DESERET ALLIANCE

This summary plan description, or SPD, outlines the major provisions of Deseret Alliance as of January 1, 2022.

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Deseret Alliance Key Points

- Deseret Alliance is a Medicare supplement plan, meaning it provides additional benefits after Medicare has paid.
- Medicare is your primary plan provider and Deseret Alliance is your secondary plan.
- You must be properly enrolled in both Medicare Part A and Part B to have adequate benefits and to be eligible for Deseret Alliance. Also, you must not enroll in another Part D Medicare prescription plan. If you do, you'll lose your Deseret Alliance medical and prescription drug benefits and won't be able to re-enroll later.
- Your basic office visit copayments will be no more than $15 and some specialist office visits copayments will be up to $30.
- Your annual out-of-pocket maximum is $3,000 per person.
- You must receive services from providers eligible to bill Medicare and who choose to accept you as a Medicare patient unless you're traveling outside the United States.
- The plan partners with Navitus MedicareRx, underwritten by Dean Health Insurance, to administer your prescription drug benefits.
- The plan is not designed to pay all amounts not covered by Medicare.

Enrolling in Medicare

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

Medicare benefits are divided into three parts:

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

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

Navitus MedicareRx administers your Part D prescription drug benefits for you. **You should not enroll in another Medicare prescription plan.** If you do, you'll lose your Deseret Alliance medical and prescription drug benefits and won't be able to re-enroll later.

Maximizing Your Benefits

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

If you use a provider who does not participate in Medicare, you may be "balance billed" 15% more than Medicare's allowable amount. Balance-billed amounts are not covered by

the plan. You'll be responsible for paying any balance-billed amounts to non-participating providers.

You may not always realize a provider is not Medicare eligible. Here are some examples of expenses that aren't eligible:

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

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

- They require full payment up front
- They will not submit the claim to Medicare
- They ask you to sign a form explaining they are not participating with Medicare

Providers who have completely opted out of the Medicare program, or who have been excluded for cause by Medicare, are not eligible to bill Medicare for services. Neither Medicare nor DMBA will pay for services performed by an "opted-out" or excluded provider. (Providers are obligated to inform Medicare patients if they have opted out of or been excluded from Medicare.)

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

Identification Cards

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

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

Medicare	800-MEDICARE (800-633-4227)
Social Security Administration	800-772-1213

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

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

DMBA Member Services	801-578-5600 or 800-777-3622

When you go to a doctor or hospital, tell them you're a participant of Deseret Alliance, a Medicare Supplement plan, and show them both your Medicare card and your Deseret Alliance ID card. This will let the provider know to submit claims directly to Medicare first. After Medicare has paid, your claim information will automatically be forwarded to DMBA.

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

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

Important Rules and Guidelines

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

Except for a few medications, preauthorization is not required. See Preauthorization for Specific Medications.

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

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

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

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

Your Medical Benefits

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

All benefits are subject to the allowable amounts determined by either Medicare or DMBA. Medicare benefit limits also apply. See the *Medicare & You* handbook for more information. You can access a copy online at www.medicare.gov/medicare-and-you.

Services not covered by Medicare

Annual routine eye exam

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

You pay up to a $15 copayment.

One exam per calendar year is eligible.

Annual routine physical exam

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

You pay $0.

One exam per calendar year is eligible.

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

Labs and routine procedures associated with an ineligible physical exam are not covered.

Benefits for foreign missionaries

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

You pay applicable copayments and coinsurance.

This benefit applies if you receive Medicare Part B services in the United States only while you're disenrolled from Part B because of voluntary foreign missionary service.

Benefits during foreign travel (when you're outside the U.S.)

Medicare pays 80% of the Medicare-approved amount in limited circumstances only.

Deseret Alliance pays 20% of the Medicare-approved amount minus any copayments and coinsurance if covered by Medicare; or 100% of all covered services up to DMBA's allowable amount, minus any copayments and coinsurance (based on the type of service received) if not covered by Medicare.

You pay applicable copayments and coinsurance.

Eye refraction exams

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

You pay $0.

Hearing aids

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

You pay applicable copayments:

- $399 copayment per aid for Advanced model
- $699 copayment per aid for Premium model
- $50 per aid to change from battery-powered to rechargeable

One hearing aid per ear from TruHearing is eligible annually.

Services from all other providers are not eligible.

To learn more or to schedule an appointment with a TruHearing-contracted provider in your area, call 866-929-5584.

Immunizations not covered by Medicare

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

You pay $0.

Services covered by Medicare Part A

Home health services

Medicare pays 100% of Medicare-approved amount.

Deseret Alliance pays $0.

You pay $0.

Hospice care

Medicare pays 100% of Medicare-approved amount.

Deseret Alliance pays $0.

You pay $0.

Hospital care—inpatient (including mental health inpatient care)

Days 1 to 60

Medicare pays 100% after your Medicare Part A deductible ($1,556 in 2022).

Deseret Alliance pays 100% of the Medicare Part A deductible minus $750.

You pay up to $750 copayment.

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

Days 61 to 90

Medicare pays 100% after your Medicare Part A daily coinsurance amount ($389 per day in 2022).

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

You pay $0.

After day 90 (per benefit period)

Medicare pays $0, unless Medicare's lifetime reserve days are used.

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

Deseret Alliance pays $0.

You pay 100% for inpatient days that exceed Medicare's day limit.

Lifetime reserve days

Medicare pays 100% after your Medicare Part A daily coinsurance amount ($778 per day in 2022) for days 91 to 150.

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

You pay $0.

Skilled nursing facility care

Days 1 to 20

Medicare pays 100%.

Deseret Alliance pays $0.

You pay $0.

Days 21 to 100

Medicare pays 100% after your Medicare Part A daily coinsurance amount ($194.50 per day in 2022).

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

You pay up to a $100 copayment per day.

After day 100 (per benefit period)

Medicare pays $0.

Deseret Alliance pays $0.

You pay 100%.

Services covered by Medicare Part B

Medicare applies an annual Medicare Part B deductible ($233 in 2022). No payment for charges is made until the deductible has been met.

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

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

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

Ambulance services

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus a $75 copayment.

You pay up to a $75 copayment per day.

Ambulatory surgical center

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus up to a $275 copayment.

You pay up to a $275 copayment.

Cardiac rehabilitation (outpatient)

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Chemotherapy

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Chiropractic services (limited)

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Up to 25 visits per calendar year are eligible.

Diabetes self-management training

Medicare pays 80% of the Medicare-approved amount.

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

You pay $0.

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

Diabetic supplies

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Eligible supplies:

- Blood sugar testing monitors
- Blood sugar test strips
- Lancet devices and lancets
- Therapeutic shoes (in some cases)

Some supplies are covered by the prescription drug benefit.

Dialysis

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Doctor and other healthcare provider services—inpatient

Medicare pays 80% of the Medicare-approved amount.

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

You pay $0.

Some physician services you receive while admitted to the hospital are eligible.

Doctor and other healthcare provider services—outpatient

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus up to a $30 copayment per day.

You pay up to a $30 copayment per day.

Durable medical equipment

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Emergency department services

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus a $65 copayment per day.

You pay up to a $65 copayment per day.

The copayment is waived if the patient is admitted to the hospital from the emergency room.

Eyewear—glasses

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Glasses are covered only after cataract surgery.

Hearing exams

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Routine hearing exams are not covered.

Injections and IV therapy

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Mental healthcare—outpatient evaluation, therapy, and medication management

Office visit to diagnose

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Counseling for outpatient treatment

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Occupational therapy

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to a $15 copayment per visit.

Outpatient hospital services

Clinic visits

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus up to a $30 copayment per day.

You pay up to a $30 copayment per day.

Outpatient surgery

Medicare pays 80% of the Medicare-approved amount.

Deseret Alliance pays 20% of the Medicare-approved amount minus up to a $275 facility copayment per surgery.

You pay up to a $275 facility copayment.

Parenteral nutrition services

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Physical therapy

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to $15 copayment per visit.

Prescription drugs covered by Medicare Part B

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Preventive services (screening exams)

Medicare pays 100% of the Medicare-approved amount.

Deseret Alliance pays $0.

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

You pay $0.

Prosthetic/orthotic items

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

Radiology (imaging)

Medicare pays 80% of the Medicare-approved amount.

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

You pay 10% coinsurance.

X-rays, MRIs, MRAs, CT scans, PETs, SPECTs, etc. are eligible.

Speech language pathology services

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to $15 copayment per visit.

Supplies

Medicare pays 80% of the Medicare-approved amount.

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

You pay $0.

Tests (lab tests)

Medicare pays 100% of the Medicare-approved amount.

Deseret Alliance pays $0.

You pay $0.

A1C, urinalysis, blood chemistry, glucose, lipid profile, etc. are eligible.

Urgent care

Medicare pays 80% of the Medicare-approved amount.

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

You pay up to $15 copayment per visit.

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

Medicare Part D prescription drug benefits (from your Navitus MedicareRx PDP)

Because Navitus MedicareRx administers your prescription benefits, please direct medication and prescription questions to them, toll free, at 866-270-3877 (TTY 711).

Use Costco Mail Order Pharmacy for your mail-order prescriptions.

Here's a summary of your prescription benefits from Navitus MedicareRx. Limitations, copayments, and restrictions may apply.

Prescription category	For a 30-day supply from a retail pharmacy you'll pay . . .	For a 90-day supply from a mail-order or retail pharmacy you'll pay . . .
Tier 1: Preferred generic medications	25%, or at least $5	25%, or at least $10, but no more than $225
Tier 2: Preferred brand-name medications	25%, or at least $5	25%, or at least $10, but no more than $225
Tier 3: Non-preferred medications (generic and brand-name)	50%, or at least $5*	50%, or at least $10*
Tier 4: Specialty medications	25%, or at least $150, but no more than $225	100% (not covered)
Insulin	25%, but no more than $35	25%, but no more than $70 (60-day supply) 25%, but no more than $105 (90-day supply)
Catastrophic coverage: Brand-name medications**	5%, or at least $9.85	5%, or at least $9.85
Catastrophic coverage: Generic medications**	5%, or at least $3.95	5%, or at least $3.95
Excluded medications	100% (not covered)	100% (not covered)

* Reduced to 25% coinsurance after your total payments for prescriptions reach $4,430 in 2022.
** You qualify for Catastrophic Coverage when your total payments for prescriptions reach $7,050 in 2022.

Prescription drug expenses don't count toward your out-of-pocket maximum.

Some injections, oral cancer drugs, drugs used with durable medical equipment, and drugs given in a hospital setting are not covered.

Supplies used to administer diabetes medications

Deseret Alliance pays 90% of the allowable amount.

You pay 10%.

Syringes, needles, alcohol swabs, gauze, and inhaled insulin devices are eligible.

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

Preauthorization for Specific Medications

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

Preauthorization is only required for certain medications. The Navitus MedicareRx formulary drug list includes information about which medications require preauthorization. If you have questions about your personal situation, please call Navitus Customer Care.

If you don't preauthorize when necessary, your benefits may be reduced or denied.

Medical Emergencies

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

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

Out-of-pocket Maximum

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

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

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

Errors on Bills or EOB Statements

If you see services listed on an *Explanation of Benefits* (EOB) statement that were not performed or could be considered fraudulent, please call DMBA at 801-578-5600 or 800-777-3622.

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

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

If you find an error on any claims related to Medicare's payment, please contact Medicare as well.

Submitting Claims

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

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

1. Get an itemized bill from the provider or facility that includes the following:
   - » Patient's name
   - » Provider's name, address, phone number, and tax identification number
   - » Diagnosis and diagnosis code(s)
   - » Procedure and procedure code(s)
   - » Place and date of service(s)
   - » Amount charged for service(s)
2. Write your name and DMBA ID number on the bill.
3. Have the provider indicate the amount of payment already collected, if applicable.
4. Fill out a *Medical & Dental Claim Form*, which you can find in the *Forms Library* at www.dmba.com.
5. Mail the claim to DMBA:

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

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

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

Coordination of Benefits

When you or your dependents have medical or dental benefits from more than one health plan, benefits are coordinated between the plans to avoid duplication of payments. Coordination of benefits involves determining which insurer is required to pay benefits as the primary payer, which insurer must pay as the secondary payer and so on.

You or your dependents must inform DMBA of other medical or dental benefits in force when you enroll or when other benefits become effective. If applicable, you may be required to submit court orders or decrees. You must also keep us informed of any changes in the status of the other benefits.

Multiple health plans

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

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

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

Order of payment

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

Coordination with other plans

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

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

Subrogation

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

If you do not attempt to recover damages from the third party as described above, DMBA has the right to act in your place and initiate legal action against the liable third party to recover the amount it has paid for your injuries.

For more information about subrogation, please see your *General Information* SPD.

Eligible Dependents

Your eligible dependents include your spouse and dependent children. Your spouse is the person to whom you are legally married.

Exclusions

Services that do not meet the definition of eligible, as previously defined, are not eligible for benefits. All procedures or treatments are excluded until specifically included in the plan. To be eligible for payment, services must meet Medicare's criteria. In addition, the following services and their associated costs are excluded from benefits:

1. Custodial care

1.1. Custodial or long-term care, education, training, or rest cures, which is defined as maintaining an individual beyond the acute phase of injury or sickness and includes room, meals, bed, or skilled or unskilled medical care at any hospital, care facility, or home to assist the individual with activities of daily living including, but not limited to, feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, or ambulation; and where the individual's impairment, regardless of the severity, requires such support to continue for more than two weeks after establishing a pattern of this type of care, except as provided for by the terms of the plan

1.2. Inpatient hospitalization or residential treatment for the primary purpose of providing shelter or safe residence

2. Dental care

2.1. Dental services, including care and treatment of the teeth, gums, or alveolar process; dentures, crowns, caps, permanent bridgework, and appliances; and supplies used in such care and treatment, except as provided for by the terms of the plan

3. Diagnostic and experimental services

3.1. Care, service, diagnostic procedures, or operations for diagnostic purposes not related to an injury or sickness, except as provided for by the terms of the plan

3.2. Care, treatment, diagnostic procedures, or operations that are

- considered medical research;
- investigative/experimental technology (unproven care, treatment, procedures, or operations);
- not recognized by the U.S. medical profession as usual and/or common;
- determined by DMBA not to be usual and/or common medical practice; or
- illegal

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

Investigative/experimental technology means a service, procedure, facility, equipment, drug, device, or supply that does not, as determined by DMBA, meet all of the following criteria:

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

For plan purposes, *substantial* means sufficient to allow DMBA to conclude that the technology is

- both medically necessary and appropriate for the covered person's treatment,
- safe and efficacious,
- more likely than not beneficial to the covered person's health, and
- generally recognized as appropriate by the regional medical community as a whole.

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

4. Fertility, infertility, family planning, home delivery, surrogate pregnancy, and adoption

4.1. Family planning, including contraception, birth control devices, and/or sterilization procedures, unless the covered individual meets DMBA's current medical criteria
4.2. Abortion and medications to induce abortion, except in cases of rape, incest, or when the life of the mother and/or fetus would be seriously endangered if the fetus were carried to term
4.3. Services related to in vitro fertilization that do not meet plan guidelines
4.4. Reversal of sterilization procedures
4.5. Planned home delivery for childbirth and all associated costs
4.6. All pregnancy- and birth-related expenses (prenatal and postnatal) of an individual (including a covered individual) acting as a surrogate or gestational carrier*
4.7. Services, drugs, or supplies to treat sexual dysfunction, erectile dysfunction, enhance sexual performance, or increase sexual desire, except the external erectile vacuum erection device under the durable medical equipment benefit

* An infant born to a surrogate or gestational carrier is eligible for coverage from the date on which the infant became a dependent of the participant.

5. Government/war

5.1. Services and supplies received as a result of a covered individual's participation in insurrection, terrorism, war or act of war (declared or undeclared), or due to an injury or illness sustained in the armed services of any country, unless a veteran is furnished medical services by the United States for a non-service-connected condition and the veteran would be eligible to recover the cost had the services been provided by the United States

5.2. Services that would have been covered by any governmental plan had the participant complied with the requirements of the plan including, but not limited to, Medicare

5.3. Services and supplies that school systems are legally required to provide

6. Hearing

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

7. Legal exclusions

7.1. Services that the individual is not, in the absence of this benefit, legally obligated to pay

7.2. Care, treatment, operations, or prescription drugs incurred after termination of benefits

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

7.4. Complications resulting from excluded services

7.5. Services provided as a result of a court order or for other legal proceedings

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

7.7. Care, treatment, diagnostic procedures, or operations for diagnostic purposes that are not related to an injury or illness except as provided for by the terms of the plan

7.8. Mandated state service charges and taxes

8. Medical equipment

8.1. General/multipurpose equipment or facilities, including related appurtenances, controls, accessories, or modifications thereof, including, but not limited to, buildings, motor vehicles, air conditioning, air filtration units, exercise equipment or machines, vibrating chairs and beds, air filtration systems, dehumidifiers, humidifiers, nonprescription braces or orthotics, learning devices, spa and gym memberships, vision devices, and modifications associated with activities of daily living, homes, or vehicles

8.2. Upgrade or replacement of medical equipment when the existing equipment is still functional, unless otherwise specified by the plan

8.3. Replacement of a device when damage is due to the covered individual's abuse or neglect

9. Medical necessity

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

9.2. Care, services, or supplies that are not clearly a medical necessity as defined by the plan (Covered individuals will receive benefits under this plan only for services that are determined to be medically necessary and not investigative/experimental technology. That a provider has

prescribed, ordered, recommended, or approved services, or has informed the covered individual of its availability, does not in itself make it medically necessary or a covered expense. The plan administrator will make the final determination of whether any services are medically necessary or considered investigative/experimental technology. If a particular service is not medically necessary as defined by this plan and determined by the plan administrator, the plan will not pay for any charges related to such services, and any such charges will not be counted toward the out-of-pocket maximum. The charges will be outside the plan and will be the covered individual's financial responsibility.)

9.3. Care, services, or supplies for convenience, contentment, or other non-therapeutic purposes

9.4. Cardiopulmonary fitness training or conditioning either as a preventive or therapeutic measure, except as provided for by the terms of the plan

9.5. Care, services, diagnostic procedures, or other expenses, which include, but are not limited to, an abdominoplasty, lipectomy, panniculectomy (except when medical criteria have been met), skin furrow removal, or diastasis rectus repair

10. Mental health, counseling, chemical dependency

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

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

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

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

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

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

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

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

11. Miscellaneous

11.1. Services of any practitioner of the healing arts who

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

11.2. Care, treatment, diagnostic procedures, or other expenses when it has been determined that brain death has occurred

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

11.4. Reproductive organ prosthesis

11.5. Acupuncture treatment and/or services

11.6. Charges over and above the allowable amount or reasonable and customary amount as determined by the plan administrator
11.7. Education and training

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

12. Obesity

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

13. Other insurance/workers' compensation

13.1. Services covered or that could have been covered by applicable workers' compensation statutes
13.2. Services covered or that could have been covered by insurance required or provided by any statute had the participant complied with the statutory requirements including, but not limited to, no-fault insurance
13.3. Services for which a third party, the liability insurance of the third party, underinsured motorist, or uninsured motorist insurance pays or is obligated to pay
13.4. Physical examination for the purpose of obtaining insurance, employment, government licensing, or as needed for volunteer work except as provided for by the terms of the plan

14. Prescription drugs

14.1. Medications, such as contraceptives for purposes of family planning, dietary or nutritional products or supplements (including special diets for medical problems), herbal remedies, holistic or homeopathic treatments, products used to stimulate hair growth, medications used for sexual dysfunction, medications whose use is for cosmetic purposes, over-the-counter products (non-legend), vitamins (except prenatal vitamins and prescribed infant vitamins), weight-reduction aids, and non-formulary drugs, except to the extent specifically provided in the plan (including any requirements regarding preauthorization)
14.2. Specific medications, unless specifically authorized by Navitus MedicareRx

15. Testing

15.1. Some allergy tests including, but not limited to, leukocyte histamine release test (LHRT), cytotoxic food testing (Bryan's test, ACT), conjunctival challenge test, electroacupuncture, passive transfer (P-X) or Prausnitz-Küstner (P-K) test, provocative nasal test, provocative food and chemical testing (intradermal, subcutaneous, or sublingual), Rebuck skin window test, and Rinkel test

16. Transplants

16.1. Care, services, medications, or supplies in relation to organ transplants (donor or artificial), unless the covered individual characteristics and transplant procedures meet Medicare's current medical criteria

17. Vision

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

Patient Protection and Affordable Care Act

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

For information about which protections do or don't apply, please call us or contact the Employee Benefits Security Administration, U.S. Department of Labor, at 866-444-3272 or www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act.

Claims Review and Appeal Procedures

If your claim is denied in whole or in part and you feel that the denial is in error, you have the right to file an appeal. If your appeal is related to Medicare's payment, you must appeal directly to Medicare. To appeal a Deseret Alliance benefit determination, **you must submit your appeal in writing within 12 months from the date we send your adverse benefit decision.** For more information about how to appeal a claim, please refer to your *General Information* SPD.

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

Notification of Discretionary Authority

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

decisions by DMBA shall be final, binding and conclusive on the Employers, the Employees and any other parties affected thereby.

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

Notification of Benefit Changes

DMBA reserves the right to amend or terminate the plan at any time.

Legal Notice

We have made every effort to accurately describe the benefits and ensure that information given to you is consistent with other benefit-related communications. However, if there is any discrepancy or conflict between information in this document and other plan materials, the terms outlined in the Legal Plan Document *will govern.*