

Senior General Information

<u>Overview</u>	1
<u>Customer Service Information</u>	1
<u>Participating Employers</u>	2
<u>Benefit Plans</u>	3
<u>Insurance Benefit Eligibility & Enrollment</u>	3
<u>Retiree Eligibility</u>	3
<u>Eligible Dependents</u>	4
<u>Guidelines for Eligibility and Enrolling Dependents 19 and Older</u>	5
<u>Guidelines for Eligibility and Enrolling Stepchildren</u>	6
<u>Enrollment Processes</u>	6
<u>Insurance Benefits</u>	6
<u>Open Enrollment</u>	7
<u>Coordination of Benefits</u>	8
<u>Premiums</u>	9
<u>Notification of Changes in Family Status</u>	11
<u>Termination of Coverage</u>	12
<u>Family Survivor Benefit</u>	13
<u>Protection for You and Your Benefits</u>	14
<u>Protecting Your Privacy</u>	15
<u>Protecting You</u>	15
<u>Protecting Your Benefits: Employee Retirement Income Security Act</u>	16
<u>Protecting Deseret Mutual: Fraud Policy Statement</u>	17
<u>Benefit Administration</u>	17
<u>Subrogation</u>	17
<u>Claims Review Procedures</u>	18

Senior General Information

<u>Definitions and Exclusions</u>	18
<u>Notification of Discretionary Authority</u>	18
<u>Notification of Benefit Changes</u>	19

Senior General Information

The insurance and retirement benefits available to you are a vital and substantial part of your total retiree compensation from your former employer. And Deseret Mutual Benefit Administrators (Deseret Mutual) administers these benefits for you. To help you become familiar with your benefits, this *Benefits Handbook* includes a complete description of the plans in your benefit program as of January 1, 2009.

Please note, your Handbook includes information about the medical, dental, and life insurance plans in which you are enrolled. If you want information about other medical or dental plans offered by Deseret Mutual, please visit our Web site or call us.

Customer Service Information

To answer your questions and help you with your benefits, we have a staff of qualified representatives who can help you.

Our office hours are from 8 a.m. to 5 p.m. (Mountain Time) each weekday except Wednesday. On Wednesdays our office hours begin at 9 a.m. Or you can visit our Web site — 24 hours a day, seven days a week — for a wealth of information. Here's how to reach us:

Salt Lake City area	1-801-578-5600
Toll free	1-800-777-3622
Web site	www.dmba.com

If your hearing is impaired, we have telephones to accommodate Telecommunications Devices for the Deaf (TDD). Our telephone numbers for this service are:

Salt Lake City area	1-801-578-5655
Toll free	1-800-333-9715

If you want to visit a Team member in person, our offices are located in the Eagle Gate Plaza and Tower at 60 East South Temple in downtown Salt Lake City. You can make an appointment or simply drop by during our regular office hours.

Deseret Mutual's mailing address is:

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

Senior General Information

Participating Employers

In 1970, The Church of Jesus Christ of Latter-day Saints, along with other companies owned and operated by the Church, formed a private trust to administer benefits for its employees. Today, that trust is known as Deseret Mutual Benefit Administrators, or Deseret Mutual for short.

Deseret Mutual is not an insurance company. Rather, it's a private, non-profit trust that administers health and pension benefits exclusively for employees of the Church and its related organizations. Our purpose — or mission — is to improve your health and financial well-being.

Deseret Mutual's participating employers include:

- AgReserves, Inc.
- Beneficial Financial Group
- Berberian Nut Company
- Bonneville International Corporation
- Brigham Young University
- Brigham Young University — Hawaii
- Brigham Young University — Idaho
- Church Education System
- City Creek Reserves
- Corporation of the President
- Corporation of the Presiding Bishop
- Deseret Book Company
- Deseret Management Corporation
- Deseret Mutual Benefit Administrators
- Deseret Morning News
- Deseret Trust Company
- East Central Florida Services, Inc.
- Ensign Peak Advisors, Inc.
- Farmland Reserve, Inc.
- Hawaii Reserves, Inc.
- LDS Business College
- LDS Family Services
- Polynesian Cultural Center
- Property Reserve, Inc.
- South Valley Almond
- Suburban Land Reserve, Inc.
- Taylor Creek Management Company
- Temple Square Hospitality Corporation
- Zions Securities Corporation

Senior General Information

Benefit Plans

Deseret Mutual's retiree benefit program includes:

- Core insurance benefit plans
 - Medical
 - Group Term Life (GTL)
- Supplemental insurance benefit plans
 - Dental
 - Supplemental Group Term Life (SGTL)
- Retirement benefit plans
 - Master Retirement Plan
 - Thrift Plan
- Value-added benefits

To see which of all these Deseret Mutual retiree benefit plans are available to you, please contact Deseret Mutual.

Insurance Benefit Eligibility & Enrollment

Retiree Eligibility

Your eligibility is based on the benefit credit you have earned in Deseret Mutual's Master Retirement Plan.

- If you were 55 or older on September 1, 1996, and you were employed by a participating employer on that date, but you retire after that date, you must have at least five years of benefit credit in the Master Retirement Plan to participate in the post-retirement insurance plans.
- However, if you were younger than 55 on September 1, 1996, or if you were hired after that date, you must have at least 10 years of benefit credit to participate in the post-retirement insurance plans.

Senior General Information

Medical Coverage: To continue coverage, you and your dependents must have been enrolled in a Deseret Mutual medical plan or another group plan for at least 12 months immediately before your retirement.

If you do not meet all Deseret Mutual's eligibility requirements and you are not eligible for Medicare or another group medical plan, you may be eligible for COBRA coverage. For more information, call Deseret Mutual's Membership Team.

Dental Coverage: You are eligible if you meet the eligibility requirements for continued medical coverage. After you retire, dental benefits are optional and separate from the medical plans. Please be aware that if you don't enroll in dental coverage at the time you retire, you won't be able to choose it later.

Life Insurance Coverage: You may be eligible to keep some Group Term Life insurance if you have been enrolled in this program for at least 12 months immediately before you retire. Your spouse and other dependents are not covered by Group Term Life insurance after you retire.

However, you, your spouse, and your other dependents may be eligible for some Supplemental Group Term Life insurance. You must apply for coverage before you retire. See the *Life Insurance* section of your Benefits Handbook.

Eligible Dependents

Your eligible dependents include your spouse and your eligible children. Your spouse is a person of the opposite sex who is your legal husband or your legal wife. Eligible children are your unmarried children who are younger than 26 including:

- Natural children (including infants from the date of birth), legally-adopted children, stepchildren, and children appointed by a court of law to your custody or your spouse's custody.

In the case of a child who is committed by a court of law to your custody or the custody of your spouse, you must submit a copy of the certified court order granting the adoption, custody, or guardianship.

- A grandchild who is the child of your covered, unmarried, dependent child. The unmarried dependent child and the grandchild must reside in your home and depend primarily upon you for support. A direct lineal relationship must exist between you and the grandchild (or a direct line created through adoption) for the grandchild to be covered.

Senior General Information

- A child placed with you under the direction of a licensed child placement agency
- Your unmarried child who is 26 or older and incapable of self-support because of mental or physical incapacity that existed before the child reached 26, and who is primarily dependent upon you for support

To apply for this coverage, submit proof of these circumstances within 60 days from the end of the month when the child reaches age 26 or within 30 days after your eligibility date. Please contact Deseret Mutual for a copy of the *Application for Dependent Coverage After Age 26*.

If one of your dependents is hospitalized before benefits are effective and the dependent is in the hospital on the date benefits become effective, medical benefits do not begin for the dependent until the day after being discharged from the hospital.

When you get a new dependent, you have 60 days to enroll that dependent.

Guidelines for Eligibility and Enrolling Dependents 19 and Older

Your dependent children 19 and older are eligible for insurance coverage only if they are not eligible for their own employment-based medical coverage. Other dependent children (full-time students, missionaries, unemployed dependents, or dependents working for employers who do not offer them health insurance) may continue coverage until they reach age 26, marry, or obtain employment that offers health insurance, whichever comes first.

We ask you to verify this dependent child's eligibility status when you first enroll the dependent, and again before the child's birthday each year thereafter. It is your responsibility to respond to our requests for verification. If you do not respond, the dependent child's coverage ends on the first day of the month following the dependent's birthday.

These eligibility guidelines do not apply to dependent children 19 and older in situations where the only employment-based insurance offered is catastrophic medical insurance that has an annual deductible of \$1,500 or more. Therefore, dependent children with only catastrophic coverage can continue to be covered by your plan.

Re-enrollment: If a dependent loses eligibility for his/her own employment-based medical coverage, you are allowed to re-enroll the dependent with Deseret Mutual within 30 days of losing other coverage.

Senior General Information

Dual Deseret Mutual Coverage: Dependents who are eligible for Deseret Mutual coverage because of their own employment with a participating employer are subject to this guideline. In these situations, the dependent must enroll with Deseret Mutual as an employee. The dependent's coverage under your (the parent's) policy terminates.

Surviving Spouses and Dependents: Everyone enrolled in the Family Survivor Benefit is subject to this guideline (see [Family Survivor Benefit](#) on page 13). If employment-based medical coverage is available, either through the individual's own employment or through the surviving parent's employment, coverage with Deseret Mutual ends. However, if the surviving spouse or dependent child loses employment-based medical coverage, this dependent is allowed to re-enroll in the Family Survivor Benefit within 30 days of losing other coverage.

Guidelines for Eligibility and Enrolling Stepchildren

Just as for all other dependent children, coverage may continue until the stepchild either reaches age 26, marries, or is eligible for their own employment-based medical insurance, whichever comes first.

You may enroll your eligible stepchild if you do so at your eligibility date or within 60 days after your marriage to the child's parent. If you do not enroll the stepchild within 60 days, you may not enroll the child until the next open enrollment period unless the child was covered by another group medical insurance plan and subsequently loses eligibility for that coverage. In this case you must apply within 30 days.

In the case of divorce, you must provide a certified copy of the divorce decree.

Enrollment Processes

Insurance Benefits

You must enroll for retiree benefits at the time you retire. If you do not, you are not eligible for retiree benefits.

If you meet the eligibility requirements but do not enroll for medical or dental coverage because you have other group coverage, then you later lose eligibility for the other coverage, you may enroll with Deseret Mutual for medical or dental coverage if you do so within 30 days from losing eligibility. You must meet all of Deseret Mutual's eligibility requirements for coverage, be enrolled in another group medical plan at the time you retire, and then involuntarily lose eligibility for that group coverage.

Senior General Information

Medical Coverage: If you are younger than 65, you may enroll in the same plan as an active employee. If you are 65 or older, the Deseret Mutual medical plans available to you are Deseret Secure and Deseret Secure *PLUS* (which includes a higher prescription drug benefit).

Deseret Secure and Deseret Secure *PLUS* are Medicare Advantage Private Fee-for-Service plans. With these plans, you won't have to worry about coordinating claims with Medicare and Deseret Mutual. We'll handle your Medicare Part A (hospital insurance), Part B (medical insurance), and prescription drug coverage.

In some areas, you may be able to enroll in one of our contracted HMOs. Please call Deseret Mutual to find out what plans we offer to retirees with Medicare in your area.

Dental Coverage: You may enroll in the optional Senior Dental Plan if you meet the [eligibility requirements](#) described on pages 3 and 4. You are responsible for the entire premium for the Senior Dental Plan, and you must stay in the plan for a minimum of two years.

Please see the *Dental* section of your Benefits Handbook for more information.

Life Insurance Coverage: You may continue a portion of your Group Term Life and Supplemental Group Term Life (SGTL) insurance coverage when you retire if you meet the [eligibility requirements](#) described on pages 3 and 4. You and your dependents may be eligible to continue SGTL coverage. Please see the *Life Insurance* section of your Benefits Handbook for more information.

Please be aware that if you don't enroll in coverage at the time you retire, you won't be able to choose it later.

Open Enrollment

Generally, open enrollment is held annually during November. Changes in coverage are then effective January 1 of the following year.

During open enrollment, if you meet plan guidelines you may change from your current medical plan to another plan that is available in your area.

To see which medical plans are available to you, please contact your Deseret Mutual Membership Team. Or you can visit our Web site.

Senior General Information

Coordination of Benefits

To help you make the most of your coverage, coordination of benefits combines the medical/dental benefits of two or more insurance plans.

Please note: If you are covered by more than one plan, **you are legally responsible** to notify Deseret Mutual.

If you're eligible for Medicare, you can only enroll in one Medicare Advantage plan at a time. That means you can't be enrolled in Deseret Secure, Deseret Secure *PLUS*, a contracted HMO, or another Medicare Advantage plan as both a retiree and a dependent of another retiree.

Also, if you choose to enroll in Deseret Secure or Deseret Secure *PLUS*, you cannot enroll in another Medicare prescription drug plan at the same time. It's your responsibility to inform Deseret Mutual of any prescription drug coverage you have or may get in the future.

If you're not eligible for Medicare and you are enrolled in Deseret Mutual coverage as both a retiree and a dependent of another employee or retiree, we coordinate benefits between:

- Deseret Choice
- Deseret Premier
- Deseret Select
- Deseret Value
- Deseret Protect
- Deseret Mutual contracted HMOs
- Other medical plans not associated with Deseret Mutual

We do not coordinate benefits between Deseret Value and Deseret Value. In other words, if you or a dependent could be covered by two Deseret Value plans with two participating employers (as either the participant or the dependent), we do not consider the second Deseret Value plan.

Senior General Information

Which Plan Pays First

When you are insured by two plans, the coordination of benefits provision designates one plan as the primary insurer and the other plan as the secondary insurer. To find out which of your medical plans pays first for you and your dependents, please call the Deseret Mutual Membership Team.

Premiums

Medical Benefits

If you qualify to participate in Deseret Mutual's retiree medical plans, your former employer contributes a fixed dollar amount toward your premiums each month. Your former employer's maximum contribution does not pay the entire monthly premium. Therefore, you are responsible for paying the balance.

Depending on the years of benefit credit you have earned in Deseret Mutual's Master Retirement Plan before you retire, you may be eligible to receive either part or all of your former employer's maximum contribution for retiree medical coverage.

Eligibility for your former employer's maximum contribution toward your monthly premiums is defined in Schedule A:

Schedule A

Years of Benefit Credit	Percent of Maximum Employer Contribution
1 to 9 years	Not eligible
10 years	50%
11 years	50%
12 years	60%
13 years	60%
14 years	70%
15 years	70%
16 years	80%
17 years	80%
18 years	90%
19 years	90%
20 or more years	100%

Senior General Information

If you were age 55 on or before September 1, 1996, and you were employed by a participating employer on that date, you are grandfathered under Schedule B below. Your accrual under this schedule was frozen on September 1, 1996.

Schedule B

Years of Benefit Credit	Percent of Maximum Employer Contribution
1 to 4 years	Not eligible
5 years	50%
6 years	60%
7 years	70%
8 years	80%
9 years	90%
10 or more years	100%

If you qualified for Deseret Mutual's retiree medical coverage on September 1, 1996 (because you were at least age 55 with five years of benefit credit) and you continued to work beyond that date, when you retire you are eligible for the greater of:

- Your former employer's contribution level based on Schedule B, but only including the benefit credit you have earned as of September 1, 1996
- Your former employer's contribution level based on Schedule A, including all of the benefit credit you have earned through your actual retirement date

Dental Benefits

You are responsible for the entire premium for the Senior Dental Plan.

Supplemental Insurance Benefits

For SGTL coverage, premiums vary depending on the options you choose. Please refer to the *Life Insurance* section of your Benefits Handbook for more information.

You are responsible for the entire premium for SGTL.

Senior General Information

Premium Adjustments

Please be aware that premium adjustments because of enrollment changes or errors are limited to 15 months immediately preceding the date Deseret Mutual receives evidence that such adjustments should be made. These adjustments can be either returned premium dollars or additional premium charges.

In the case of a dependent's death, if you do not notify Deseret Mutual within 15 months, we still refund any extra premium you paid back to the date of the dependent's death, but we withhold 10% of the refund up to \$200.

Notification of Changes in Family Status

To make sure your benefits are provided quickly and efficiently, it is vital your records at Deseret Mutual are accurate. If any of the following changes occur, contact the Deseret Mutual Membership Team immediately:

- Address (retiree's signature required)
- Marriage (you or your dependent children)
- Birth
- Adoption
- Placement of a foster child
- Death
- Divorce
- Name
- Dependent status
- You or any of your dependents qualify for Medicare
- You or any of your dependents acquire other medical insurance, including Medicare
- Any other situation that may affect your participation in the benefit program

Senior General Information

Termination of Coverage

Coverage may end under certain circumstances or at specific events. Your insurance coverage automatically terminates on the earliest of the following dates:

- Last day of the month for which premium is paid
- Last day of the month in which you request your coverage to end
- Last day of the month in which you are no longer eligible for benefits
- Date you enter active duty in the armed forces of any country (contact Deseret Mutual for special military rules)
- Date of termination of the plan

In addition to the above, your dependent's insurance coverage automatically terminates on the earliest of the following dates:

- Last day of the month in which your dependent no longer qualifies as a dependent
- Last day of the month you are divorced (your spouse's coverage ends but your dependent children's coverage does not end)
- Date your dependent enters active duty in the armed forces of any country (contact Deseret Mutual for special military rules)

Special Termination Dates

If you or your dependents are in the hospital on the date benefits terminate, you are entitled to extend medical benefits solely for the injury or illness for which you or your dependents were admitted.

In your case, extended benefits will end on the date of your release from the hospital. In the case of your dependents, extended benefits will end on the date of release from the hospital or 30 days from the date of termination of insurance eligibility, whichever comes first.

Senior General Information

Family Survivor Benefit

When you die, your survivors who are covered on the date of your death may continue medical and dental coverage with Deseret Mutual. Survivors may continue Supplemental Group Term Life insurance if they choose to do so (see the *Life Insurance* section of your Benefits Handbook).

If your survivors choose to continue coverage, they must complete and return the forms Deseret Mutual sends them within 60 days after the date of your death.

Consider the following guidelines:

- Monthly medical premiums for your survivors are waived for a maximum of one year following your death. Thereafter, depending on the years of Master Retirement Plan benefit credit you earned before your death, your family may be eligible to receive the same percentage either part or all of your former employer's maximum contribution for medical coverage that you were eligible to receive (see pages 9 to 10).
- Survivors who are working and have been offered health insurance by their own employers are no longer eligible for medical coverage from Deseret Mutual after the first year of coverage. (This does not apply to participants who became surviving spouses before January 1, 2001.)

This applies to survivors who enrolled in health insurance offered by their employers, as well as those who previously elected not to enroll in their employers' plans. Survivors who have not enrolled in their employers' plans have 30 days to do so, beginning the date their Deseret Mutual coverage ends (one year from the time of your death).

Employers are required by law to offer eligible employees this 30-day window to enroll when they lose eligibility for the other insurance they had when they originally declined enrollment in the employer's group plan.

If at some time in the future any of your survivors lose eligibility for insurance with their current employers, they have 30 days to re-enroll with Deseret Mutual.

Survivors who were enrolled in the Senior Dental Plan may, at their own expense, remain in the Senior Dental Plan. Please see the *Dental* section of your Benefits Handbook for more information.

Senior General Information

If your surviving spouse is eligible for other coverage and that policy covers any of your surviving children, the children are no longer eligible for coverage from Deseret Mutual. In this case, the same 30-day window applies to your eligible children to enroll for coverage with the surviving spouse's current employer.

- Other eligible survivors (those who are unemployed or working for employers who do not offer them health insurance) may continue to be covered by Deseret Mutual until they obtain employment that offers health insurance or otherwise they no longer qualify as dependents.

Note: Newly acquired dependents of your survivors may not be added to the survivor coverage.

For more information, please see [*Insurance Benefit Eligibility & Enrollment*](#) on page 3.

Protection for You and Your Benefits

As your benefits administrator, we must protect both your benefits and the benefit program for all of us: for you, for your former employer, and for Deseret Mutual. In doing so, we follow federal guidelines and the internal policies presented here.

Protecting Your Privacy

Protected Health Information

Deseret Mutual does not disclose your personal, protected health information without your express permission, unless allowed by law. Therefore, if you would like other individuals (including your spouse or other family members) to have access to your protected health information, you must submit a *Privacy Authorization Form* to Deseret Mutual.

Deseret Mutual Identification Number

We are committed to protecting the confidentiality of the personal information that we receive either from or about you. Therefore, although we use your Social Security number when communicating financial information to the federal government, generally we no longer use your Social Security number to identify you. We use a number that is specific to you, your Deseret Mutual identification number.

All physicians, dentists, and any other business partners must use your Deseret Mutual identification number. Otherwise your claims may be delayed or denied.

Senior General Information

For added security when accessing your information on our Web site, we ask you to provide a password to accompany your Deseret Mutual identification number. To ensure that you are entering Deseret Mutual's Web site and not an imposter's, we will display a security phrase selected by you.

Your password provides access to your personal health and financial information at Deseret Mutual. You can protect your private information by safeguarding your password. If you give your password to anyone, or if you suspect that someone else knows your password, contact us immediately.

We also take steps to protect your password. If you forget your password and call Deseret Mutual to ask us for it, we will mail the password to you.

Protecting You

Notice of Creditable Coverage

The Deseret Secure or Deseret Secure *PLUS* prescription drug benefits on average are both more comprehensive and more generous than Medicare's benefits. In Medicare's terms, that means we provide "creditable coverage."

If you choose to drop your Deseret Mutual coverage and enroll in another Medicare-approved prescription drug plan, we can provide you with a letter that will help you get other Medicare coverage without having to pay late enrollment penalties.

Please be aware that if you drop your Deseret Mutual coverage, you will not be able to re-enroll later. Also, if you go for 63 days or longer without prescription drug coverage that's as comprehensive as Medicare's, your monthly premiums for any Medicare prescription drug program you enroll in thereafter will increase at least 1% per month for every month that you did not have that coverage.

Special Enrollment Periods for Qualifying Events

If you meet the eligibility requirements for retiree benefits but do not enroll because you have other group coverage, then you later lose eligibility for other coverage, you may enroll with Deseret Mutual for medical coverage if you do so within 30 days from losing eligibility. You must meet all of Deseret Mutual's eligibility requirements for coverage, be enrolled in another group medical plan at the time you retire, and then involuntarily lose eligibility for that group coverage.

Senior General Information

Protecting Your Benefits: Employee Retirement Income Security Act

As a participant in the benefit program, you are entitled to certain rights and protections from the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the program administrator's and former employer's offices, all program documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the program with the U.S. Department of Labor, such as annual reports and plan descriptions (Deseret Mutual is the program administrator).
- Obtain copies of all program documents and other program information upon written request to Deseret Mutual. Deseret Mutual may charge a reasonable fee for the copies.
- Receive a summary of the program's annual financial report. Deseret Mutual is required by law to furnish each participant with a copy of this summary financial report.

Your former employer may not discriminate against you to prevent you from obtaining a benefit or for exercising your rights under ERISA.

If your claim for benefits is denied in whole or in part, Deseret Mutual sends you a written explanation of the reason for the denial. You have the right to have Deseret Mutual review and reconsider your claim. Under ERISA, you can take steps to enforce the above rights.

For information about how to file a grievance or appeal, see the *Medical* section of your Benefits Handbook. If you have questions about the program, contact Deseret Mutual. If you have questions about this statement or about your rights under ERISA, contact the nearest Area Office of the U.S. Department of Labor.

Protecting Deseret Mutual: Fraud Policy Statement

It is unlawful to knowingly provide false, incomplete, or misleading facts or information with the intent of defrauding Deseret Mutual. An application for insurance or statement of claim containing any materially false or misleading information may lead to reduction, denial, or termination of benefits or coverage under the policy and recovery of any amounts Deseret Mutual may have paid. Non-compliance with a

Senior General Information

contract prepared by Deseret Mutual addressing abuse of health-care benefits or systems may also lead to reduction, denial, or termination of benefits or coverage under the policy and recovery of any amounts Deseret Mutual may have paid.

Benefit Administration

Subrogation

If you have an injury or illness that is the liability of another party and you have the right to recover damages, Deseret Mutual requires reimbursement for any amount it has paid when damages are recovered from the third party.

Deseret Mutual is reimbursed:

- First
- From any claim against the third party, the third party's liability insurer, or your uninsured/underinsured motorist insurer
- Whether the recovery is obtained by settlement, judgment, or any other source
- Regardless of how the settlement is allocated by the third party or insurer
- Regardless of whether the settlement is considered to have recovered full compensation or damages

In addition, if you do not attempt to recover damages from the third party as described above, Deseret Mutual has the right to initiate legal action against the liable third party to recover the amount it has paid for your injuries.

Your acceptance of Deseret Mutual benefits for the injury gives Deseret Mutual the right to subrogate. You need to provide all information Deseret Mutual requests for subrogation purposes. If you fail to do so, we withhold the payment of your benefit and you are responsible for reimbursing all costs and expenses paid by Deseret Mutual for the injury.

Claims Review Procedures

At Deseret Mutual, we want to make sure you get the best care possible. So if you are not satisfied with a decision we make about a claim, you have the right to appeal.

Senior General Information

Please send a written statement to:

Deseret Mutual
Attention: Claims Management
P.O. Box 45530
Salt Lake City, Utah 84145

Deseret Secure and Deseret Secure *PLUS* Plans

For information about how to file a grievance or appeal, see the *Medical* section of your Benefits Handbook.

Definitions and Exclusions

Each benefit plan has unique limitations and exclusions. Please pay particular attention to the exclusions in each section and the *Definitions* section of your Benefits Handbook. Use the definitions to verify your understanding of concepts in the handbook.

Notification of Discretionary Authority

Deseret Mutual has full discretionary authority to interpret the plans and to determine benefit eligibility. Deseret Mutual has the sole right to construe plan terms. All Deseret Mutual decisions relating to plan terms or eligibility for benefits are binding and conclusive.

Notification of Benefit Changes

Deseret Mutual is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Deseret Mutual reserves the right to amend or terminate the plan at any time. If benefit changes are made, we will notify you within 30 days before the effective date of change.

Senior General Information

This *Senior General Information* section of your Benefits Handbook outlines the general provisions of your employee benefit program. If you would like a copy of the legal documents, please contact Deseret Mutual.

If you have questions, please call us or visit our Web site:

Salt Lake City area 1-801-578-5600

Toll free 1-800-777-3622

Web site www.dmba.com

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Deseret Secure

<u>Welcome to Deseret Secure</u>	1
<u>Deseret Secure</u>	4
<u>Medicare</u>	4
<u>Medical Benefits</u>	4
<u>Allergy Testing</u>	5
<u>Ambulance Services</u>	5
<u>Anesthesia</u>	5
<u>Cardiac Rehabilitation</u>	5
<u>Cardiovascular Testing</u>	5
<u>Chemical Dependency — Inpatient</u>	5
<u>Chemical Dependency — Outpatient</u>	5
<u>Chemotherapy</u>	6
<u>Chiropractic Services</u>	6
<u>Diabetes Education</u>	6
<u>Diabetic Foot Care</u>	6
<u>Diabetic Supplies</u>	6
<u>Dialysis</u>	7
<u>Emergency Room</u>	7
<u>Eye Exams</u>	7
<u>Eyewear (Glasses or Contact Lenses)</u>	7
<u>Food Supplements</u>	7
<u>Hearing Aids for Children</u>	7
<u>Hearing Exams</u>	8
<u>Home Health Care</u>	8
<u>Hospice Care</u>	8

Deseret Secure

<u>Hospital — Inpatient</u>	8
<u>Hospital — Outpatient</u>	8
<u>Immunizations</u>	8
<u>Injections — Allergy, Intramuscular, Therapeutic</u>	9
<u>IV Therapy</u>	9
<u>Laboratory Services</u>	9
<u>Lifestyle Screenings</u>	9
<u>Medical Equipment (Durable)</u>	10
<u>Medical Supplies</u>	10
<u>Mental Health — Outpatient</u>	10
<u>Mental Health — Inpatient</u>	11
<u>Mental Health — Alternative Care</u>	11
<u>Nutrition Education</u>	11
<u>Nutrition Therapy</u>	11
<u>Obesity Surgery — Inpatient</u>	11
<u>Obesity Surgery — Outpatient</u>	12
<u>Occupational Therapy — Outpatient</u>	12
<u>Pain Clinics — Inpatient</u>	12
<u>Pain Clinics — Outpatient</u>	12
<u>Physical Exams</u>	12
<u>Physical Therapy — Outpatient</u>	12
<u>Physician Visits</u>	13
<u>Prescription Drugs — from your Local Retail Pharmacy</u>	13
<u>Prescription Drugs — from the Mail-Service Pharmacy</u>	13
<u>Prescription Drugs — from the Specialty Pharmacy</u>	14

Deseret Secure

<u>Prescription Drugs — Other</u>	14
<u>Preventive Screenings</u>	15
<u>Prosthetics</u>	15
<u>Radiation Therapy</u>	15
<u>Radiology — Routine</u>	15
<u>Radiology — Major</u>	15
<u>Respiratory Rehabilitation</u>	15
<u>Skilled Nursing Facility</u>	16
<u>Speech Therapy — Outpatient</u>	16
<u>Surgery — Inpatient</u>	16
<u>Surgery — Outpatient</u>	16
<u>Temporomandibular Joint (TMJ) Dysfunction</u>	16
<u>Transplants</u>	17
<u>Transportation</u>	17
<u>Urgent Care</u>	17
<u>Providers Who Choose Not to Participate in Deseret Secure</u>	18
<u>Medical Emergencies</u>	18
<u>Prenotification</u>	18
<u>Preauthorization for Specific Medications</u>	18
<u>Catastrophe Protection</u>	19
<u>Errors on Bills or Explanation of Benefits Statements</u>	19
<u>Filing Claims</u>	20
<u>Coordination of Benefits</u>	20
<u>Subrogation</u>	21
<u>Your Medicare Rights</u>	21

Deseret Secure

<u><i>Your Medicare Responsibilities</i></u>	24
<u><i>Grievances</i></u>	25
<u><i>Advance Coverage Determinations</i></u>	26
<u><i>Appeals</i></u>	26
<u><i>Exclusions</i></u>	33
<u><i>Definitions</i></u>	38
<u><i>Notification of Discretionary Authority</i></u>	38
<u><i>Notification of Benefit Changes</i></u>	38

Welcome to Deseret Secure!

At Deseret Mutual, we're pleased you're a part of **Deseret Secure**, our comprehensive and generous health plan for members covered by Medicare.

Deseret Secure is what's known as a **Medicare Advantage Private Fee-for-Service plan**. So it's been approved by the Centers for Medicare & Medicaid Services (CMS). And Deseret Mutual administers the plan for you.

This section of your Benefits Handbook outlines **Deseret Secure** as of January 1, 2009. To help you understand how the plan works, here is a brief summary. Then more specific information about plan benefits, procedures, and limitations follows.

- Because Deseret Secure is a Medicare Advantage Private Fee-for-Service plan, you must be enrolled in Medicare Parts A and B. In other words, you're still covered by Medicare, but you receive your Medicare benefits as a member of Deseret Secure. (Deseret Secure is not a "Medigap" or traditional supplement to Medicare.)
- Once you're properly enrolled in Medicare Parts A and B, Deseret Mutual takes care of your Medicare claims, as well as all the additional benefits Deseret Secure provides. So Deseret Secure covers all aspects of your health-care needs.
- In fact, the plan covers your Medicare **Part A** (hospital insurance), **Part B** (medical insurance), and **prescription drugs**, plus many benefits Medicare doesn't cover. And you don't have to worry about any of the paperwork because we take care of it for you (for more information about Medicare, please see [page 4](#)).
- You can choose to purchase higher prescription drug coverage with **Deseret Secure PLUS**. The plans are identical in all other respects. For more information about the differences in the prescription drug benefits, please see [pages 13 and 14](#).
- You can increase your benefits if you **prenotify** us of certain services like inpatient hospital stays, home health care, and certain durable medical equipment. The [benefits section](#) on pages 5 to 17 outlines when to prenotify. To prenotify, call Deseret Mutual's Medical Management Team.
- Since Deseret Secure is a private fee-for-service plan, you're not required to receive care from specific providers (except when indicated). Instead, you can choose any **Medicare participating** physician or health-care provider who chooses to be "deemed."
- To be "deemed," providers must agree to the terms and conditions of Deseret Secure on a visit-by-visit basis. They must also accept the same amount of payment as traditional Medicare — including your copayments and/or coinsurance — as payment in full. And providers must agree to send all claims directly to Deseret Mutual, **not** to Medicare.

Deseret Secure

- You should always make sure your providers will accept you as a patient in this Medicare Advantage Private Fee-for-Service plan.
- To receive services, **you must use your Deseret Secure health insurance identification card** instead of your red, white, and blue Medicare card. Keep your red, white, and blue Medicare card in a safe place in case you're asked to show it, but you will not use it to receive services.
- Here's an example of a Deseret Secure identification card for your reference:

FRONT:



BACK:

MEMBER:

- For questions about Deseret Secure benefits, call **1-800-777-3622**
- If your hearing is impaired, call **1-800-333-9715**
- For questions about your prescription drug benefits, call Deseret Mutual at **1-800-777-3622** or Medco at **1-800-711-4542**
- To find a participating retail pharmacy, visit **www.medco.com**

PROVIDER:

- Deseret Secure is a Medicare Advantage Private Fee-for-Service plan for Deseret Mutual's members on Medicare
- For claims or billing questions, call **1-877-220-0110**
- **Do not bill Medicare!** Send all claims to:
Deseret Mutual, P.O. Box 45530, Salt Lake City, UT 84145-0530
- For information about the benefits, terms, and conditions of the plan, visit our Web site at **www.dmba.com/provider/medicare**

- Because each person enrolled in Deseret Secure is a separate Medicare beneficiary, each person receives a separate identification card with his/her own name. So if your spouse is also covered by Deseret Secure, he/she will receive a separate card.
- When you go to a doctor or hospital, inform them that you're a member of Deseret Secure, a Medicare Advantage Private Fee-for-Service plan, and show them your Deseret Secure identification card. Your provider will then decide if he or she will treat you as a member of this Medicare Advantage plan.

Deseret Secure

- If providers have any questions about Deseret Mutual as your benefits administrator or about the plan's terms and conditions, please ask them to visit our Web site at www.dmba.com/provider/medicare.
- If your providers have claims or billing questions, they should call **1-877-220-0110**.
- If your provider decides not to participate in Deseret Secure, you must seek care from another provider who is willing to treat you as a member of this Medicare Advantage Private Fee-for-Service plan.
- Because you must show your Deseret Secure identification card when you receive services, please carry it with you at all times. If your card is ever damaged, lost, or stolen, please call your Deseret Mutual Benefits Team right away and we'll send you a new card.
- Internists, family practice physicians, and general practitioners are considered "primary care physicians." All other doctors are considered "specialists," so you pay a higher office copayment, as shown in the benefits section.
- To be eligible for some benefits, you must meet Medicare's medical criteria. Also, benefit limitations and eligibility requirements may be different with Deseret Secure than they have been in the past (for example, see [Medical Equipment and Medical Supplies](#) on page 10). So if you have any question about your personal situation, please call your Deseret Mutual Benefits Team first.
- Except for a few medications, preauthorization is not required with Deseret Secure (see [Preauthorization for Specific Medications](#) on page 18).
- Please note, you can be enrolled in only one Medicare Advantage plan at a time. And you cannot be enrolled in a separate prescription drug plan while you're enrolled in Deseret Secure. It's your responsibility to inform Deseret Mutual of any other medical or prescription drug coverage you have or may get in the future.
- As a member of Deseret Secure, you have the right to appeal plan decisions about payments and/or services if you disagree. For more information, see [pages 26 to 33](#).
- If you would rather not be enrolled in Deseret Secure (or Deseret Secure *PLUS*), you can choose to have your coverage directly with Medicare or with a commercial supplement to Medicare. To "opt out" or disenroll from Deseret Secure, please call Deseret Mutual's Membership Team directly.
- Keep in mind that if you decide to drop your Deseret Mutual medical and prescription drug coverage, you cannot pick it up later. So carefully review your options.

Deseret Secure

Deseret Secure

This section of your handbook, together with your enrollment and any updates we may send you, is our contract with you. It explains your benefits, rights, and responsibilities as a member of Deseret Secure. It also explains our responsibilities to you.

Again, you're still covered by Medicare, but you are getting your Medicare benefits as a member of Deseret Secure, directly from Deseret Mutual. This section gives you the details, including:

- What's covered by Deseret Secure and what's not
- How to get the care you need, including some rules you must follow
- What you'll pay for your health care
- What to do if you're unhappy about something related to your benefits

Medicare

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

Medicare benefits are divided into three parts: Part A, Part B, and Part D coverage.

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

Generally, you're automatically enrolled in Part A when you turn 65. But it's up to you to enroll in Medicare Part B as soon as you're eligible (visit www.medicare.gov for help or call 1-800-MEDICARE — 1-800-633-4227). And as for Part D benefits, Deseret Secure — and Deseret Secure *PLUS* — covers it for you! **So you should not enroll in a separate Medicare Part D prescription drug plan.** In fact if you do, you'll lose your Deseret Mutual coverage and won't be able to pick it up later!

Medical Benefits

Your Deseret Secure and Deseret Secure *PLUS* [medical benefits](#) follow alphabetically on pages 5 to 17:

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Allergy Testing

- The plan pays 100%
- Some allergy tests, such as ALCAT, are not covered (see [exclusion 15.1](#) on page 37)
- For information about allergy injections, see [page 9](#)

Ambulance Services

- The plan pays 100% after your \$50 copayment (charged only once per day)

Anesthesia

- The plan pays 100%

Cardiac Rehabilitation

- The plan pays 100% after your \$20 copayment per visit

Cardiovascular Testing

- The plan pays 100%

Chemical Dependency – Inpatient

- The plan pays 100% after your \$500 admission copayment. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team

Chemical Dependency – Outpatient

- The plan pays 80%; you pay 20%
- Expenses do not apply to the catastrophe protection benefit (see [page 19](#))

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Chemotherapy

- The plan pays 90%; you pay 10%

Chiropractic Services

- The plan pays 100% after your \$20 copayment per visit
- Only spinal manipulations for specific medical conditions are covered. Maintenance treatments for chronic conditions are not covered, nor are X-rays performed by a chiropractor. For more information, call your Deseret Mutual Benefits Team

Diabetes Education

- You must be diagnosed with diabetes to qualify
- The plan pays 100% when provided by a licensed dietician or nutritionist
- You're eligible for 10 hours of education in the first year and 2 hours of education in all subsequent years. For more information, call your Deseret Mutual Benefits Team

Diabetic Foot Care

- Routine diabetic foot care is covered (with limitations). For more information, call your Deseret Mutual Benefits Team

Diabetic Supplies

	Plan Pays	You Pay
Glucometers	80% (or 90% if you prenotify)	20% (or 10% if you prenotify)
Lancets, test strips, and pump supplies	90%	10%
Insulin pumps	80% (or 90% if you prenotify)	20% (or 10% if you prenotify)

- To maximize your benefits, purchase supplies from **Veridicus Rx**. For more information, call Deseret Mutual's Prescription Team
- You're free to purchase your diabetic supplies from other providers who are able to bill Deseret Mutual directly. But you cannot purchase supplies from Medco through the mail or from certain retail pharmacies

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Dialysis

- The plan pays 100%

Emergency Room

- The plan pays 100% after your \$50 copayment (charged only once per day). The copayment is waived if you're admitted to the hospital. Additional copayments may apply if you receive other services like injections or IV therapy. See the appropriate benefits.

Eye Exams

- The plan pays 100% after your \$20 copayment per exam (eligible once a year)
- Exams for medical conditions, such as glaucoma, may be covered more often

Eyewear (Glasses or Contact Lenses)

- The plan pays 100% after your \$20 copayment per item
- Eyewear is only covered following certain eye surgeries. For more information, please call your Deseret Mutual Benefits Team

Food Supplements

- The plan pays 100%
- For patients using enteral feeding tubes, food supplements must meet Medicare's medical criteria
- Supplements are covered for patients with cystic fibrosis or inborn errors of metabolism. Supplements prescribed for other reasons are not covered
- Over-the-counter supplements are not covered. If you have any questions about your particular situation, please call your Deseret Mutual Benefits Team

Hearing Aids for Children

- Hearing aids are only covered for children younger than 19
- For hearing aids that cost **less than \$750**, the plan pays 85%; you pay 15%
- For hearing aids that cost **more than \$750**, the plan pays 75%; you pay 25%. This reduces to 15% if you **prenotify** by calling Deseret Mutual's Medical Management Team
- The maximum benefit is \$1,200 per ear, available once every three years

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Hearing Exams

- The plan pays 100% after your **\$10 copayment** per visit to an internist, family practice physician, or general practitioner
- For any other physician, the plan pays 100% after your **\$20 copayment** per visit

Home Health Care

- The plan pays 100% after your \$20 copayment per day. This reduces to \$0 per day if you **prenotify** by calling Deseret Mutual's Medical Management Team

Hospice Care

- For information about the hospice care benefit, please call Medicare directly at 1-800-MEDICARE (or 1-800-633-4227)

Hospital – Inpatient

- The plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team
- If you're admitted to the hospital again within 60 days of your discharge, you don't have to pay a second admission copayment

Hospital – Outpatient

- The plan pays 100% after your \$75 copayment per visit
- Additional coinsurance may apply if you receive injections or infusion services. See the appropriate benefits

Immunizations

- The plan pays 100%
- Covered immunizations include:
 - Diphtheria/Pertussis/Tetanus (DPT)
 - Diphtheria/Tetanus (DT)
 - Hepatitis
 - Hemophilus Influenza (HIB)
 - Influenza (VZV)
 - Measles/Mumps/Rubella (MMR)
 - Polio
 - Pneumococcal
 - Shingles (Zoster Vax)
 - Tetanus
 - Tetramune

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Injections – Allergy, Intramuscular, Therapeutic

- The plan pays 90%; you pay 10%
- Some expensive injectable medications that require special handling and are used to treat complex and/or rare conditions may be covered by the specialty pharmacy, as follows:

Deseret Secure	Deseret Secure <i>PLUS</i>
You pay 10%, but no more than \$120 each time you fill a single prescription	You pay 10%, but no more than \$85 each time you fill a single prescription

- For medications from the specialty pharmacy, the plan covers a 30-day supply per prescription
- ***You must purchase these specialty pharmacy supplies and medications from Medco.*** For more information, please call Deseret Mutual's Prescription Team
- Expenses for injectable medications from the specialty pharmacy do not apply to the catastrophe protection benefit (see [page 19](#))

IV Therapy

- The plan pays 90%; you pay 10%
- For IV therapy administered at home, you must meet Medicare's medical criteria. For more information, please call your Deseret Mutual Benefits Team

Laboratory Services

- The plan pays 100%

Lifestyle Screenings

- The plan pays 100%, up to \$100, after your \$20 copayment per screening
- You are responsible for all costs that exceed the \$100 limit
- One screening is covered every three years
- Expenses do not apply to the catastrophe protection benefit (see [page 19](#))

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Medical Equipment (Durable)

- For equipment that costs **less than \$750**, the plan pays 85%; you pay 15%
- For equipment that costs **more than \$750**, the plan pays 75%, you pay 25%. This reduces to 15% if you **prenotify** by calling Deseret Mutual's Medical Management Team
- You must meet Medicare's criteria to be eligible for certain types of equipment. Plus, benefit limitations and eligibility requirements may be different than they have been in the past. So please call Deseret Mutual's Medical Management Team first
- Here's a list of some common items that are excluded. This list is not intended to be comprehensive but to give you an idea of equipment that's not covered:

Excluded Medical Equipment

Air filtration systems	Learning devices
Dehumidifiers	Modifications associated with:
Exercise equipment	• Activities of daily living
Hearing aids for anyone 19 or older	• Homes
Hearing devices	• Vehicles
Humidifiers	Spa / gym memberships
Knee braces used solely for sports	

Medical Supplies

- The plan pays 100%
- Benefit limitations and eligibility requirements may be different than they have been in the past. So please call Deseret Mutual's Medical Management Team first
- Medical supplies are disposable, one-use-only medical items for immediate use
- For information about diabetic supplies, see [Diabetic Supplies](#) on page 6

Mental Health – Outpatient

- For psychiatric testing, the plan pays 100% (repeat testing within 12 months is not covered)
- For outpatient therapy, the plan pays 100% after your \$20 copayment per visit for individual therapy or your \$10 copayment per visit for group therapy

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Mental Health – Inpatient

- The plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team
- If you're admitted to the hospital again within 60 days of your discharge, you don't have to pay a second admission copayment

Mental Health – Alternative Care

- In some cases, intensive outpatient treatment may be an appropriate alternative to inpatient care. So if you can be discharged from an inpatient acute care setting to a less expensive setting, such as day treatment or partial-day treatment, without compromising the quality of care, you may qualify for the alternative care benefit
- The plan pays 50%; you pay 50%

Nutrition Education

- The plan pays 100% when provided by a licensed dietician or nutritionist
- You must be diagnosed with anorexia, bulimia, or renal disease to qualify. For more information or for benefit limitations, please call your Deseret Mutual Benefits Team
- You're eligible for 3 hours of education in the first year and 2 hours of education in all subsequent years. For more information, call your Deseret Mutual Benefits Team
- If you've been diagnosed with diabetes, see [Diabetes Education](#) on page 6

Nutrition Therapy

- The plan pays 100% when provided by a licensed dietician or nutritionist
- You must be diagnosed with diabetes or renal disease to qualify. For more information, please call your Deseret Mutual Benefits Team
- You're eligible for 3 hours of education in the first year and 2 hours of education in all subsequent years. For more information, call your Deseret Mutual Benefits Team

Obesity Surgery – Inpatient

- You must meet Medicare's criteria to qualify and the surgery must be performed in a Medicare-approved facility. For more information, call Deseret Mutual's Medical Management Team
- The plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team
- If you're admitted to the hospital again within 60 days of your discharge, you don't have to pay a second admission copayment

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Obesity Surgery – Outpatient

- You must meet Medicare's criteria to qualify and the surgery must be performed in a Medicare-approved facility. For more information, call Deseret Mutual's Medical Management Team
- The plan pays 100% after your \$75 copayment per outpatient surgery

Occupational Therapy – Outpatient

- The plan pays 100% after your \$20 copayment per visit

Pain Clinic – Inpatient

- The plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team
- If you're admitted to the hospital again within 60 days of your discharge, you don't have to pay a second admission copayment

Pain Clinic – Outpatient

- The plan pays 100% after your \$20 copayment per visit

Physical Exams

- Physical exams are limited to one exam per calendar year
- The plan pays 100% after your **\$10 copayment** per visit to an internist, family practice physician, or general practitioner
- For any other physician, the plan pays 100% after your **\$20 copayment** per visit

Physical Therapy – Outpatient

- The plan pays 100% after your \$20 copayment per visit

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Physician Visits

- The plan pays 100% after your **\$10 copayment** per visit to an internist, family practice physician, or general practitioner
- For any other physician, the plan pays 100% after your **\$20 copayment** per visit

Prescription Drugs – from your Local Retail Pharmacy

	Deseret Secure	Deseret Secure <i>PLUS</i>
Formulary Drugs	You pay 45% or at least \$5 each time you fill a single prescription	You pay 30% or at least \$5 each time you fill a single prescription
Non-formulary Drugs	You pay 50% or at least \$5 each time you fill a single prescription	

- The plan covers up to a 30-day supply or 90 unit doses, whichever is greater
- If you need a larger supply, you may save money by purchasing your medication from the mail-service pharmacy (see below)
- Because of state and/or federal regulations, certain medications may not be available in a 30-day supply or 90 unit doses. So you may receive less
- To find a participating retail pharmacy, visit www.medco.com
- Prescription benefits provided from Medco do not apply to the catastrophe protection benefit (see [page 19](#))

Prescription Drugs – from the Mail-Service Pharmacy

	Deseret Secure	Deseret Secure <i>PLUS</i>
Formulary Drugs	You pay 35% or at least \$10 but no more than \$120 each time you fill a single prescription	You pay 25% or at least \$10 but no more than \$85 each time you fill a single prescription
Non-formulary Drugs	You pay 50% or at least \$10 each time you fill a single prescription	

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Prescription Drugs – from the Mail-Service Pharmacy (continued)

- For medications you take on a regular basis or for an extended period of time, you may save money by purchasing these drugs from our mail-service pharmacy
- The plan covers up to a 90-day supply per prescription
- Because of state and/or federal regulations, certain medications may not be available in a 90-day supply. So you may receive less
- For questions about your prescription drug benefits, call Medco at 1-800-711-4542
- Prescription benefits provided from Medco do not apply to the catastrophe protection benefit (see [page 19](#))

Prescription Drugs – from the Specialty Pharmacy

- Some expensive medications that require special handling and are used to treat complex and/or rare conditions may be covered by the specialty pharmacy, as follows:

Deseret Secure	Deseret Secure <i>PLUS</i>
You pay 10%, but no more than \$120 each time you fill a single prescription	You pay 10%, but no more than \$85 each time you fill a single prescription

- For medications from the specialty pharmacy, the plan covers a 30-day supply per prescription
- You must purchase these specialty pharmacy supplies and medications from Medco. For more information, call Deseret Mutual's Prescription Team
- Prescription benefits provided from Medco do not apply to the catastrophe protection benefit (see [page 19](#))

Prescription Drugs – Other

- Several drugs that are typically covered by Medicare Part B are not available from Medco but they are available from **Veridicus Rx**, a mail-service pharmacy. For more information, please call Deseret Mutual's Prescription Team
- The plan pays 90%; you pay 10%

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Preventive Screenings

- The plan pays 100%, after applicable copayments, for the following screenings:

Bone mass measurement	One exam every other year
Cardiovascular screening	One exam a year
Cervical/vaginal cancer screening . . .	No limit
Colorectal exams	One exam every other year
Eye exams.	One exam a year
Glaucoma screening	One exam a year (more often for high risk)
Hearing tests	No limit
Mammograms	For women 40 and older, one exam a year
Prostate cancer screening	No limit

Prosthetics

- For prosthetics that cost **less than \$750**, the plan pays 85%; you pay 15%
- For prosthetics that cost **more than \$750**, the plan pays 75%; you pay 25%. This reduces to 15% if you **prenotify** by calling Deseret Mutual's Medical Management Team
- Includes prosthetics such as artificial arms, legs, and eyes

Radiation Therapy

- The plan pays 100% after your \$20 copayment per visit

Radiology – Routine

- The plan pays 100%
- Includes X-rays and CT scans
- X-rays from a provider who is not a medical doctor or an osteopath are not covered (for example, X-rays provided by a chiropractor are not covered)

Radiology – Major

- The plan pays 100% after your \$25 copayment (charged only once per day)
- Includes MRIs, MRAs, PET and SPECT scans

Respiratory Rehabilitation

- The plan pays 100% after your \$20 copayment per service

Deseret Secure

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Skilled Nursing Facility

- The plan pays 100% after your \$100 copayment per benefit period. The copayment is waived if you **prenotify** by calling Deseret Mutual's Medical Management Team
- You must have been in the hospital for at least three days for a related illness or injury before you're eligible to be covered for care in a skilled nursing facility
- If you're in a skilled nursing facility for more than 15 days, you pay \$75 per day from day 16 on, or until you reach your annual out-of-pocket maximum (see [page 19](#))
- Up to 100 days are covered per benefit period. If you have questions about your benefit period, call your Deseret Mutual Benefits Team

Speech Therapy – Outpatient

- The plan pays 100% after your \$20 copayment per visit

Surgery – Inpatient

- The plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team

Surgery – Outpatient

- The plan pays 100% after your \$75 copayment per outpatient surgery

Temporomandibular Joint (TMJ) Dysfunction

- The plan pays 80%; you pay 20%
- The maximum benefit is \$1,000 per lifetime. This limit does not apply to MRIs or surgery for TMJ dysfunction
- Night guards for grinding teeth are not eligible for benefits
- Orthognathic surgery is not covered when used to treat a diagnosis of TMJ dysfunction
- Services are only covered in certain circumstances. For more information, please call your Deseret Mutual Benefits Team
- Expenses do not apply to the catastrophe protection benefit (see [page 19](#))

All benefits are subject to the maximum allowable limits determined by Deseret Mutual.

Transplants

- You must meet Medicare's criteria to qualify and the surgery must be performed in a Medicare-approved facility. For more information, call Deseret Mutual's Medical Management Team
- For eligible transplants, the plan pays 100% after your \$500 copayment per admission. This reduces to \$400 if you **prenotify** by calling Deseret Mutual's Medical Management Team
- If you meet eligibility requirements, the following transplants are covered:
 - Bone marrow — Cornea — Heart — Intestine
 - Kidney — Liver — Lung — Pancreas / kidney
- If you meet the eligibility requirements, outpatient cornea transplants are covered at 100% after your \$75 copayment per surgery
- Other transplants are not covered

Transportation

- In some serious circumstances, the plan covers medically necessary transportation to the nearest medical facility equipped to furnish the appropriate care
- This benefit covers transportation for the patient. But in some situations, it covers transportation for one parent or guardian to accompany a member who is unable to travel by themselves and is covered by Medicare
- The plan pays 100%
- If you travel by automobile, the plan pays the IRS's standard mileage rate for eligible medical travel (27¢ per mile for 2009), after the first 200 miles
- If you travel by airplane or train, please call your Deseret Mutual Benefits Team for more information
- For more information about the ambulance benefit, see [Ambulance Services](#) on page 5

Urgent Care

- The plan pays 100% after your \$30 copayment per visit

Deseret Secure

Providers Who Choose Not to Participate in Deseret Secure

Sometimes a doctor, specialist, hospital, clinic, or other health-care provider might decide to not participate in Deseret Secure. This could happen because your doctor has decided to not accept Deseret Secure's terms and conditions or Medicare's standard reimbursement.

If this happens, you'll need to find a provider who is willing to treat you as a member of Deseret Secure. If you need help finding a provider who will accept Deseret Secure's terms and conditions of payment, please call your Deseret Mutual Benefits Team and we'll be happy to help.

Medical Emergencies

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

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

Prenotification

Prenotification means you notify Deseret Mutual in advance about specific procedures such as inpatient hospital stays, home health care, and some durable medical equipment. Then we reduce your copayment and help direct you to receive the most cost-effective care. Our registered nurse case managers can also help you manage your care if you have a chronic illness or would simply like some help.

Keep in mind that if you're admitted to the hospital because of an emergency, you should call Deseret Mutual within 48 hours of your admission or as soon as reasonably possible.

Preauthorization for Specific Medications

Preauthorization means we're notified in advance about specific medications your doctor has prescribed. Then we can tell you what will be covered before you're faced with your share of the costs. Remember, preauthorization is only required for certain medications. So if you have any questions about your personal situation, please call Deseret Mutual's Prescription Team. Otherwise, if you don't preauthorize when necessary, your benefits may be reduced or denied.

Catastrophe Protection

If your share of eligible expenses reaches \$2,500 per calendar year (your annual out-of-pocket maximum), your benefits for the remainder of the calendar year are paid at 100% for eligible charges, based on the catastrophe protection of the plan.

Some benefits do not apply to your out-of-pocket limit, so they're not covered by the catastrophe protection. These include:

- Chemical dependency — outpatient
- Lifestyle screenings
- Prescription medications, except for drugs that are traditionally covered by Medicare Part B (see [Prescription Drugs — Other](#) on page 14)
- Temporomandibular joint (TMJ) dysfunction

Errors on Bills or Explanation of Benefits Statements

If services appear on an *Explanation of Benefits* statement that were not performed or could be considered fraudulent, please call your Deseret Mutual Benefits Team.

If you find an error on any of your bills after your claims have been processed and paid, please verify the charges with the provider. Then submit a written description of the error to Deseret Mutual at the following address:

Deseret Mutual
Overpayment Team
P.O. Box 45530
Salt Lake City, Utah 84145

This is called an audit reimbursement request. Audit reimbursement is a valuable benefit of Deseret Secure because if the mistake was not otherwise detected, you can receive 50% of the eligible savings, up to \$500 per claim.

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 Deseret Mutual detects an error on a 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 of 1974 (ERISA).

Deseret Secure

Filing Claims

You shouldn't have to file any claims because providers will send bills directly to Deseret Mutual. But you could receive a bill for care you receive in an emergency situation or if you need care when you're traveling outside the United States.

If you receive a medical bill in one of these situations, please follow these steps to file a claim:

- Make sure the bill is itemized, including the physician name and address, service dates, and diagnosis and procedure codes
- Write your name and Deseret Mutual identification number on the bill
- Have the provider indicate the amount of payment already collected, if applicable.
- Mail the claim to:

Deseret Mutual
P.O. Box 45530
Salt Lake City, Utah 84145

You must submit claims within **15 months** from the date of service. Deseret Mutual will send you an *Explanation of Benefits* statement when your claims have been processed. Please review your statements for accuracy.

Coordination of Benefits

To help you make the most of your medical coverage, coordination of benefits combines the benefits of two or more medical plans. So if you or your dependents have medical coverage with two plans, your medical benefits may be coordinated.

If you are covered by more than one plan, you are legally responsible to notify Deseret Mutual. But keep in mind that when you're enrolled in Deseret Secure, this rarely happens.

We will **not** coordinate benefits between Deseret Secure and any other Medicare Advantage plans. Again, you can be enrolled in only one Medicare Advantage plan at a time.

The total benefit will not exceed Deseret Mutual's maximum allowable limit. So you may be responsible for some out-of-pocket expenses.

For more information about coordination of benefits, see the *General Information* section of your Benefits Handbook.

Subrogation

If you have an injury or illness that is the liability of another party and you have the right to recover damages, Deseret Mutual must be reimbursed for any amount it has paid when damages are recovered from the third party.

In addition, if you do not attempt to recover damages from the third party as described above, Deseret Mutual has the right to step into your shoes 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 the *General Information* section of your Benefits Handbook.

Your Medicare Rights

Since you're covered by Medicare, you have certain rights to help protect you. And as your health plan, we must inform you about these rights, as well as obey the laws established to protect you. So in this section, we explain your rights as a member of Deseret Secure.

Your right to be treated with dignity, respect, and fairness

- You have the right to be treated with dignity, respect, and fairness at all times.
- You cannot be discriminated against because of your race or color, age, religion, national origin, or any mental or physical disability.
- If you think you have been treated unfairly because of your race, color, national origin, disability, age, or religion, please let us know. Or you can call the Office for Civil Rights in your area.
- For any other kind of concern or problem related to your Medicare rights and protections, call Deseret Mutual.

Your right to privacy of medical records and personal health information

- Federal and state laws protect the privacy of your medical records and personal health information.

Deseret Secure

- As your health plan, we protect your information. In other words, we make sure unauthorized people do not see your medical records or personal information that has been entrusted to our care.
- Generally, we must have your written permission before we can give your health information to anyone.
- You also have rights about how your health information is used.
- We send a notice every three years that explains your rights and how we protect the privacy of your health information.

Your right to see ‘deemed’ providers

- You have the right to seek care from any provider in the United States who is eligible to be paid by Medicare and who accepts Deseret Secure’s terms and conditions of payment.
- These providers are then considered “deemed.”

Your right to participate in health-care decisions

- You have the right to receive complete information from your health-care providers and to participate fully in decisions about your care.
- Your providers must explain things in a way you can understand.
- You have the right to know about all treatment options recommended for your condition, no matter the cost or whether they are covered by Deseret Secure.
- You have the right to be told about any risks involved in your care.
- You must be told in advance if any proposed care or treatment is part of a research experiment and be given the choice to reject such treatment.
- You have the right to refuse treatment, including the right to leave a hospital or other medical facility, even if your doctor advises you not to leave.
- You also have the right to stop taking your medication.
- If you refuse treatment, you accept responsibility for what happens as a result of your decision.

Your right to use ‘advance directives’

- Sometimes, people cannot make health-care decisions for themselves because of accidents or serious illness.
- You have the right to ask someone, such as a family member or friend, to help you make decisions about your health care.
- You also have the right to give your doctors written instructions about how you want them to treat you if you become unable to make decisions for yourself.
- The legal documents that you can use to give your directions in advance in these situations are called “*advance directives*.”
- Different types of advance directives have different names. For example, a “living will” and a “power of attorney for health care” are both types of advance directives.
- If you decide you want to have an advance directive, you can get the form from your lawyer, your doctor’s office, a local hospital, etc.
- An advance directive is a legal document, so consider having a lawyer help you prepare it.
- Make sure you sign this form and keep a copy at home. You should also give a copy to your doctor and to the person you name on the form, as well as to close friends or family members.
- If you know ahead of time that you’re going to be hospitalized and you have signed an advance directive, take a copy with you to the hospital.
- If you’re admitted to the hospital, you’ll be asked whether you have signed an advance directive and whether you have it with you. If you have not signed an advance directive, the hospital will ask if you want to sign one.
- It’s your choice whether you want to complete an advance directive, including whether you want to sign one if you’re in the hospital.
- No one can deny you care or discriminate against you based on whether you have signed an advance directive.
- If you have signed an advance directive and you believe a doctor or hospital has not followed the instructions, you may file a complaint with your state’s health department.

Deseret Secure

Your right to get information about health-care coverage and costs

- We must tell you in writing why we will not cover a specific service and how you can file an appeal.
- You also have the right to question our financial condition and how we pay health-care providers. To get this information, please call Deseret Mutual.

Your right to complain

- Federal law guarantees your right to complain if you have concerns or problems with any part of your medical care as a member of Deseret Secure, and we must be fair in how we handle it.
- Your complaint is called either a “grievance” or an “appeal,” depending on the situation. [Grievances](#) are discussed on pages 25 and 26, and [appeals](#) are discussed on pages 26 to 33.

For more information about your rights

Medicare offers a booklet called *Your Medicare Rights and Protections*. To receive a free copy, call 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. Or you can visit www.medicare.gov on the Internet.

Your Medicare Responsibilities

Along with your rights as a member of Deseret Secure, you also have certain responsibilities. And again, we’re required by law to let you know about these responsibilities. They include:

- Becoming familiar with your coverage and the procedures you must follow to receive care
- Notifying providers, unless it’s an emergency, that you’re enrolled in Deseret Secure, a Medicare Advantage Private Fee-for-Service plan
- Giving your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions you and your doctors agree upon
- Paying your premiums and copayments and/or coinsurance for the covered services you receive
- Calling Deseret Mutual if you have any questions, concerns, problems, or suggestions

Grievances

A grievance is a type of complaint you make about us or one of your health-care providers, including complaints about your quality of care. This type of complaint does not involve payment or coverage disputes (the appeals section covers these issues; see [pages 26 to 33](#)).

The following types of problems may lead you to file a grievance:

- If you feel you're being encouraged to disenroll from Deseret Secure
- Problems with the service you receive from Deseret Mutual
- If you disagree with our decision not to expedite your appeal
- If you believe our notices and other written materials are difficult to understand
- If we don't give you a decision within the required timeframe
- If we don't forward your case to the independent review entity when appropriate
- If we don't send you required notices that comply with Medicare standards

Filing a grievance with Deseret Mutual

- If you have a grievance, we encourage you to call Deseret Mutual first and we'll try to resolve your complaint over the phone.
- If we can't resolve your grievance over the phone, we have a formal procedure to review your complaints.
- We must notify you of our decision about your grievance as quickly as your case requires, but no later than 30 days after receiving your complaint.
- We may extend the timeframe by up to 14 days if you request the extension or if we need additional information and the delay is in your best interest.
- In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours.
- If you request a written response to your phone complaint, we'll respond to you in writing.
- You may file your grievance in any of the following ways:
 - In writing to: Deseret Mutual
Attention: Appeals Coordinator
P.O. Box 45530
Salt Lake City, Utah 84145-0530

Deseret Secure

- By fax at 1-801-578-5903
- By telephone at 1-801-578-5600 or toll free at 1-800-777-3622
- In person at 60 East South Temple, 4th floor of Eagle Gate Plaza, in Salt Lake City, Utah

Filing a grievance with the Quality Improvement Organization

- You can also file a grievance with the Quality Improvement Organization, or QIO. The QIO is an independent group of doctors and other health-care experts who are under contract with the federal government to check on and help improve the care given to Medicare patients.
- For information about the QIO in your area, please contact Medicare directly at 1-800-MEDICARE (1-800-633-4227).
- Deseret Mutual must cooperate with the QIO in resolving your grievance.
- Grievances filed with the QIO must be made in writing, and you're not required to file this grievance within a specific time period.

Advance Coverage Determinations

If you have any question about whether Deseret Secure will pay for a service, you (or your provider) have the right to know in advance. This is called an “advance coverage determination.” To let us know you would like an advance coverage determination, please call your Deseret Mutual Benefits Team directly at 1-801-578-5600 in the Salt Lake City area or toll free at 1-800-777-3622. And the time frames outlined in the Appeals section apply to advance coverage determinations. So please see [pages 26 to 33](#) for more information.

Appeals

Unlike a grievance, an appeal is a complaint when you want us to reconsider a decision we've made about your Deseret Secure benefits, including what we paid for these benefits. An appeal is also called a “reconsideration.”

The following types of problems may lead you to file an appeal:

- If you're not satisfied with Deseret Secure's benefits or with Deseret Mutual's payment for these benefits
- If you've received care you believe should be covered by Deseret Secure, but we have refused to pay for this care because we say it is not covered
- If you're told a treatment or service you have been receiving will reduce or stop, and you believe this could harm your health

Initial Decisions

When we first receive a claim, we make an “initial decision” about whether we will cover the medical care and services. When we make this initial decision, we are interpreting how the benefits and services of Deseret Secure apply to your specific situation.

If our initial decision is to deny benefits, you can appeal this decision. In fact, if you’re not happy with an initial decision, ***you have five levels of appeals with Deseret Secure.***

And keep in mind that when you file your appeal, your request is given to different people than those who were involved in making the initial decision. So this helps make sure we give your request a fresh look.

Asking for an initial decision

- Your doctor or another medical provider may ask whether we will cover a treatment. Or you can ask us for an initial decision yourself or you can name someone (your representative) to do it for you. Your representative can be a relative, friend, or an attorney, for example.
- To ask for a “standard decision,” you or your representative should mail or deliver a request in writing to Deseret Mutual.
- To ask for a “fast decision,” you, your doctor, or your representative should call Deseret Mutual or deliver a written request that asks for a “fast” review. This is also called an “expedited” review.
- You can ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.
- If our initial decision is to deny your request, you can appeal the decision by going on to Appeal Level 1 (see [page 28](#)).

For a decision about payment for care you’ve already received

- We’ll make a decision within 30 days after we receive your request.
- If we need more information, we can take up to 30 more days. We’ll let you know in writing if we extend the timeframe.
- If we do not approve your request for payment, we must tell you why in writing, as well as tell you how you can appeal this decision.

Deseret Secure

For a “standard” initial decision about medical care

- We'll make a decision within 14 days after we receive your request.
- We can take up to 14 more days if you request the additional time or if we need more time to gather information, such as medical records, that may benefit you.
- If we take additional days, we'll notify you in writing. If you believe we should not take any additional days, you may file a “fast grievance” (see [page 25](#)).
- If we do not approve your request, we must explain why in writing, as well as explain your right to appeal this decision.

For a “fast” decision about medical care

- We'll make a decision within 72 hours after you or your doctor asks for it, or sooner if your health requires.
- We can take up to 14 more days to make this decision if we find that some information is missing that may benefit you, or if you need more time to prepare for this review.
- If you believe we should not take any additional days to make our decision, you may file a “fast grievance” (see [page 25](#)).

Appeal Level 1

You and/or your doctor must decide whether you want a “standard” appeal versus a “fast” appeal. The procedures for deciding on a standard or fast appeal are the same as those described for a standard or fast initial decision.

Filing your appeal

- You must file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you can call us or send the appeal in writing.
- ***For a decision about payment for care you already received***, we have up to 60 days to make a decision after we receive your appeal. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.
- ***For a standard decision about medical care***, we have up to 30 days to make a decision after we receive your appeal. But we'll make a decision sooner if your health requires it. If you request it or if information is missing that can help

you, we can take up to 14 more days to make our decision. If we don't tell you our decision within 30 days (or by the end of the extended time period), your request automatically goes to Appeal Level 2.

- ***For a fast decision about medical care***, we have up to 72 hours to make a decision after we receive your appeal. But we'll make it sooner if your health requires it. If you request it or if information is missing that can help you, we can take up to 14 more days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request automatically goes to Appeal Level 2.

If we decide completely in your favor:

- ***For a decision about payment for care you already received***, we must pay within 60 calendar days of the day we received your request.
- ***For a standard decision about medical care***, we must notify you no later than 30 days after we receive your appeal.
- ***For a fast decision about medical care***, we must notify you within 72 hours after we receive your appeal, or sooner if your health would be affected by waiting this long.

If we deny any part of your appeal:

- Your appeal automatically goes on to Appeal Level 2 where an independent review organization will review it, and we will tell you in writing that your appeal has been sent to this organization.
- How quickly we must forward your appeal to the organization depends on the type of appeal:
- ***For a decision about payment for care you already received***, we must send all information to the independent review organization within 60 days from the date we receive your Level 1 appeal.
- ***For a standard decision about medical care***, we must send all information to the independent review organization as quickly as your health requires, but no later than 30 days after we receive your Level 1 appeal.
- ***For a fast decision about medical care***, we must send all information to the independent review organization within 24 hours.

Deseret Secure

Appeal Level 2

At the second level of appeal, your case is given a new review by an outside, independent review organization that contracts with the federal government. We will tell you when we have sent your appeal to this organization.

- You have the right to get a copy of your case file, and we're allowed to charge a fee for copying and sending this information to you.
- ***For an appeal about payment for care***, the independent review organization has up to 60 days to make a decision.
- ***For a standard appeal about medical care***, the independent review organization has up to 30 days to make a decision. But it can take up to 14 more days if the extension will help you.
- ***For a fast appeal about medical care***, the independent review organization has up to 72 hours to make a decision. But it can take up to 14 more days if the extension will help you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it.

- ***For an appeal about payment for care***, we must pay within 30 days after receiving notice of the decision.
- ***For a standard appeal about medical care***, we must pay between 72 hours and 14 days after receiving notice of the decision.
- ***For a fast appeal about medical care***, we must pay within 72 hours of receiving notice of the decision.

Appeal Level 3

If the independent review organization does not rule completely in your favor, you may ask for a review by an Administrative Law Judge (ALJ)

- You must make a request within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause.

- You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization.
- The ALJ will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision.
- If the dollar value is less than the minimum requirement, you may not appeal any further.
- During this review, you may present evidence, review the record, and be represented by counsel.
- The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.
- **If the ALJ decides in your favor**, we must pay for the service within 60 days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).
- **If the ALJ rules against you**, you have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you receive from the ALJ will tell you how to request this review.

Appeal Level 4

Your case may be reviewed by the Medicare Appeals Council (MAC). The MAC does not review every case it receives. If they decide not to review your case, then either you or Deseret Mutual may request a review by a Federal Court Judge (Appeal Level 5).

- The MAC will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.
- If the MAC reviews your case, they will make their decision as soon as possible.
- **If the MAC decides in your favor**, we must pay for the service within 60 days from the date we receive notice of the decision. But we have the right to appeal this decision by asking a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the contested benefit meets the minimum requirement provided in the MAC's decision. If the dollar value is less than the minimum requirement, the MAC's decision is final.

Deseret Secure

- ***If the MAC decides against you*** and the amount involved meets the minimum requirement provided in the MAC's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the MAC's decision is final and you may not take the appeal any further.

Appeal Level 5

To request judicial review of your case, you must file a civil action in a United States district court. The letter you receive from the MAC in Appeal Level 4 will tell you how to request this review.

- The Federal Court Judge will first decide whether to review your case, as long as the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision.
- If the contested amount meets the minimum requirement, you may ask a Federal Court Judge to review the case.
- The Federal judiciary controls the timing of any decision.

Complaints if you think you're being discharged from the hospital too soon

When you are hospitalized, you have the right to receive all the hospital care covered by Deseret Secure that's necessary to diagnose and treat your illness or injury.

The day you leave the hospital, or your "discharge date," is based on when your stay in the hospital is no longer medically necessary.

If you believe you're being discharged from the hospital too soon, you have the right to appeal this decision. You must file your appeal with the Quality Improvement Organization by noon of the first working day after you are notified of the discharge date. Contact Medicare directly and they can walk you through the appeal options available to you. To reach Medicare, call 1-800-633-4227.

Complaints if you think your coverage for specific services is ending too soon

When you're a patient in a skilled nursing facility, comprehensive outpatient rehabilitation facility, or receiving home health care, you have the right to receive all the appropriate care that's necessary to diagnose and treat your illness or injury.

The day your skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health care coverage ends is based on when your treatment is no longer medically necessary.

If you believe your coverage for any of these services is ending too soon, you can appeal this decision. You must file your appeal with the Quality Improvement Organization as soon as possible after you are notified of the discharge date. Again, contact Medicare directly and they can walk you through your appeal options. To reach Medicare, call 1-800-633-4227.

Exclusions

Services that do not meet the definition of eligible, as previously defined, are not eligible for coverage. All procedures or treatments are excluded until specifically included in Deseret Secure. In addition, the following services and their associated costs are excluded from coverage:

Custodial Care

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

Dental Care

- 2.1 Dental treatments, including care and treatment of the teeth, gums, or alveolar process, dentures, crowns, caps and permanent bridgework, appliances, or supplies used in such care and treatment, unless otherwise provided for by the terms of the plan

Diagnostic & Experimental Services

- 3.1 Care, treatment, diagnostic procedures, or operations for diagnostic purposes not related to an injury or sickness, unless otherwise provided for by the terms of the plan

Deseret Secure

3.2 Care, treatment, diagnostic procedures, or operations that on January 1, 1986, and/or thereafter were:

- Considered medical research
- Investigative/experimental technology
- Not recognized by the U.S. medical profession as usual and/or common
- Determined by Deseret Mutual not to be usual and/or common medical practice
- Illegal

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

Investigative/experimental technology means treatment, procedure, facility, equipment, drug, device, or supply that does not, as determined by Deseret Mutual on a case-by-case basis, meet all of the following criteria:

- The technology must have final approval from all appropriate governmental regulatory bodies, if applicable
- The technology must be available in significant number outside the clinical trial or research setting
- The available research about the technology must be substantial. For plan purposes, substantial means sufficient to allow Deseret Mutual to conclude that the technology is:
 - both medically necessary and appropriate for the covered person's treatment
 - safe and efficacious
 - more likely than not will be beneficial to the covered person's health, and
 - must be generally recognized as appropriate by the regional medical community as a whole

Procedures, care, treatment, or operations falling in the categories described herein on January 1, 1986, and/or thereafter, continue to be excluded until actual experience clearly defines them as non-experimental and they are specifically included in the medical policy by Deseret Mutual

Fertility / Family Planning / Home Delivery

- 4.1 Family planning, including contraception, birth control devices, and/or sterilization procedures, unless the patient meets Deseret Mutual's current medical criteria
- 4.2 Abortions, except in cases of rape or 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, treatment, diagnostic procedures, or operations in relation to in-vitro fertilization
- 4.4 Reversal of sterilization procedures
- 4.5 Planned home delivery for childbirth
- 4.6 All services and expenses related to a surrogate pregnancy, including care, treatment, delivery, diagnostic procedures, or operations, as well as maternity care for the surrogate mother and prenatal/postnatal care for the newborn child. All services and expenses for complications related to a surrogate pregnancy are also excluded

Government / War

- 5.1 Services required as a result of war or act of war or service in the military forces of any country at war, declared or undeclared
- 5.2 Services covered or that could have been covered by any governmental plan had the participant complied with the requirements of the plan
- 5.3 Services furnished by a hospital or facility owned or operated by the United States Government or any agency thereof, or services for individuals participating in government-entitled programs, such as veterans' programs

Hearing

- 6.1 The purchase or fitting of hearing aids, except for children younger than 19

Legal Exclusions

- 7.1 Services that the individual is not, in the absence of this coverage, legally obligated to pay
- 7.2 Care, treatment, operations, or prescription drugs incurred after termination of benefits
- 7.3 Injury arising from participation in or attempt at committing an assault or felony
- 7.4 Complications resulting from excluded services
- 7.5 Services not specified as covered

Medical Equipment

- 8.1 Multipurpose equipment or facilities, including related appurtenances, controls, accessories, or modifications thereof, or any other medical equipment not covered by Medicare. This includes, but is not limited to: buildings, motor vehicles, air conditioning, air filtration units, exercise equipment or

Deseret Secure

machines, and vibrating chairs and beds. This also includes certain medical equipment, including air filtration systems, dehumidifiers, exercise equipment, hearing aids for anyone 19 or older, hearing devices, humidifiers, nonprescription braces or orthotics, learning devices, spa/gym memberships, vision devices, or modifications associated with activities of daily living, homes, or vehicles, or otherwise not covered by Medicare

Medical Necessity / Cosmetic

- 9.1 Care, treatment, or operations performed primarily for cosmetic purposes, except for expenses incurred as a result of injury suffered while covered by the plan, or as otherwise provided for by the terms of the plan
- 9.2 Care, treatment, or operations not clearly a medical necessity
- 9.3 Care, treatment, or operations for convenience, contentment, or other non-therapeutic purposes
- 9.4 Cardiopulmonary fitness training or conditioning either as a preventive or therapeutic measure, except as provided for by the terms of the plan
- 9.5 Care, treatment, diagnostic procedures, or other expenses for an abdominoplasty, lipectomy, panniculectomy (except when strict medical criteria has been met), skin furrow removal, or diastasis rectus repair

Mental Health / Counseling / Chemical Dependency

- 10.1 Mental or emotional conditions without manifest psychiatric disorder or with non-specific symptoms
- 10.2 Marriage and family counseling, recreational therapy, or therapy over the telephone
- 10.3 Services and materials in connection with surgical procedures undertaken to remedy a condition diagnosed as psychological
- 10.4 Care and treatment for the abuse of or addiction to alcohol or drugs, unless otherwise provided for by the terms of the plan
- 10.5 Evaluation and/or treatment for learning disabilities and/or physical or mental developmental delay, including pervasive developmental disorders, and/or cognitive dysfunctions
- 10.6 Mental health services provided in a day treatment program and/or residential care facility, unless the individual receiving such services meets the requirements for the mental health alternative care benefit as defined by Deseret Mutual, unless otherwise provided for by the terms of the plan
- 10.7 Care or treatment of the chronic phase of mental illness

Miscellaneous

- 11.1 Services of any practitioner of the healing arts who:
 - Ordinarily resides in the same household with you or your dependents, or

- Has legal responsibility for financial support and maintenance of you or your dependents
- 11.2 Care, treatment, diagnostic procedures, or other expenses when it has been determined that brain death has occurred
- 11.3 Acupuncture treatment and/or services
- 11.4 Reproductive organ prosthesis

Obesity

- 12.1 Care, treatment, or operations in connection with obesity, unless the patient meets Medicare's current medical criteria

Other Insurance / Workers' Compensation

- 13.1 Services covered or that could have been covered by applicable workers' compensation statutes
- 13.2 Services or materials 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 or materials that 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 unless otherwise provided for by the terms of the plan

Prescription Drugs

- 14.1 Excluded medications such as contraceptive pills for birth control, dietary or nutritional products and/or supplements (including special diets for medical problems), herbal remedies, homeopathic treatments, products used to stimulate hair growth, medications used for sexual dysfunction, medications whose use is for cosmetic purposes, over-the-counter products, vitamins, and weight reduction aids
- 14.2 Specific medications, unless specifically authorized by Deseret Mutual

Testing

- 15.1 Some allergy tests including but not limited to ALCAT testing / food intolerance testing, cytotoxic food testing (Bryan's Test, ACT), Conjunctival Challenge Test (electro-acupuncture), Leukocyte Histamine Release Test (LHRT), Passive Transfer (PX) or Prausnitz-Kustner (PK) Test, Provocative Nasal Test, provocative food and chemical testing (intradermal, subcutaneous, or sublingual), Rebuck Skin Window Test, Rinkel Test, and skin endpoint titration

Transplants

- 16.1 Care, treatment, diagnostic procedures, or operations in relation to transplants

Deseret Secure

(donor or artificial), unless the patient characteristics and transplant procedures meet Medicare's current medical criteria

Vision

- 17.1 Eye/visual training, the purchase or fitting of glasses or contact lenses; care, treatment, diagnostic procedures, or other expenses for elective surgeries to correct vision, including radial keratotomy or LASIK surgery, unless otherwise provided for by the terms of the plan

Definitions

For definitions of words and terms applicable to Deseret Secure and Deseret Secure *PLUS*, please refer to the *Definitions* section of your Benefits Handbook.

Notification of Discretionary Authority

Deseret Mutual has full discretionary authority to interpret the plan and to determine benefit eligibility. Also, Deseret Mutual has the sole right to construe plan terms. All Deseret Mutual decisions relating to plan terms or eligibility for benefits are binding and conclusive.

Notification of Benefit Changes

Deseret Mutual reserves the right to amend or terminate the plan at any time. If benefit changes are made, we will notify you within 30 days before the effective date of change.

This section of your Benefits Handbook outlines the major provisions of Deseret Mutual's Deseret Secure and Deseret Secure *PLUS* medical plans. It is not the plan legal document. If you would like a copy of the plan legal document, please contact Deseret Mutual.

If you have any questions, please call your Deseret Mutual Benefits Team or visit our Web site. Our telephone numbers and Web site address are:

Salt Lake City area 1-801-578-5600

Toll free 1-800-777-3622

Web site www.dmba.com

If your hearing is impaired, we also have lines to accommodate Telecommunications Devices for the Deaf (TDD). Our telephone numbers for this service are:

Salt Lake City area 1-801-578-5655
Toll free 1-800-333-9715

Notes

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Notes

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Notes

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Senior Dental Plan

<u>Introduction</u>	1
<u>Eligibility for Coverage</u>	1
<u>Enrollment Requirement</u>	1
<u>Monthly Premiums</u>	1
<u>Maximum Benefits</u>	1
<u>Contracted Dental Network</u>	2
<u>Dental Benefits</u>	2
<u>Anesthesia</u>	3
<u>Endodontic Procedures</u>	3
<u>Oral Surgery</u>	3
<u>Orthodontic Procedures</u>	4
<u>Outpatient Hospitalization</u>	4
<u>Periodontal Procedures</u>	5
<u>Preventive / Diagnostic Procedures</u>	5
<u>Prosthodontic Procedures</u>	6
<u>Restorative Procedures</u>	6
<u>Ridge Augmentation / Extension</u>	7
<u>Sealants</u>	7
<u>Other Benefits</u>	7
<u>Supplemental Accident Benefit</u>	8
<u>Filing Claims</u>	8
<u>Errors on Bills or Explanation of Benefits Statements</u>	9
<u>Coordination of Benefits</u>	10
<u>Subrogation</u>	10
<u>Exclusions</u>	10

Senior Dental Plan

<u>Definitions</u>	13
<u>Notification of Discretionary Authority</u>	13
<u>Notification of Benefit Changes</u>	13

Senior Dental Plan

Your total health is important to us, including your dental health. Deseret Mutual's Senior Dental Plan provides valuable protection. And that should give you something to smile about. This section of your Benefits Handbook outlines the **Senior Dental Plan** as of January 1, 2007.

Eligibility for Coverage

If you meet the eligibility requirements for medical coverage when you retire, you also have the opportunity to enroll in the Senior Dental Plan. This means you must be at least 55 years old with at least 10 years of benefit credit in Deseret Mutual's Master Retirement Plan.

Please note that if you decide not to enroll in the Senior Dental Plan within 30 days of retirement, you cannot select dental coverage in the future. And remember, Medicare does not cover expenses for dental care.

If you're enrolled in a medical plan, your level of dental coverage must match your level of medical coverage. For example if you've chosen medical coverage for you and your spouse, you must also select dental coverage for you and your spouse; you can't select dental coverage just for yourself.

Enrollment Requirement

If you choose to enroll in the Senior Dental Plan, you must remain enrolled for at least two full calendar years. If you want to drop your Senior Dental Plan coverage later (after the first two years), you may do so only during the next open enrollment.

Monthly Premiums

You pay the entire monthly premium if you choose to enroll. For information about the monthly premiums for the Senior Dental Plan, please contact Deseret Mutual.

Maximum Benefits

The **annual maximum** benefit is \$900 per person for you and each of your eligible dependents. For orthodontic benefits, the **lifetime maximum** is \$1,350 per person, including any benefits you received while you were an active employee.

Senior Dental Plan

For information about other maximum benefits, please see [Supplemental Accident Benefit](#) on page 8.

Contracted Dental Network

With the Senior Dental Plan, you're free to receive care from any licensed provider of your choice. But when you receive care from members of our contracted dental network, you're financially protected. Contracted dentists accept your copayments and coinsurance and Deseret Mutual's payment as payment in full.

In other words, they do not bill you for amounts that exceed our maximum allowable limits. But you are still responsible for any charges that are considered ineligible or not covered by the plan.

Please keep in mind that our arrangements with contracted dentists do not change any of your Senior Dental Plan benefits. They simply protect you from paying unnecessary expenses. Again, you can receive care from any licensed provider of your choice. But to take advantage of this financial protection, receive care from providers in our contracted dental network.

For information about contracted dentists in your area, please visit our Web site at www.dmba.com or call your Benefits Team directly.

Dental Benefits

Generally, the Senior Dental Plan covers routine checkups, fluoride treatments, and cleanings at 100 percent after your \$15 copayment. Most other services, such as restorative procedures (including fillings) and orthodontic procedures are covered at 50 percent.

Of course, all benefits are based on medical necessity and are subject to the maximum allowable limits determined by Deseret Mutual. Charges are considered incurred on the date of service or the date treatment begins. One exception is for dentures; the service date is the date you receive the dentures.

Your [Senior Dental Plan benefits](#) follow alphabetically on pages 3 to 7.

Senior Dental Plan

All benefits are subject to maximum allowable limits determined by Deseret Mutual.

Anesthesia

- The plan pays 50% and you pay 50%
- General anesthesia expenses are covered when used as a part of oral surgery or in a case approved for the outpatient hospitalization benefit (see [Outpatient Hospitalization](#) on page 4)
- Generally, local anesthesia and relative analgesia are included in the cost of a complete procedure. If they are billed separately, they are not covered.
- When general anesthesia is administered as part of an eligible outpatient hospitalization, expenses do not count toward your annual maximum benefit

Endodontic Procedures

- The plan pays 50% and you pay 50%
- Pulpal and root canal therapy is covered
- Pulp caps are covered
- Generally, bases are included in the cost of a restorative or prosthodontic procedure. If they are billed separately, they are not covered.

Oral Surgery

- The plan pays 50% and you pay 50%
- Extractions and most other oral surgeries are covered:
 - Reimplanting knocked-out teeth
 - Single tooth implants, replacing an implant once every five years
- Generally, routine post-operative visits included in the cost of the total surgical procedure. If they are billed separately, they are not covered. For tooth transplants, oral surgery expenses and other related expenses are not covered.

Senior Dental Plan

All benefits are subject to maximum allowable limits determined by Deseret Mutual.

Orthodontic Procedures

- The plan pays 50% and you pay 50%
- The lifetime maximum benefit is \$1,350 per person
- Benefits are paid on a monthly basis for the duration of treatment. This includes 50% of the down payment (not to exceed \$400), and 50% of the monthly payment for the length of the treatment, up to the \$1,350 maximum
- Monthly payments stop when you or your dependent becomes ineligible or if you end treatment before it is completed
- Charges for molds, x-rays, and exams in connection with orthodontic treatment are considered part of the treatment and are included in the benefit maximum
- Habit-control appliances, such as nightguards, are not covered

Outpatient Hospitalization

- The plan pays 50% and you pay 50%
- Submit a doctor's statement to Deseret Mutual, including the treatment plan, fees, and a description of medical necessity
- Outpatient hospital expenses for dental treatment may be covered if:
 - A medical problem exists that must be monitored in connection with general anesthesia and surgical procedures
 - General anesthesia is required because of extended work on a child younger than 5
 - Dental or surgical procedures are performed on a patient who has a mental disability, such as Down Syndrome, or a sensory disability, such as deafness or blindness
- Eligible outpatient hospitalization expenses do not count toward your annual \$900 maximum benefit

Senior Dental Plan

All benefits are subject to maximum allowable limits determined by Deseret Mutual.

Periodontal Procedures

- The plan pays 50% and you pay 50%
- Periodontal maintenance is covered twice each calendar year
- Non-surgical procedures, including deep scaling, root planing, full-mouth debridement, periodontal exams, and chemotherapeutic agents, are payable once every six months (to the date)
- Covered surgical procedures include gingivectomy, osseous surgery, and grafting

Preventive / Diagnostic Procedures

- The plan pays 100% after your office visit copayment
- Cleaning (prophylaxis)
 - Twice each calendar year
- Exams
 - Twice each calendar year
 - Utah & Idaho: \$10 copayment per visit; MetLife areas: \$15 deductible per
 - Initial and routine exams by a general or pediatric dentist
- Fluoride treatment
 - Topical application twice each calendar year
- Sealants (see [Sealants](#) on page 7)
- Space maintainers
 - One time per lifetime
 - Charges to replace lost or stolen space maintainers are not covered
- X-rays
 - Complete mouth x-rays or panorex x-rays once every three years (to the date)
 - Series of two or four bitewing x-rays twice each calendar year
 - Periapical x-rays as necessary

Senior Dental Plan

All benefits are subject to maximum allowable limits determined by Deseret Mutual.

Prosthodontic Procedures

- The plan pays 50% and you pay 50%
- For most services, the service date is the date treatment begins. For dentures, the service date is the date you receive the dentures.
- Crowns, veneers, bridges, onlays, inlays, and partial and complete dentures are covered based on the following guidelines:
 - Covered once every five years (to the date); for stainless steel crowns on permanent teeth, payable once every two years (to the date)
 - Charges for relining or rebasing dentures are eligible once every three years (to the date)
 - Separate payment is not made for tooth preparation, temporary restorations, impressions, analgesia, or local anesthesia. These procedures are normally included in the cost of the complete prosthodontic procedure.
 - Periapical x-rays must be submitted for all bridges, crowns, onlays, and veneers before payment can be made
- Charges to replace lost or stolen dentures are not covered

Restorative Procedures

- The plan pays 50% and you pay 50%
- Amalgam, porcelain, composite or resin, and metal restorations are covered based on these guidelines:
 - One restoration per tooth surface every two years (to the date) or every five years (to the date) for gold restorations, no matter how many restorations are placed on the surface
 - Separate payment is not made for tooth preparation, temporary restorations, cement bases, impressions, analgesia, or local anesthesia. These procedures are normally included in the cost of a complete restorative procedure.
- Changing restorations from amalgam to composite fillings because of amalgam/mercury sensitivity is not covered

Senior Dental Plan

All benefits are subject to maximum allowable limits determined by Deseret Mutual.

Ridge Augmentation / Extension

- The plan pays 50% and you pay 50%
- This benefit includes procedures to restore the alveolar ridge to accommodate dentures
- These expenses do not apply toward your annual maximum benefit

Sealants

- The plan pays 100% based on these guidelines:
 - Only patients younger than 16 are eligible
 - The benefit covers permanent molars only
 - A molar sealant is covered once every five years (to the date)

Other Benefits

The following benefits are paid at 50%:

- Application of desensitizing medications (when eligible; subject to review)
- Emergency exams and eligible treatment for pain
- Exams or consultations by specialists
- Eligible drugs or medications
- Recementing space maintainers
- Therapeutic drug injections (when eligible; subject to review)

Senior Dental Plan

Supplemental Accident Benefit

If you need dental treatment because of an accident, eligible charges will be covered according to regular Senior Dental Plan benefits, based on the services performed. Benefits are based on the following guidelines:

- The injury and the treatment occur while you're covered by Deseret Mutual's Senior Dental Plan
- The cause of the condition must meet the definition of an accident as defined by the plan
- Benefits are determined by the date of the accident. Eligible expenses must be incurred within two years of the accident. Some additional benefits may be available for dependent children.
- Orthodontic expenses are not covered by the supplemental accident benefit
- The first \$2,000 per accident does not count toward the annual maximum benefit
- If five or more teeth are involved, additional benefits may be available up to \$5,000 per accident and do not count toward your annual maximum benefit
- For more information about this benefit, call your Deseret Mutual Benefits Team

Filing Claims

You must submit claims within **15 months** from the date of service. Deseret Mutual will send you an *Explanation of Benefits* statement when your claims have been processed. Please review your statements for accuracy. If you live in Utah or Idaho, your claims history is also available on our Web site.

If your provider does not submit a claim for you, get a *Dental Claim Form* from Deseret Mutual and follow these steps:

1. Complete the information in the appropriate sections of the claim form and sign the form.
2. Take the claim form with you when you visit your dentist (each patient will need a separate form).
3. Have the dentist complete the rest of the form.

Senior Dental Plan

4. For all crowns and/or veneers, submit periapical x-rays with the claim form.
5. Send the completed claim form and x-rays (when applicable) to the appropriate address:

Utah and Idaho

Deseret Mutual
P.O. Box 45530
Salt Lake City, Utah 84145

All Other Areas

MetLife: Group Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Errors on Bills or Explanation of Benefits Statements

If services appear on an *Explanation of Benefits* statement that were not performed or could be considered fraudulent, please call our Deseret Mutual Benefits Team.

If you find an error on any of your bills after your claims have been processed and paid, please verify the charges with the provider. Then submit a written description of the error to Deseret Mutual at the following address:

Deseret Mutual
Overpayment Team
P.O. Box 45530
Salt Lake City, Utah 84145

This is called an audit reimbursement request. Audit reimbursement is a valuable benefit of the Senior Dental Plan because if the mistake is not otherwise detected, you can receive 50% of the eligible savings, up to \$250.

Because the error usually means the provider was overpaid, we must recover the money from the provider before we can return the savings to you. So please be patient while we correct the error.

If Deseret Mutual detects an error on a 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 of 1974 (ERISA).

Senior Dental Plan

Coordination of Benefits

To help you make the most of your coverage, coordination of benefits combines the benefits of two or more dental plans. So if you or your dependents have dental coverage with two plans, your dental benefits may be coordinated.

If you are covered by more than one plan, you are legally responsible to notify Deseret Mutual. The total benefit will not exceed Deseret Mutual's maximum allowable limit. So you may be responsible for some out-of-pocket expenses.

For more information about coordination of benefits, please see the *General Information* section of your Benefits Handbook.

Subrogation

If you have an injury or illness that is the liability of another party and you have the right to recover damages, Deseret Mutual must be reimbursed for any amount it has paid when damages are recovered from the third party.

In addition, if you do not attempt to recover damages from the third party as described above, Deseret Mutual has the right to step into your shoes 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 the *General Information* section of your Benefits Handbook.

Exclusions

Services that do not meet the definition of eligible, as previously defined, are not eligible for coverage. In addition, the following services and their associated costs are excluded from coverage:

Cosmetic

- 1.1 Surgery or dentistry done for cosmetic reasons
- 1.2 Services for primarily non-therapeutic purposes

Diagnostic & Experimental Services

Senior Dental Plan

2.1 Dental treatments or procedures that on the effective date or renewal date of this policy are:

- Considered dental research
- Investigative/experimental technology
- Not recognized by the U. S. dental profession as usual and/or common
- Determined by Deseret Mutual not to be usual and/or common dental practice
- Illegal

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

Investigative/experimental technology means a treatment, procedure, facility, equipment, drug, device, or supply that does not, as determined by Deseret Mutual on a case-by-case basis, meet all of the following criteria:

- The technology has final approval from all appropriate governmental regulatory bodies, if applicable
- The technology is available in significant number outside the clinical trial or research setting
- The available research about the technology is substantial. For plan purposes, substantial means sufficient to allow Deseret Mutual to conclude:
 - The technology is both necessary and appropriate for the covered person's treatment
 - The technology is safe and efficacious
 - More likely than not, the technology will be beneficial to the covered person's health
 - The technology is generally recognized as appropriate by the regional dental community as a whole

Procedures or treatments falling in these categories continue to be excluded from Deseret Mutual's Dental Plan until they are specifically included in the Senior Dental Plan.

Education

3.1 Expenses for educational programs, plaque control, myofunctional therapy, and oral hygiene or dietary instruction

Government / War

4.1 Services furnished by a hospital or facility owned or operated by the United States Government or agency thereof

4.2 Services or materials incurred as a result of war or act of war, or service in the

Senior Dental Plan

military forces of any country at war, declared or undeclared. War includes hostilities conducted by force or arms by one country against another country, or between countries or factions within a country, either with or without a formal declaration of war.

Legal Exclusions

- 5.1 Services the patient is not charged or is not legally obligated to pay
- 5.2 Services that began before the patient was covered by this plan
- 5.3 Treatment or care done after termination of benefits
- 5.4 Services incurred in connection with injury arising from participation in or attempt at committing an assault or felony
- 5.5 Other dental treatment, except as outlined

Miscellaneous

- 6.1 Charges that exceed Deseret Mutual's maximum allowable limits
- 6.2 Failure to keep a scheduled dentist appointment
- 6.3 Completing claim forms
- 6.4 Unfinished dental work
- 6.5 Care and treatment by anyone who:
 - Ordinarily resides in the same household with you or your dependents
 - Has legal responsibility for financial support and maintenance of you or your dependents

Other Insurance / Workers' Compensation

- 7.1 Injuries or conditions that are compensable by workers' compensation, no-fault auto insurance, employment liability laws, or services provided by a federal or state government agency. Services provided by a group, franchise, or other insurance or prepayment program approved through an employer, union, trust, or association.

Replacements

- 8.1 Lost or stolen dentures, bridges, or appliances
- 8.2 Replacing fillings that are less than two years old (to the date) or replacing dentures, bridges, or crowns less than five years old (to the date)

Specific Products & Services

- 9.1 Services or supplies not furnished and/or prescribed by a dentist or physician (for example, denturist services), except cleaning, scaling, or fluoride treatments that may be performed by a licensed dental hygienist under the dentist's supervision

Senior Dental Plan

- 9.2 Tooth preparation, temporary restorations, cement bases, impressions, or acid etching
- 9.3 Appliances, restorations, or treatment, other than full dentures, whose primary purpose is to alter vertical dimension or restore occlusion
- 9.4 Protective athletic mouthguards or habit-control appliances, such as nightguards
- 9.5 Fluoride rinse, toothpaste, toothbrush, or other products or supplies intended for use by the patient
- 9.6 Study models or photos, unless used for orthodontic treatment
- 9.7 Emergency room services
- 9.8 Infection control
- 9.9 General anesthesia other than for oral surgery, unless otherwise covered by the plan
- 9.10 Treatment for disturbances of the temporomandibular joint

Definitions

For definitions of words and terms applicable to the Senior Dental Plan, please refer to the *Definitions* section of your Benefits Handbook.

Notification of Discretionary Authority

Deseret Mutual has full discretionary authority to interpret the plan and to determine benefit eligibility. Also, Deseret Mutual has the sole right to construe plan terms. All Deseret Mutual decisions relating to plan terms or eligibility for benefits are binding and conclusive.

Notification of Benefit Changes

Deseret Mutual reserves the right to amend or terminate the plan at any time. If benefit changes are made, we will notify you within 30 days before the effective date of change.

This section of your Benefits Handbook outlines the major provisions of Deseret Mutual's Senior Dental Plan. It is not the plan legal document. If you would like a copy of the plan legal document, please contact Deseret Mutual.

Senior Dental Plan

If you have any questions, please call your Deseret Mutual Benefits Team or visit our Web site. Our telephone numbers and Web site address are:

Salt Lake City area 1-801-578-5600

Toll free 1-800-777-3622

Web site www.dmba.com

If your hearing is impaired, we also have lines to accommodate Telecommunications Devices for the Deaf (TDD). Our telephone numbers for this service are:

Salt Lake City area 1-801-578-5655

Toll free 1-800-333-9715

Senior Life Insurance

<u>Introduction</u>	1
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Retiree Group Term Life Insurance

<u>Enrollment</u>	3
<u>Coverage</u>	3
<u>Dependent Coverage</u>	3
<u>Benefits</u>	3
<u>Exclusions</u>	4
<u>Filing Claims</u>	4

Retiree Supplemental Group Term Life Insurance

<u>Enrollment</u>	5
<u>Coverage</u>	5
<u>Spouse Coverage</u>	5
<u>Surviving Spouse Coverage</u>	5
<u>Dependent Children Coverage</u>	6
<u>Premiums</u>	6
<u>Benefits</u>	7
<u>Exclusions</u>	8
<u>Filing Claims</u>	8

General Life Insurance Information

<u>Definitions</u>	9
<u>Notification of Discretionary Authority</u>	9
<u>Notification of Benefit Changes</u>	9

Senior Life Insurance

Senior Life Insurance

Most of us plan to have life insurance, yet it's something many of us postpone until we think we can afford it. But no one wants to leave family or loved ones behind without some financial help. And finding affordable life insurance is vital to establishing a secure financial future.

Fortunately, as a retiree of Deseret Mutual's employee benefits program, **two life insurance options are available to you:** Retiree Group Term Life Insurance and Retiree Supplemental Group Term Life Insurance. This section of your Benefits Handbook outlines the major provisions of Deseret Mutual's retiree life insurance plans as of January 1, 2009. Plan benefits apply as long as you're enrolled.

Remember, Occupational Accidental Death & Dismemberment and 24-Hour Accidental Death & Dismemberment insurance don't continue when you retire.

Senior Life Insurance

Retiree Group Term Life Insurance

Enrollment

At the time you retire, you complete the *Retiree Benefit Program Enrollment Form*. If you apply for any of the medical plans available to you, Retiree Group Term Life insurance coverage is included as a part of your core benefits as long as you were enrolled in Basic Group Term Life before you retired. Or you can choose to participate in Group Term Life insurance only.

If you don't enroll at the time you retire, you cannot enroll in the future.

Coverage

As a retiree, your Group Term Life insurance coverage is \$12,000. To qualify for this coverage, you must be at least 55 years old and have 10 years of benefit credit in Deseret Mutual's Master Retirement Plan. Also, you must have been enrolled in the plan for at least 12 months before you retired.

Dependent Coverage

Once you retire, Retiree Group Term Life Insurance is not available to any of your dependents.

Benefits

After you die, life insurance benefits are paid to the beneficiary you named.

If you die without naming a beneficiary, benefits are paid to your estate. Or if your beneficiary dies before you do and you have not named an alternate beneficiary or you do not name a new beneficiary, benefits are paid to your estate. In some cases, the estate may be small enough that an affidavit of small estate can be submitted. Then the funds are released directly to the person designated in the affidavit and probate can be avoided.

In other cases, either the court recognizes the personal representative you named in your estate plan or it appoints a personal representative. This person files the necessary paperwork with Deseret Mutual and Deseret Mutual releases your funds to the personal representative on behalf of your estate.

Retiree Group Term Life Insurance

Note: You may change your beneficiary at any time in writing or on our Web site. We suggest you always provide an alternate beneficiary.

Exclusions

Retiree Group Term Life insurance benefits are not available for loss caused wholly or partly, directly or indirectly, by war or act of war, or service in the military forces of any country at war, declared or undeclared. War includes hostilities made by force or arms by one country against another country, or between countries or factions within a country, either with or without a formal declaration of war.

Filing Claims

To receive benefits, your beneficiary must:

- Step 1:** Contact Deseret Mutual. Deseret Mutual sends your beneficiary a packet of applicable forms.
- Step 2:** Obtain an original certified copy of the death certificate.
- Step 3:** Complete the forms in the packet.
- Step 4:** Send the completed forms and the original certified copy of the final death certificate to Deseret Mutual.

Retiree Supplemental Group Term Life Insurance

Enrollment

To enroll in Retiree Supplemental Group Term Life insurance, you complete the *Retiree Supplemental Group Term Life Insurance Application* at the time you retire. This application also includes a health questionnaire to measure whether you meet Deseret Mutual's health standards.

If you do not enroll within 30 days of your retirement, you will not be eligible for life insurance coverage in the future.

Coverage

To qualify for this coverage, you must be at least 55 years old and have five years of benefit credit in the Deseret Mutual Master Retirement Plan. Also, you must apply for this coverage before you retire. **After you retire, you will not be able to enroll or to increase your levels of coverage.**

You can select one of four coverage amounts, depending on your age: \$5,000, \$10,000, \$15,000, or \$25,000. You must meet health standards for \$10,000, \$15,000, or \$25,000 of coverage, or for all levels if you were not enrolled before you retired.

If you choose \$25,000 of coverage, your coverage reduces to \$15,000 when you turn 75.

Spouse Coverage

Your spouse can select \$5,000, \$10,000, \$15,000, or \$25,000 of coverage, depending on his/her age. Your spouse must meet health standards for \$10,000, \$15,000, or \$25,000 of coverage, or for all levels if he/she was not enrolled before you retired.

Surviving Spouse Coverage

If your spouse's Retiree Group Term Life or Retiree Supplemental Group Term Life insurance is in force at the time of your death, your spouse does not need to meet health standards to continue the same level of Retiree Supplemental Group Term Life coverage as a surviving spouse. If your spouse does not have any Retiree Group Term Life in effect at the time of your death, your surviving spouse can apply for \$5,000 of Retiree Supplemental Group Term Life coverage.

For more information about surviving spouse benefits, please contact Deseret Mutual.

Retiree Supplemental Group Term Life Insurance

Dependent Children Coverage

If your dependents were enrolled before you retired, they can continue the same levels of coverage without meeting health standards. If they weren't previously enrolled, they must enroll within 30 days of your retirement and must meet health standards.

You may choose between three coverage options for your eligible dependent children:

	Option 1	Option 2	Option 3
Birth to 6 months	\$ 1,000		
6 months to 26 years	\$ 3,000	\$ 7,500	\$ 15,000

These levels of coverage may continue during your retirement, but coverage will end when you die.

If you acquire a new dependent after you retire, you can enroll him/her within 60 days of the date you acquired the dependent. The dependent must meet health standards for coverage options 2 or 3.

Premiums

To determine the monthly premium for you and your spouse, see the table below. Find the amounts per thousand opposite your age, or your spouse's age, as of last January 1. Then multiply these amounts by the number of thousands of coverage for which you or your spouse are applying:

Premiums as of January 1, 2009					
Age Last January 1	Amount per \$1,000	Amounts of Coverage			
		\$5,000	\$10,000	\$15,000	\$25,000
Younger than 55	0.20	1.00	2.00	3.00	5.00
55 to 59	0.34	1.70	3.40	5.10	8.50
60 to 64	0.54	2.70	5.40	8.10	13.50
65 to 69	0.86	4.30	8.60	12.90	21.50
70 to 74	1.38	6.90	13.80	20.70	34.50
75 to 79	2.21	11.06	22.10	33.16	N/A
80 to 84	3.54	17.70	35.40	53.10	N/A
85 and older	6.37	31.86	63.70	95.56	N/A

Retiree Supplemental Group Term Life Insurance

Because this is supplemental coverage, you pay the entire cost of the premium for the coverage you choose. If the check is large enough to cover the premium, your premiums are automatically deducted from your monthly retirement check. Otherwise, you will be billed monthly.

Monthly Premiums for Dependent Children

The monthly premiums shown below cover all your eligible children, regardless of the number of children.

- \$0.42 for \$3,000 of coverage
- \$0.94 for \$7,500 of coverage
- \$1.68 for \$15,000 of coverage

Benefits

When you die, Retiree Supplemental Group Term Life insurance benefits are paid to the beneficiary you named. Remember, Deseret Mutual can only release information to your designated beneficiary.

If you die without naming a beneficiary, benefits are paid to your estate. In some cases, the estate may be small enough that an affidavit of small estate can be submitted. Then the funds are released to the person designated in the affidavit and probate can be avoided.

In other cases, either the court recognizes the personal representative you named in your estate plan or it appoints a personal representative. This person files the necessary paperwork with Deseret Mutual and we release the funds to the personal representative on behalf of your estate.

Note: You may change your beneficiary at any time in writing or on our Web site. We suggest you always provide an alternate beneficiary.

If one of your insured dependents dies, benefits are paid to you.

Retiree Supplemental Group Term Life Insurance

Exclusions

Retiree Supplemental Group Term Life insurance benefits are not available for loss caused wholly or partly, directly or indirectly, by:

- Suicide, while sane or insane, for coverage in force less than two years. Deseret Mutual pays life insurance benefits in the case of suicide for supplemental coverage that was in force for at least two years before the suicide, based on your current coverage level.
- War or act of war, or service in the military forces of any country at war, declared or undeclared. War includes hostilities made by force or arms by one country against another country, or between countries or factions within a country, either with or without a formal declaration of war.

Filing Claims

To receive benefits, you or your beneficiary must:

- Step 1:** Contact Deseret Mutual. Deseret Mutual sends you or your beneficiary a packet of applicable forms.
- Step 2:** Obtain an original certified copy of the death certificate.
- Step 3:** Complete the forms in the packet.
- Step 4:** Send all completed forms and the original certified copy of the final death certificate to Deseret Mutual.

Senior Life Insurance

Definitions

For definitions of words and terms applicable to the senior life insurance plans, please refer to the *Definitions* section of your Benefits Handbook.

Notification of Discretionary Authority

Deseret Mutual has full discretionary authority to interpret the plan and to determine benefit eligibility. Also, Deseret Mutual has the sole right to construe plan terms. All Deseret Mutual decisions relating to plan terms or eligibility for benefits are binding and conclusive.

Notification of Benefit Changes

Deseret Mutual reserves the right to amend or terminate the plan at any time. If benefit changes are made, we will notify you within 30 days before the effective date of change.

This section of your Benefits Handbook outlines the major provisions of Deseret Mutual's senior life insurance plans. It is not the plan legal document. If you would like a copy of the plan legal document, please contact Deseret Mutual.

If you have any questions, please call your Deseret Mutual Benefits Team or visit our Web site. Our telephone numbers and Web site address are:

Salt Lake City area 1-801-578-5600
Toll free 1-800-777-3622
Web site www.dmba.com

If your hearing is impaired, we also have lines to accommodate Telecommunications Devices for the Deaf (TDD). Our telephone numbers for this service are:

Salt Lake City area 1-801-578-5655
Toll free 1-800-333-9715

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Definitions

Accident: An unpremeditated event of violent and external means that happens suddenly, without intent or design, is unexpected, unusual, unforeseen, is identifiable as to time and place, and is not the result of illness.

Acute: Having rapid onset, severe symptoms, and a short course; opposite of chronic.

Alternative Care: Outpatient treatment for mental illness in lieu of inpatient care if you can be discharged from an inpatient acute care setting to a less expensive setting, such as day treatment or partial day treatment, without compromising the quality of care.

Annual Maximum Benefit: The maximum medical or dental benefit payable in a calendar year for you and each of your eligible dependents.

Appeal: A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service.

Audit Reimbursement: A reward for discovering, after a payment has been made, a provider or facility billing overcharge on any of your medical or dental bills that Deseret Mutual has not already discovered and corrected.

Benefit Period: For both Deseret Secure and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or skilled nursing facility for 60 days in a row.

If you go to the hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for skilled nursing facility stays, but not for hospital stays.

You are an inpatient in a skilled nursing facility only if your care in the facility meets certain standards. Specifically, you must need daily skilled nursing or skilled rehabilitation care, or both.

Definitions

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Brain Death: Brain death is defined in detail according to criteria established by experts for use in U.S. hospitals. Criteria include, but are not limited to, bilateral absence of cerebral hemispheric and/or brain stem function documented by silent EEG and appropriate findings on detailed neurological exam. These findings must have occurred after excluding the possibility of reversible causes. Clinical evidence of brain death must be demonstrated on multiple exams over 12 to 24 hours or else absent blood flow to the brain must be shown by brain scan or angiography.

Brand-name Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. But generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand-name drug has expired.

Catastrophe Protection: Financial protection from devastating medical expenses. If your expenses reach a certain limit, then you may qualify for a higher level of benefit payments.

Chronic: Showing little change or slow progression and long continuance of symptoms; opposite of acute.

Claim: Notification to Deseret Mutual requesting payment of a benefit.

Coinsurance: The percentage of eligible medical and dental expenses you are responsible for paying after you make the applicable copayments and your insurance plan benefits have been paid.

Coordination of Benefits: The process of combining medical or dental benefits of two or more plans.

Copayment: The initial dollar amount you pay of the charges for eligible medical and dental services that you are responsible for paying.

Definitions

Coverage Determination: Deseret Mutual makes a coverage determination when it makes a decision about the medical service you can receive under the plan, and the amount that you must pay for a drug or service.

Covered Services: All of the health-care services and supplies that are covered by Deseret Secure.

Creditable Coverage: Coverage that is at least as good as the standard Medicare prescription drug coverage.

Custodial Care: Maintaining a patient beyond the acute phase of injury or illness. Custodial care includes room, meals, bed, or skilled medical care in a hospital or extended care facility, or at home to help the patient with feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, ambulation, and so on.

Deemed Provider: A provider is considered “deemed” and must follow Deseret Secure’s terms and conditions of payment if the following conditions are met:

- Before furnishing services, the provider knows that a patient is enrolled in Deseret Secure
- The provider either possesses or has access to the plan’s terms and conditions of payment

A provider is not **required** to furnish health care services to Deseret Secure participants. But when a provider **chooses** to furnish services to a participant and the deeming conditions have been met, the provider is automatically a deemed provider (for that participant) and must follow Deseret Secure’s terms and conditions of payment.

Dentist: A person licensed to practice dentistry pursuant to the laws and regulations in the locality where the services are rendered.

Dependents: Your spouse and children, as defined below:

Spouse: A person of the opposite sex who is a husband or a wife.

Children: Your unmarried children who are younger than 26 including:

Definitions

- Natural children (including infants from the date of birth), legally adopted children, and children appointed by a court of law to the custody of the employee or employee's spouse.
- A child placed with you under the direction of a licensed child placement agency.
- A grandchild who is the child of your covered, unmarried, dependent child. The unmarried dependent child and the grandchild reside in your home and depend primarily upon you for support. A direct lineal relationship must exist between you and the grandchild (or a direct line is created through adoption) for the grandchild to be covered.
- Your unmarried child who is 26 or older and incapable of self-support because of mental or physical incapacity that existed before the child reached 26, and who is wholly dependent upon you for support.
- Your stepchildren (children of your spouse) younger than 26. If the stepchildren are younger than 18, your spouse must have an order from the court granting him/her full or partial custody.

Please note that the provisions of the Master Retirement Plan orphan benefit do not apply to all dependent children. If you need clarification, please call Deseret Mutual.

Deseret Mutual Identification Number (DMID): A participant number that Deseret Mutual assigns to you as a secure means for accessing your benefit information.

Disenroll, Disenrollment: The process of ending your membership in Deseret Secure. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment: Equipment needed for medical reasons that is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Elective Surgery: Operations or surgical procedures for a condition that is not immediately life threatening and the timing is subject to the choice or decision of the patient and the physician.

Definitions

Eligible Charges / Expenses: Expenses incurred by you or a dependent for treatment of injury or illness that are:

- Medically necessary for the care and treatment of the injury or illness and are incurred on the recommendation and while under the continuous care of a physician.
- Not in excess of the maximum allowable charges as defined by Deseret Mutual for the services performed or the materials furnished.
- Not excluded from coverage or otherwise excluded by the terms of the plan.
- Incurred for one or more of the services or materials specified in the plan.
- Incurred during a period of active enrollment in the plan.

Eligible charges incur on the date the service is performed or the purchase is made.

Emergency Care: The care required in connection with a sudden and unexpected onset of a condition requiring medical or surgical care necessary to safeguard the patient's life immediately after the onset of the emergency. This includes heart attack, severe bleeding, loss of consciousness, convulsions, acute asthmatic attacks, or temperature of more than 104° Fahrenheit.

Covered services that are furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition.

Emergency Room: See *Hospital Emergency Room*.

ERISA (Employee Retirement Income Security Act of 1974): The federal law that establishes legal requirements for plan administration and investment practices of employee benefit plans.

Evidence of Coverage and Disclosure Information: This document along with your enrollment form, which explain your covered services, defines our obligations, and explains your rights and responsibilities as a member of Deseret Secure.

Explanation of Benefits (EOB): A document that verifies how medical and/or dental benefits are applied to your claim.

Definitions

Extended Care Facility: An institution, or part of an institution, that is licensed pursuant to state or local law, and is operated primarily for the purpose of providing skilled nursing care and treatment for an individual convalescing from injury or illness as an inpatient.

Formulary Medications: A preferred list of medications that have been reviewed by an independent pharmacy and therapeutics committee for safety and efficacy and are covered by the plan.

Generic Drug: A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance: A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes.

HIPAA (Health Insurance Portability and Accountability Act of 1996): A federal law that provides rights and protections for participants and beneficiaries in group health plans.

Hospital: A facility that is licensed as a hospital and is operating within the scope of this license.

Hospital Emergency Room: Hospital facility that provides treatment for urgent medical needs that may or may not be life-threatening at that particular time.

Illness: A bodily disorder, disease, pregnancy, mental or emotional infirmity, or all sickness that is a result of the same cause or a related cause.

Injury: Harm or hurt. It may be inflicted upon oneself (such as a hamstring injury) or by an external agent (such as frostbite). The injury may be accidental or deliberate. (For benefit purposes, see the plan provisions and exclusions.)

Inpatient Care: Health care that you get when you are admitted to a hospital.

Definitions

Inpatient Hospital for Mental Illness: A general acute-care hospital that has designated beds and is licensed by the state and certified by Medicare and/or Medicaid for the treatment of mental illness disorders, or a freestanding psychiatric hospital that is licensed by the state as a health care facility and is certified by Medicare and/or Medicaid for the treatment of mental illness.

Invalid Beneficiary: A beneficiary who the participant has named but who does not have spousal consent.

Maintenance Drugs: Prescription medications for conditions that require ongoing, regular medication.

Maximum Allowable Charge (Limit): The maximum dollar amount Deseret Mutual will pay for a defined medical or dental procedure as set forth under contract provisions and/or market practice.

Medically Necessary: Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare: The federal health insurance program for people 65 or older, some people younger than 65 with disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization: A public or private organization licensed by the state as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Deseret Mutual is a Medicare Advantage Organization.

Medicare Advantage Plan: A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare. Deseret Secure is a Medicare Advantage Plan.

Definitions

Medigap (Medicare Supplement Insurance): Many people who get their Medicare through Original Medicare buy “Medigap” or Medicare supplement insurance policies to fill “gaps” in Original Medicare coverage.

Member: A person with Medicare who is eligible to receive covered services, who has enrolled in Deseret Secure, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Also called a “participant.”

Nonformulary Medications: Medications not on the list of formulary medications. For determining formulary or nonformulary status, medications are reviewed by an independent pharmacy and therapeutics committee for safety and efficacy.

Organization Determination: When the Medicare Advantage Organization makes a decision about services or payment that you believe you should receive.

Original Medicare: Some people call it “traditional Medicare” or “fee-for-service” Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health-care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Pain Clinic: A facility that deals primarily with the diagnosis and treatment of chronic pain.

Part D: The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs: Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug. Part D Drugs that are listed on our formulary, and that we pay for based on an exception or an appeal, are called “Covered Part D Drugs.”

Physician: A person who has been educated, trained, and licensed as a physician to practice the art and science of medicine pursuant to the laws and regulations in the locality where the services are rendered.

Definitions

Plan Provider: “Provider” is the general term we use for doctors, health-care professionals, hospitals, and health-care facilities that are licensed or certified by Medicare and by the state to provide health-care services.

Plan Representative: An authorized employee of Deseret Mutual, not your employer.

Preauthorization: A vital process in your making sure your care is medically appropriate. It is required for a number of benefits and gives you guidelines and tells you what services are eligible for benefits before you commit to the costs.

Preferred Network Pharmacy: A network pharmacy that offers covered drugs to members of our plan at lower cost-sharing levels than apply at another network pharmacy.

Premium: A regular periodic payment for an insurance plan.

Primary Care Physician (PCP): A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing covered services while you are a plan member.

Prenotification: A process where your benefits increase if you notify Deseret Mutual about certain procedures like inpatient hospital stays, home health care, and certain durable medical equipment. You do so by calling Deseret Mutual’s Medical Management Team.

Private Fee-for-Service Plan: A Medicare Advantage private fee-for-service plan pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. A Medicare Advantage Organization offering a private fee-for-service plan must meet general requirements including:

- Providing for all original Medicare covered services
- Providing for emergency and urgent care
- Allowing beneficiary appeals for services that are limited, not provided, not paid for, or not allowed
- Disclosing its terms and conditions of payment and a list of services it provides
- Not varying the rates for a provider based on the utilization of that provider’s services

Definitions

- Not restricting enrollees' choices among providers that agree to accept the plan's terms and conditions of payment and are lawfully authorized to provide services
- Not limiting enrollees to a provider network (no "lock in")

Special access rules apply to private fee-for-service plans. Members of a private fee-for-service plan may go to any doctor or hospital in the U.S. that is:

- eligible to be paid by Medicare (that is (a) the provider is state licensed, (b) is eligible to receive, or has received, a Medicare billing number, and, (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and
- is willing to accept the plan's terms and conditions of payment

Private fee-for-service plans may offer supplemental benefits or a Part D prescription drug benefit.

Terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a private fee-for-service plan. At a minimum the terms and conditions will specify:

- A list of all services that the plan provides
- The amount the private fee-for-service organization will pay for all plan-covered services
- Provider billing procedures
- The amount the provider is permitted to collect from the enrollee including balance billing

The private fee-for-service plan is not required to reimburse providers for services to private fee-for-service plan enrollees, if these services are not covered by the plan.

A private fee-for-service organization is required to make its terms and conditions of participation reasonably available—through phone, fax, email, or Web sites—to providers in the U.S. from whom its enrollees seek health-care services.

Prosthesis: An artificial replacement of a limb or other body part.

Quality Improvement Organization (QIO): Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient

Definitions

departments, hospital emergency rooms, skilled nursing facilities, home health agencies, private fee-for-service plans, and ambulatory surgical centers.

Referral: You do not need a referral to obtain care in a private fee-for-service plan. If you have any question whether Deseret Secure will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Deseret Mutual and tell us you would like a decision if the service will be covered.

Rehabilitation Services: These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Spouse: A person of the opposite sex who is a husband or a wife.

Treatment: Care provided under the direction of a physician in connection with an injury or illness.

Urgent Care Facility: A facility or clinic, not a hospital emergency room or physician's office, that provides treatment for urgent medical needs that are not life threatening at that particular time.

For a complete description of all applicable definitions of terms, please refer to the various plan legal documents available from Deseret Mutual.

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