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I. Overview

A. About Deseret Mutual Benefit Administrators
Deseret Mutual Benefit Administrators is headquartered in Salt Lake City, Utah. Deseret Mutual is a self-funded, not-for-profit ERISA trust that provides medical and dental benefits to approximately 120,000 members. These members are comprised of employees of The Church of Jesus Christ of Latter-day Saints and its affiliated organizations. For a complete list of these organizations, please see Page 2 of the Deseret Secure Handbook found at http://www.dmba.com/nsc/handbooks/pdf/ginsnr.pdf.

B. About Deseret Secure
Deseret Secure is the Medicare Advantage Private Fee-For-Service (PFFS) plan offered by Deseret Mutual. There are approximately 12,000 participants on the Deseret Secure plan. Deseret Secure members primarily reside in Utah and Southeast Idaho, but we have members spread throughout all 50 states.

C. Deseret Secure PFFS Provider Network
Deseret Mutual created the Deseret Secure PFFS Provider Network in the Salt Lake, Utah, Davis, and Washington counties in the state of Utah. In all other areas of Utah and throughout the remainder of the United States, Deseret Secure members can use any provider (such as a physician, health professional, hospital or other Medicare provider that agrees to treat the member) that is eligible to provide health care services under Medicare Part A and Part B (also known as ‘Original Medicare’), or is eligible to be paid by Deseret Secure for benefits not covered under Original Medicare.

The Deseret Secure PFFS Provider Network is comprised of providers with whom Deseret Mutual has a contractual arrangement. Deseret Mutual will only contract with providers who:

- are licensed or certified by the state to engage in that activity in the state
- are licensed or certified to deliver those services (if such licensing or certification is required by state law or regulation)
- meet the credentialing criteria, standards, and policies established by Deseret Mutual and Centers for Medicare and Medicaid Services (CMS)
- are approved through Deseret Mutual’s Provider Quality and Credentialing Committee

Providers located in Salt Lake, Utah, Davis, and Washington counties who are interested in becoming part of the Deseret Secure PFFS Provider Network should call Deseret Mutual at 1-801-578-5600 or 1-800-777-3622, and choose options 1, 3, and then 5.
D. **Purpose of this Manual**

Deseret Mutual created this manual to help providers understand the Deseret Secure plan. This manual is designed as an extension of any provider agreement and is intended to provide information about Deseret Mutual’s policies, procedures, claims, appeals, and other guidelines.

Questions or comments about this manual should be directed to the Healthcare Systems Division at Deseret Mutual by calling 1-800-777-3622, then selecting options 1, 3, and then 5. You may also contact us in writing by e-mailing providerrelations@dmba.com, or by mail at:

Deseret Mutual Benefit Administrators  
Attn: Healthcare Systems  
PO Box 45530  
Salt Lake City, UT 84145

II. **Contact Information**

A. **Provider Address Change or Change to Other Practice Information**

1. **Providers contracted for the Deseret Secure PFFS Provider Network:**

   To accurately maintain your provider information for directories and reimbursement purposes, please submit all changes in writing. The information may be faxed to 1-800-777-5113 or be sent by mail to:

   Deseret Mutual Benefit Administrators  
   Attn: Healthcare Systems  
   PO Box 45530  
   Salt Lake City, UT 84145

   Please provide written notification to Deseret Mutual of the following changes:

   - Address – both physical and billing
   - Tax Identification Number
   - Phone number
   - Practice name
   - NPI
   - Adding new providers to the group or practice
   - Deletions of providers from group or practice
   - Medicare Numbers
When new providers are added to the group or practice, they must go through the application process if they wish to join the Deseret Secure PFFS Provider Network. For information about the application process, please call Deseret Mutual at 1-800-777-3622. Select options 1, 3, and then 5.

2. **Providers NOT contracted for the Deseret Secure PFFS Provider Network:**
   
   Non-contracted providers do not need to notify Deseret Mutual of address or practice changes as long as the correct or new address or practice information is included on a claim (either paper or EDI) at the time of billing. If for any reason Deseret Mutual needs to discuss these changes with you, a member of Deseret Mutual’s Provider Maintenance Team will contact you.

B. **Contact Deseret Mutual**
   
   - For questions about member eligibility or claim status, please call 1-877-220-0110. Providers enrolled with the Utah Health Information Network (UHIN) can verify member eligibility online through a 270/271 transaction by going to [www.uhin.org](http://www.uhin.org). All providers may also verify member eligibility by going to [www.dmba.com](http://www.dmba.com).
   
   - For questions about claim appeals, please call 1-800-777-3622 and ask to speak with the Medicare Appeals Coordinator.
   
   - For questions about contracting with the Deseret Secure PFFS Provider Network, please call 1-800-777-3622, choose options 1, 3, and then 5.

C. **Hours of Operation**
   
   You can reach us on our Deseret Secure customer service line Monday thru Friday, 6 a.m. to 5 p.m. MST, at 1-877-220-0110.

III. **Provider Resources**

A. **Member ID Cards**
   
   Deseret Secure issues member ID cards upon enrollment. The member ID cards contain copayment amounts and Deseret Mutual’s contact information. Deseret Secure members should present their member ID card at the time of service.
B. **EDI Help**

At Deseret Mutual, we encourage providers to submit claims electronically using Electronic Data Interchange (EDI). We have an *EDI Companion Document* to help providers with EDI questions. You can read it online at http://www.dmba.com/provider/HipaaEDI.aspx.

For questions about EDI claim submission that aren’t answered by reading the *EDI Companion Document*, please call Deseret Mutual’s Provider Maintenance Team at 1-800-777-3622, options 1, 3, and then 4.

C. **Reimbursement**

Deseret Secure claims are paid according to the traditional fee-for-service Medicare fee schedule. Any eligible services not covered under Original Medicare are reimbursed using Deseret Mutual’s Medicare Advantage PFFS fee schedule. For rates or other reimbursement information, please call us at 1-877-220-0110.

### IV. Medical Services

A. **Medical Benefits**

Generally speaking, the medical benefits of the Deseret Secure plan fall in line with those of a traditional Medicare Advantage PFFS plan. But Deseret Secure allows for certain benefits a traditional Medicare Advantage PFFS plan may not. For example, the Deseret Secure plan will pay for one preventive eye exam annually. Deseret Secure also covers hearing exams as needed. To get benefit details for a Deseret Secure member, please call us at 1-877-220-0110.

The following table shows the patient responsibility for some of the benefits offered to Deseret Secure members. For more detailed benefits or benefits not listed in this chart, please call us at 1-877-220-0110.
<table>
<thead>
<tr>
<th>Category</th>
<th>2012 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance</td>
<td>$75 copayment per day</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>No copayment</td>
</tr>
<tr>
<td>Annual Maximum Out-of-Pocket</td>
<td>$2,500 limit</td>
</tr>
<tr>
<td>Chiropractic Therapy</td>
<td>$20 copayment per visit</td>
</tr>
<tr>
<td>DME/Prosthetics</td>
<td>• 15% coinsurance</td>
</tr>
<tr>
<td></td>
<td>• Members and providers are encouraged to notify the plan</td>
</tr>
<tr>
<td></td>
<td>• DME over $750 requires a letter of medical necessity</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$50 copayment per visit, waived if admitted</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>• No copayment</td>
</tr>
<tr>
<td></td>
<td>• Members and providers are encouraged to notify the plan</td>
</tr>
<tr>
<td>Home Infusion Therapy Services</td>
<td>See explanation on page 8</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No copayment</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>• $550 copayment per admission</td>
</tr>
<tr>
<td></td>
<td>• Members and providers are encouraged to notify the plan</td>
</tr>
<tr>
<td>Lab Work (Outpatient)</td>
<td>No copayment</td>
</tr>
<tr>
<td>CT, MRI, MRA, PET, SPECT Scans, etc</td>
<td>$50 copayment per day</td>
</tr>
<tr>
<td>Outpatient Hospital or Ambulatory Surgical Center</td>
<td>$100 copayment (Preventive Services exempt)</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Physical, Speech, &amp; Occupational Therapy</td>
<td>$25 copayment per visit</td>
</tr>
<tr>
<td>Physician Visits</td>
<td>• $25 copayment for each specialist visit for Medicare-covered benefits</td>
</tr>
<tr>
<td></td>
<td>• $10 copayment for each PCP visit</td>
</tr>
<tr>
<td></td>
<td>• Medicare Preventive Services exempt</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>No copayment for Medicare Preventive Services</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>• $100 copayment for days 1-15</td>
</tr>
<tr>
<td></td>
<td>• $75 per day copayment for days 16-100 until Annual Maximum Out-of-Pocket limit has been met</td>
</tr>
<tr>
<td></td>
<td>• Members and providers are encouraged to notify the plan</td>
</tr>
<tr>
<td>Surgeon</td>
<td>No copayment</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30 copayment per visit</td>
</tr>
<tr>
<td>X-ray/Ultrasound</td>
<td>15% coinsurance (Preventive Services exempt)</td>
</tr>
</tbody>
</table>
1. **Home Infusion Therapy Services**

   Home infusion therapy services are covered under a sole service provider agreement. Pharmacy benefits apply to covered medications. To obtain benefits for home infusion therapy, please contact our Pharmacy Benefits Team at 1-800-777-3622, options 1, 3 then 3.

V. **Claims**

   A. **EDI Claims**

   1. **Enrolling with Deseret Mutual for EDI**


      To send medical or dental claims to Deseret Mutual electronically, you will need to complete the Electronic Billing Enrollment Form and return it to Deseret Mutual by e-mail, mail, or fax. You can get the Electronic Billing Enrollment Form online at [http://www.dmba.com/provider/pdf/EDIBilling.pdf](http://www.dmba.com/provider/pdf/EDIBilling.pdf).

      To enroll for electronic claims, you’ll need to provide Deseret Mutual with your Utah Trading Partner Number. The Utah Trading Partner Number is assigned by UHIN and is used to identify providers. If you use a clearinghouse other than UHIN for claim submission, you must get their Utah Trading Partner Number. You may need to give your clearinghouse Deseret Mutual’s Trading Partner Number, HT000006-001, so they can identify us.

      All enrollment forms must have a Utah Trading Partner Number listed for your group, individual provider, or clearinghouse.

      If Deseret Mutual doesn’t have your Utah Trading Partner Number on file, you must go through a period of claims submission testing to pass HIPAA edits. We’ll contact you with more details if this is the case. For more information about our testing process, see our **EDI Companion Document** online at [http://www.dmba.com/provider/HipaaEDI.aspx](http://www.dmba.com/provider/HipaaEDI.aspx).

      Deseret Mutual doesn’t store payer ID numbers assigned by clearinghouses (typically five digits). **To obtain Deseret Mutual’s payer ID number, please contact your clearinghouse.**

      When enrolling for EDI claim submission, please include all group and individual National Provider Identifier (NPI) numbers. Any claims submitted without NPI numbers
will be rejected. Your only notice of rejection will be returned 277FE. An NPI is required for all EDI transactions. If you need more information about NPIs, call UHIN at 1-801-466-7705 ext 204, or visit the dedicated CMS Web page at www.cms.hhs.gov/nationalprovidentstand.

If your practice is already set up for EDI claim submission and a new provider joins the practice at a later date, please contact Deseret Mutual to enroll that provider for EDI claim submission.

When you sign up to receive 835 transmissions (Electronic Remittance Advice), you will also receive a paper Explanation of Payment (EOP). To send 835 transmissions, we need to have the provider’s Tax ID number. Please note that we do not send 835s for paper or manually entered claims, but you will still receive a paper EOP.

If you have any additional questions about EDI enrollment, please call a Provider Maintenance Representative at 1-801-578-5600 in the Salt Lake City area or toll free at 1-800-777-3622, options 1, 3, and then 4. You may also e-mail us at edienrollment@dmba.com.

2. Electronic Transactions Following Enrollment with Deseret Mutual

Once you are enrolled for EDI with Deseret Mutual, we can receive and generate the following HIPAA-compliant transactions:

- 837 004010X098A1 (professional claim)
- 837 004010X096A1 (institutional claim)
- 270/271 004010X092A1 (eligibility — both batch and real-time)
- 835 004010X091A1 (remittance)

For more information about all the EDI transactions Deseret Mutual receives and generates, please see our EDI Companion Document online at http://www.dmba.com/provider/HipaaEDI.aspx.

If your practice is already set up for EDI claim submission and a new provider joins the practice at a later date, please contact Deseret Mutual to enroll that provider for EDI claim submission.

Deseret Mutual accepts corrected claims and coordination of benefits (COB) claims electronically. We encourage providers to submit all claims to Deseret Mutual electronically.

If you have any additional questions about EDI submission or enrollment, please call a Provider Maintenance Representative at 1-801-578-5600 in the Salt Lake City area or toll free at 1-800-777-3622, options 1, 3, and then 4. You may also e-mail us at edienrollment@dmba.com.
If you have any questions about member eligibility or claim status for claims submitted through EDI, please call us at 1-877-220-0110. Providers enrolled with UHIN may also verify member eligibility online by going to www.uhin.org. Providers not enrolled directly with UHIN may verify member eligibility by going to www.dmba.com.

B. **Paper Claims**

Deseret Mutual accepts both the standard CMS-1500 and CMS-1450 (UB-04) paper claim forms. These paper claims can be mailed to Deseret Mutual at:

Deseret Mutual Benefit Administrators  
PO Box 45530  
Salt Lake City, UT 84145

C. **Timely Filing**

You must submit a claim to Deseret Secure for an original Medicare covered service within the same time frame you would submit under Original Medicare—**within 12 months from the date of service**. Claims, including revisions or adjustments that are not filed by the provider before the claim-filing limit may result in non-payment, will then be the provider’s liability, and can’t be billed to the patient.

Providers must agree to provide any additional information reasonably necessary to determine benefits and to verify performance under the plan. The criteria for Original Medicare submission of claims can be found in Section 70 of Chapter 1 of the *Medicare Claims Processing Manual* located at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.

D. **Prompt Payment**

At Deseret Mutual, we define a clean claim as a claim that:

- has no defect, impropriety, lack of substantiating documentation required by Deseret Mutual, or particular circumstance requiring special treatment that prevents timely payment
- otherwise conforms to the clean claim requirements for equivalent claims under Original Medicare
- includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare for Medicare covered benefits

We’ll process and pay clean claims within 30 days of receipt. If a clean claim is not paid within 30 days, we’ll pay interest on the claim according to Medicare guidelines. And we’ll process all non-clean claims and notify providers of the determination within 60 days of receipt.
E. **Coordination of Benefits**

Providers should identify primary coverage and provide that information to Deseret Secure at the time of billing. Deseret Mutual accepts COB claims electronically.

F. **Claim Edits**
We’ll process complete and accurate Deseret Secure claims in accordance with Deseret Mutual, CMS, and AMA guidelines. All Deseret Secure claims are edited through an automated system according to CMS and AMA guidelines. You can request reconsideration of any of the adjustments or edits made by this automated system by sending a written appeal to our Medicare Appeals Coordinator as outlined under Claim Appeals.

G. **Advance Coverage Determinations**
If you have a question about whether Deseret Secure will pay for a service for your patient, you can request an advance coverage determination before you perform services. This is also known as an advance organization determination. To request an advance organization determination from Deseret Secure, call 1-877-220-0110, or fax the request to 1-800-777-5113. If you fax the information to Deseret Secure, the fax cover page needs to clearly state “Advance Organization Determination.” For your convenience, Deseret Mutual has created an Advance Organization Determination Request form that can be used to assist you in this process. Please see [http://www.dmba.com/provider/medicare/DSAdvanceOrgDetermination.pdf](http://www.dmba.com/provider/medicare/DSAdvanceOrgDetermination.pdf).

Your request must include adequate supporting documentation to allow us to determine eligibility for coverage, including the appropriate ICD-9 diagnosis, CPT and/or HCPCS coding information. We’ll make a decision and notify you and the member within 14 days of receiving the request. We may extend that time period by up to 14 additional days if we believe a delay is in the member’s best interest, or if the member requests the delay.

If you believe that waiting for a decision under this time frame could place the member’s life, health, or ability to regain maximum function in serious jeopardy, you may request an expedited determination.

For an expedited determination, call Deseret Secure at 1-877-220-0110 or fax the request to 1-800-777-5113. If you fax the information to Deseret Secure, the fax cover page needs to clearly state “Expedited Advance Coverage Determination.” We’ll notify you of the decision as quickly as the member’s health condition requires, but no later than 72 hours after receiving the request. If necessary, we may extend that time period...
by up to 14 additional days if we believe a delay is in the member’s best interest, or if the member requests the delay.

H. **Claim Appeals**
If you are not satisfied with a determination made by Deseret Mutual relating to a member on the Deseret Secure plan, two options are available to you:

1. **Payment Dispute**
If you believe the payment of a claim for a Deseret Secure member is less than the amount Original Medicare would have paid on the same service, you can dispute the payment. You have 120 days from the date you received the payment to do so. Please submit the appropriate documentation to support your payment dispute. We will respond to your dispute within 30 days of receipt. For further information on the payment dispute process, please see Item 8 of *Deseret Secure Terms and Conditions* online at [http://www.dmba.com/provider/medicare/TermsConditions2012.pdf](http://www.dmba.com/provider/medicare/TermsConditions2012.pdf).

Send your Deseret Secure payment disputes to:

Deseret Mutual Benefit Administrators  
Attn: Medicare Appeals Coordinator  
PO Box 45530  
Salt Lake City, UT 84145

2. **Appeals**
Consistent with Medicare guidelines outlined in Chapter 13 of the *Medicare Managed Care Manual* (Publication 100-16), we provide a grievance and appeals process for participants enrolled in Deseret Secure. Grievances relate primarily to the services provided by the plan or its providers, while appeals relate to benefit and/or payment determinations.

You can represent your patient in the appeal of a benefit determination, but only as an authorized representative. To become an authorized representative, you can either complete Medicare’s Appointment of Representative form (CMS – 1696), or sign a Waiver of Liability, which holds the patient harmless regardless of the outcome of the appeal. You can use the Waiver of Liability to be validated as the patient’s representative or as a provider-as-party. You must provide documentation that you are an authorized representative when you submit an appeal. If the appeal lacks this documentation, we'll make two attempts to obtain it from you before sending the request to Maximus Federal Services, Medicare’s Independent Review Entity (IRE), for
dismissal. We cannot provide a response to an appeal that lacks a valid document empowering the provider to represent the patient.

Appeals must be submitted within 60 days of the event or incident to which they are related. Once we determine that you’re an authorized representative, we consider the claim validated. We have 30 days from the date of that validation to respond to a pre-service appeal or 60 days from the date of validation to respond to a post-service appeal. We’ll respond to validated requests in writing, notifying you of the outcome.

Adverse or partially adverse appeal determinations will automatically be forwarded to Maximus Federal Services for independent review and we will comply with the outcome of that review. If Maximus agrees with the decision made by Deseret Mutual, the provider maintains the right to pursue the appeal further. You can get more information under Item 9 in Deseret Secure Terms and Conditions online at http://www.dmba.com/provider/medicare/TermsConditions2012.pdf, or in the “Appeals” section in the Deseret Secure handbook, beginning on Page 26. The Deseret Secure handbook is available at http://www.dmba.com/nsc/handbooks/pdf/desscr.pdf.

I. Overpayments
In the case that Deseret Mutual identifies an overpayment, we will notify you in writing. Refunds for overpayments should be sent to:

Deseret Mutual Benefit Administrators
Attention: Accounting Division
PO Box 45530
Salt Lake City, UT 84145-0530

If you have questions about an overpayment notification from Deseret Mutual, please call us at 1-877-220-0110.

J. Medical Record Reviews and Audits
Any provider treating a Deseret Secure member should maintain records and any related contracts for a period of 10 years. We reserve the right to review and/or audit these records to:

• make coverage determinations
• complete CMS risk adjustment evaluations
• determine whether services are covered under the plan, reasonable, or medically necessary
• determine whether the plan was appropriately billed for services rendered
• investigate fraud and abuse
We won’t use these records for any purpose other than the stated intended uses.

VI. Responsibilities

A. Provider Responsibilities

To be paid for services provided to a Deseret Secure member, you must:

- have a National Provider Identifier in order to submit electronic transactions to Deseret Secure, in accordance with HIPAA requirements
- agree to submit claims to Deseret Secure following Medicare established time frames and using Medicare coding and billing guidelines, including the use of Medicare appropriate CPT codes, defined modifiers, and diagnosis codes to the highest specificity
- provide services to a Deseret Secure member within the scope of your licensure or certification
- provide only services that are covered by our plan and that are medically necessary as defined by Medicare
- meet applicable Medicare certification requirements (applies to institutional providers such as hospitals or skilled nursing facilities)
- not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- not be on the HHS Office of Inspectors General excluded and sanctioned provider lists
- not be a Federal health-care provider, such as a Veterans’ Administration provider, except when providing emergency care
- comply with all applicable Medicare and other applicable Federal health-care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA, that apply to covered services furnished to members
- agree to cooperate with Deseret Secure representatives to resolve any member grievance involving the provider within the time frame required under Federal law
- provide applicable beneficiary appeals notices (applies to hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities)
- make reasonable efforts to verify Deseret Secure member eligibility and benefits before providing services, except in the case of an emergency
- not charge the member in excess of the plan defined cost sharing under any condition, including the event of plan bankruptcy
- agree that you will not balance bill members for covered services
This list is not intended to be all-inclusive. Other provider responsibilities may be found throughout this manual and in provider agreements.

B. Member Responsibilities
To help with the claims payment process, Deseret Secure members:

- should make a reasonable effort to present their provider with a copy of the Deseret Secure ID card at the time of service
- should be prepared to pay any applicable copayments at the time of service
- have the right to file appeals and grievances with Deseret Secure when they have concerns or problems related to coverage or care. Members may appeal a decision made by Deseret Secure to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints not related to the provision or payment for health care

C. Deseret Mutual’s Responsibilities
To help with the claims payment process and to comply with Federal Guidelines, Deseret Mutual will:

- provide member ID cards to Deseret Secure members upon enrollment
- apply edits to claims in accordance with Desert Mutual, CMS, and AMA guidelines
- pay claims according to the traditional fee-for-service Medicare fee schedule
- pay clean claims within 30 days of receipt
- follow guidelines for claims and appeals created by Medicare