrence), which is payable by you, in addition to your coinsurance. Not all denied claims are eligible for post-service review.

All procedures, services, therapies, devices, etc., must meet our medical criteria to be covered. 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.

You must preauthorize certain prescription drugs with Navitus. For a list of these medications call Navitus at 833-354-2226 or visit memberportal.navitus.com/landing.

Some provider-administered medications must be preauthorized by Archimedes at 888-504-5563. For a list of medications preauthorized by Archimedes, visit www.archimedesrx.com/resources or DMBA's *Provider Services* at www.dmba.com/provider.

Out-of-pocket Maximum

If your share of eligible medical expenses reaches a certain amount in a 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 $2,800, benefits increase to 100% for eligible charges, based on allowable amounts.

For families

After your family's share of eligible expenses reaches $5,600, benefits increase to 100% for eligible charges, based on allowable amounts.

Exceptions

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

These expenses do not apply to your eligible expenses and will not apply to your out-of-pocket maximum:

- Amounts that exceed the allowable amounts

- Annual deductible
- Charges for not preauthorizing
- Premium payments
- 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, please call DMBA at 801-578-5600 or 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:

Attn: Audit Reimbursement
DMBA
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. 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.

To submit a claim for benefits:

1. Get an itemized bill from the provider or facility that includes the following:
    - » 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)

2. Write your name and DMBA ID number on the bill.
3. Complete a *Medical & Dental Claim Form* (available at www.dmba.com in the *Forms Library*).
4. Mail the claim and bill to DMBA:

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

Submit pharmacy claims to Navitus, not DMBA. Find the Navitus prescription claim form at memberportal.navitus.com/landing. Submit original pharmacy receipts or printouts with your claim. Call Navitus at 833-354-2226 with any questions.

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

Financial Disclosure

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

Fraud Policy Statement

It is unlawful to knowingly provide false, incomplete, or misleading facts or information with the intent of defrauding the plan or DMBA. An application for benefits or a claim containing any materially false or misleading information, or any non-compliance with the terms of the plan, as determined by 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 plans 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 or dental benefits in force when you enroll or when any other benefits become effective. 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 we pay more than the participant is responsible to pay after the primary carrier has paid the claim.

We generally coordinate benefits among 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 under age 26. 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 or long-term care, education, training, or rest cure, which is defined as maintaining an 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 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; and where the 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, except as provided for by the terms of the plan

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:

- The technology has final approval from all appropriate governmental regulatory bodies, if applicable. (Federal Drug Administration approval does not necessarily mean a service is not investigational/experimental.)
- The technology is available in significant numbers outside the clinical trial or research setting.
- The available research about the technology is 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, and
- generally recognized as appropriate by the regional medical community as a whole.

A service, care, treatment, or operation falling in these categories 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, home delivery, surrogate pregnancy, and adoption

4.1. Implantable rods, contraceptive sponges, cervical caps, male and female condoms, spermicides, and emergency contraceptive products (e.g., levonorgestrel and ulipristal acetate)
4.2. Sterilization procedures, unless the covered individual meets DMBA's current medical criteria
4.3. 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
4.4. 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
4.5. Donor eggs, sperm, or embryos (including services related to procurement of donor material) used in assisted reproductive technologies
4.6. Cryopreservation (freezing), storage, and thawing of sperm, eggs, embryos, and ovarian and/or testicular tissue
4.7. Reversal of sterilization procedures
4.8. Planned home delivery for childbirth and all associated costs
4.9. All pregnancy- and birth-related expenses (prenatal and postnatal) of an individual (including a covered individual) acting as a surrogate or gestational carrier*
4.10. Services, drugs, or supplies to treat sexual dysfunction, erectile dysfunction, enhance sexual performance, or increase sexual desire, except the external erectile vacuum erection device under the durable medical equipment benefit

* 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.

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, except as required by federal law
5.3. Services and supplies that school systems are legally required to provide

6. Hearing

6.1. 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, unless 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, subject to the nondiscrimination provisions of HIPAA
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, including but not limited to buildings, motor vehicles, air conditioning, air filtration units, exercise equipment or machines, and vibrating chairs and beds; as well as certain medical equipment, including air filtration systems, dehumidifiers, hearing devices, humidifiers, nonprescription braces and orthotics, learning devices, spa and gym memberships, vision devices, and 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*
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 have been met), skin furrow removal, or diastasis rectus repair

* 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.

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 with non-specific symptoms

10.2. Counseling, including but not limited to marriage and family counseling, recreational therapy, or other therapy*

10.3. Services and materials in connection with surgical procedures undertaken to remedy a condition diagnosed as psychological

10.4. Care and services for the abuse of or addiction to alcohol or drugs, except as provided for by the terms of the plan

10.5. Care and services for learning disabilities or physical or mental developmental delay, including pervasive developmental disorders or cognitive dysfunctions, except as provided for by the terms of the plan

10.6. Mental health services provided in a day treatment program or residential care facility, unless the individual receiving such services meets the requirements for the mental health alternative care benefit, as defined by DMBA, and as otherwise provided for by the terms of the plan

10.7. Custodial and supportive care for covered individuals with mental illness

* Counseling for a covered individual's diagnosed psychiatric disorder is not considered family or marriage therapy even with the family or spouse present.

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. Charges for services, supplies, or drugs received as a result of medical tourism, or for traveling out of the United States to seek medical services, medications, or devices, including any complications thereof, unless provided for by the terms of the plan

12. Education and training

12.1. Education available to the general public without charge
12.2. Educational evaluation and therapy, testing, consultation, rehabilitation, remedial education, services, supplies, or treatment for developmental disabilities, communication disorders, or learning disabilities
12.3. Educational treatment, including reading or math clinics or special schools for the intellectually disabled or behaviorally impaired individuals
12.4. Therapy that is part of a special educational program

13. Obesity

13.1. Care, services, or supplies in connection with obesity, unless the covered individual meets DMBA's current medical criteria

14. Other insurance/workers' compensation

14.1. Services covered or that could have been covered by applicable workers' compensation statutes
14.2. 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
14.3. 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
14.4. 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

15. Prescription drugs

15.1. Medications such as emergency contraceptives (see *Exclusion 4.1* for other excluded contraceptives), 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)

16. Testing

16.1. 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

17. Transplants

17.1. 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

18. Vision

18.1. 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/agencies/ebsa/laws-and-regulations/laws/affordable-care-act.

Claims Review and Appeal Procedures

If your claim is denied and you feel that the denial is in error, you have the right to file an appeal. For more information about how to appeal a claim, please refer to your *General Information* SPD.

Notification of Discretionary Authority

DMBA is the plan administrator and, in its sole discretion, determines appropriate courses of action in light of the reason and purpose for which the plan is established and maintained. In particular, DMBA has full and sole discretionary authority to interpret and construe the terms of all plan documents, including but not limited to the following: resolve and clarify inconsistencies, ambiguities, and/or omissions in all plan documents; make determinations for all questions of eligibility for and entitlement to benefits; determine the status and rights of employees and other persons under this plan; make all interpretive and factual determinations as to whether any individual is entitled to receive any benefits under the terms of this plan; and determine the manner, time, and amount of payment of any benefits under this plan. Benefits will be paid under this plan only if the plan

administrator decides in its sole discretion that the individual is entitled to them. All such interpretations and decisions by DMBA shall be final, binding, and conclusive on the employers, the employees, and any other parties affected thereby.

Any interpretation, determination, or other action of the plan administrator shall be given deference in the event the determination is subject to judicial review. Any review by a court of a final decision or action of plan administrator shall be based only on such evidence presented to or considered by DMBA at the time it made the decision that is the subject of the court's review. Accepting any benefits or making any claim for benefits under this plan constitutes agreement with and consent to any decisions that DMBA makes, in its sole discretion and, further, constitutes agreement to the limited and deferential scope of review described herein.

DMBA may allocate or delegate its duties and responsibilities under this plan and may designate any person or entity to carry out any of its duties or responsibilities with respect to administration of this plan, including the appointment of one or more claims administrators to evaluate benefit claims under this plan. In the case of such allocation or delegation, all references to "DMBA" or "plan administrator" shall be deemed to refer to such person or entity to the extent of such allocation or delegation. However, DMBA has a continuing duty to monitor the performance of any of its delegates or designees.

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 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.

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 plan document will govern.