DESERET CHOICE HAWAII

This summary plan description, or SPD, outlines the major provisions of Deseret Choice Hawaii as of January 1, 2025.

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Deseret Choice Hawaii Key Points

- Generally, Deseret Choice Hawaii covers in-network providers at 90% and out-of-network providers at 70% of DMBA's allowable amount.
- Certain preventive care services—such as colonoscopies, mammograms, physical exams, and well-child care—from in-network providers are covered at 100%.
- Your annual out-of-pocket maximum is $2,000 per person or $3,500 per family for services from in-network providers and $3,000 per person or $7,000 per family for services from out-of-network providers. In-network and out-of-network maximums accumulate separately. All out-of-pocket expenses for eligible medical and prescription drug services count toward your out-of-pocket maximum.
- Copayments apply to some benefits, including office visits. Copayments for most benefits are not required after your annual out-of-pocket maximum is reached.
- You or your physician must preauthorize some services with DMBA, such as some surgeries and home healthcare.

Maximizing Your Benefits

In-network providers

All DMBA health plans are preferred provider organizations, or PPOs, meaning you pay less out of pocket when you receive care from your plan's in-network providers (physicians, hospitals, etc.).

When you receive care from in-network providers, they accept your copayments and coinsurance, along with what DMBA pays, as payment in full for eligible services. They won't bill you for more than DMBA's allowable amount.

When you receive care from out-of-network providers, they can bill you for the difference between the amount they charge and DMBA's allowable amount. Your share of the expenses increases and you are responsible for all expenses that exceed the plan's allowable amounts.

Provider networks vary by location. For information about in-network providers in your area for your specific plan, go to www.dmba.com and select *Find a Provider*. Our in-network organizations include the following:

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

Preauthorize when needed

You must ensure your provider preauthorizes some services with DMBA.

When you preauthorize with DMBA, we verify that your care is medically necessary and tell you about any length-of-stay guidelines or other limitations.

If your services are not preauthorized when required, your benefits may be reduced or denied. If DMBA ultimately denies benefits for the service, you will be responsible for all charges.

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

Your Medical Benefits

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

Acupuncture

In-network provider: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $30 copayment; you pay $30 plus any remaining amount.

Up to 12 visits are covered per calendar year.

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

Allergy testing

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

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

Ambulance—emergency

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

Covered services when DMBA's medical criteria are met:

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

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

Examples of services not covered:

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

For more information about other transportation services, see the *Transportation* benefit.

Anesthesia

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

Applied behavior analysis (ABA) therapy

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

Preauthorization is required, including the initial assessment.

Behavioral (mental) health and substance use disorders

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

Outpatient

In-network or out-of-network provider: The plan pays 100% after your $15 copayment per visit; you pay $15 plus any remaining amount.

Covered services:

- Diagnostic evaluation
- Individual therapy
- Group therapy
- Medication evaluation and management

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

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

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

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

All benefits are subject to DMBA's allowable amounts.

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

Cardiac rehabilitation

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Chemotherapy—provider-administered

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required.

Oral chemotherapy agents and self-administered medications may be covered by *Your Prescription Drug Benefit—Specialty pharmacy*.

Chiropractic therapy

In-network or out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $20 copayment; you pay $20 plus any remaining amount.

Up to 30 visits per calendar year are covered.

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

Full-body X-rays are not covered.

Clinical trials

To be covered, the patient must be clinically eligible for participation in an approved clinical trial (phase I, II, III, or IV) studying the prevention, detection, or treatment of cancer or another life-threatening condition.

Covered services:

- Medically necessary routine patient care during the trial
- Associated items, services, and drugs otherwise covered by the plan
- Laboratory services, imaging services, office visits, inpatient hospital services, etc.
- Services required solely for the provision of the service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications
- Reasonable and necessary services used to prevent, diagnose, and treat complications arising from participation in the trial

Services not covered:

- The experimental or investigational service, drug, or item

- Items and services that satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Items and services provided by the research sponsors free of charge
- Transportation and travel expenses

Routine patient care is covered at the appropriate plan benefit levels for those services.

Preauthorization is required.

For more information, refer to the plan document or call DMBA.

Colorectal cancer screening or colonoscopy

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

Preventive

In-network provider: The plan pays 100%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

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

Virtual colonoscopies are not covered.

Diagnostic

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Anesthesia for diagnostic procedures is covered at the appropriate benefit level for that service. See the *Anesthesia* benefit for more information.

Virtual colonoscopies are not covered.

Diabetes

Education

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

All benefits are subject to DMBA's allowable amounts.

Programs and services not covered:

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

Glucometers

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

Insulin pumps

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

One pump every four years is covered.

Preauthorization is required.

Insulin and additional supplies are covered by *Your Prescription Drug Benefit*.

Dialysis

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Durable medical equipment

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered equipment:

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

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

All benefits are subject to DMBA's allowable amounts.

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

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

Table: Medical equipment

	Must be preauthorized	No preauthorization needed	Not covered
Air filtration system			•
Apnea monitor for infants	•		
Bilirubin light		•	
Blood pressure kit		•	
Bone growth stimulator	•		
Breast prosthetics, external, for individuals with cancer		•	
Breast pump, electric*		•	
Breast pump, hospital grade	•		
Breast pump, manual			•
Cane		•	
Cold/heat application			•
Commode, bedside (one per lifetime)		•	
Communication device (one per lifetime)	•		
Continuous passive motion machine (for knees only)**		•	
CPAP/BiPAP machine	•		
Cranial remolding helmet	•		
Crutches		•	
Defibrillator vest	•		
Dehumidifier			•
Exercise equipment			•
External erectile vacuum device (e.g., ErecAid) (one per lifetime)		•	
Gait trainer	•		
Hearing aids		•	
Hearing device			•
Hospital bed, mattress, overlay, and accessories (e.g., overhead trapeze)	•		
Hoyer lift	•		
Humidifier for home use			•
Implantable pain pump	•		
Insulin pump/continuous glucose monitor	•		
Interferential stimulator			•
Joint stretching device	•		

All benefits are subject to DMBA's allowable amounts.

	Must be preauthorized	No preauthorization needed	Not covered
Knee brace used solely for sports			•
Learning device			•
Lift chair			•
Lymph press/compression pump	•		
Modification for home, vehicle, or activities of daily living			•
Nebulizer/Pulmo-Aide (purchase only)		•	
Orthopedic brace		•	
Oxygen concentrator	•		
Oxygen, stationary**		•	
Protective helmet		•	
Respirator/ventilator	•		
Scooter, knee/knee walker***		•	
Scooter, mobility (purchase)	•		
Scooter, mobility (rental)***		•	
Seasonal Affective Disorder light (one per lifetime)	•		
Slant board/transfer board		•	
Spinal cord stimulator	•		
TENS unit		•	
Vest airway clearance system	•		
Vision device			•
Walker		•	
Wheelchair (purchase)	•		
Wheelchair (rental)***		•	
Whirlpool or hot tub			•
Wound vac	•		

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

Emergency room

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay $75 per visit plus any remaining amount.

If you receive follow-up care at the emergency room, you're responsible for another $75 copayment plus your 10% coinsurance.

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

Other services you receive during an emergency room visit that are billed separately are covered at the appropriate benefit levels for those services.

All benefits are subject to DMBA's allowable amounts.

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

Emergency room physician

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

Eye exams

In-network provider: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount after your $20 copayment; you pay $20 plus any remaining amount.

Covered services:

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

Eyewear (glasses or contact lenses)

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

Covered supplies:

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

All other eyewear is not covered.

Genetic counseling

In-network PCP: The plan pays 100% after your $15 copayment.

In-network specialist: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount; you pay $20 plus any remaining amount.

Genetic counseling must be provided by a certified genetic counselor, board-certified medical geneticist, or an appropriate provider based on DMBA's guidelines.

Genetic testing

In-network or out-of-network provider: The plan pays 100% of DMBA's allowable amount; you pay any remaining amount.

Preauthorization may be required.

Not all genetic testing is covered.

Genetic counseling is required prior to receiving genetic testing services.

All benefits are subject to DMBA's allowable amounts.

Hearing aids

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

Out-of-network provider: The plan pays 70% of DMBA's allowable amount, up to $1,200 per ear once every three years; you pay the remaining amount.

Only prescription hearing aids are covered.

To be covered, a licensed audiologist must prescribe hearing aids and perform related services, including fitting.

Over-the-counter (OTC) hearing aids and other personal sound amplification products are not covered.

Hearing exams

In-network PCP: The plan pays 100% after your $15 copayment.

In-network specialist: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount; you pay $20 plus any remaining amount.

Hearing testing (audiometry)

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

For preventive hearing loss screening, see *Preventive care services*.

Home healthcare

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

Preauthorization is required.

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

Hospice care

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

- A coordinated team of hospice professionals
- Bereavement services
- Counseling services for covered individuals and caregivers
- Medical equipment and supplies
- Medications related to the terminal illness and symptoms
- Nursing services for emergencies related to the terminal illness
- Primary caregiver respite care

Preauthorization is required.

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

Hospital—inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required.

Imaging services (radiology)—facility

Diagnostic

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Examples of covered services:

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

Advanced

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Examples of covered services:

- Electrocardiograms (EKG)
- Echocardiograms

All benefits are subject to DMBA's allowable amounts.

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

Preauthorization is required for most services.

Imaging services (radiology)—professional

Diagnostic

In-network or out-of-network provider: The plan pays 90%; you pay the remaining amount.

Examples of covered services:

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

Advanced

In-network or out-of-network provider: The plan pays 90%; you pay the remaining amount.

Examples of covered services:

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

Preauthorization is required for most services.

Immunizations

In-network or out-of-network provider or public/county health department: The plan pays 100% of DMBA's allowable amount; you pay any remaining amount.

Commonly covered immunizations/vaccines:

- COVID-19
- Diphtheria/Pertussis/Tetanus (DTaP, Tdap)
- Diphtheria/Tetanus (DT)
- Haemophilus Influenzae (Hib)
- Hepatitis A and B
- Human Papillomavirus (HPV), for individuals aged 9–26
- Influenza
- Measles/Mumps/Rubella (MMR)
- Meningococcal (MenACWY, MenB)
- Pneumococcal

All benefits are subject to DMBA's allowable amounts.

- Polio
- Rotavirus
- Shingles (zoster, Shingrix), for individuals aged 50–99
- Tetanus
- Tetramune
- Varicella/chicken pox (VAR)
- Yellow fever

Infertility services

Artificial insemination

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required.

In vitro fertilization (IVF)

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

The plan pays for in vitro fertilization one time for a participant, whether used by the participant, a spouse, a dependent, or a combination thereof.

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

Preauthorization is required.

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

Injections and IV therapy

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

- Prescription drugs, including certain specialty drugs, administered in an outpatient setting and billed as a medical benefit, such as drugs for infusion therapy, blood products, certain injectables, and any drug that must be administered by a provider
- The cost and administration of a provider-maintained drug administered in an outpatient setting

All benefits are subject to DMBA's allowable amounts.

- Administration of a pharmacy-provided drug in an outpatient setting

Archimedes administers and makes final benefit determinations on behalf of DMBA for most professionally administered drugs. For a list of drugs administered by Archimedes, call 1-888-504-5563.

Preauthorization may be required.

Laboratory services

Outpatient

In-network or out-of-network provider: The plan pays 100% of DMBA's allowable amount; you pay any remaining amount.

Preauthorization may be required.

Inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Lifestyle screenings

In-network or out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $20 copayment, up to $100 per screening; you pay $20 plus any remaining amount.

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

- Blood pressure check
- Blood test for cholesterol levels
- Body fat evaluation
- Cardiopulmonary fitness
- Flexibility test
- Medical history
- Strength test
- Weight analysis

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

Services for dependent children are not covered.

Mammograms

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

Preventive

In-network provider: The plan pays 100%.

All benefits are subject to DMBA's allowable amounts.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

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

Diagnostic

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

- Mammograms as often as medically necessary
- 3D mammograms

Maternity

Physician services

In-network provider: The plan pays 90%; you pay 10%. The plan pays 100% for ACA-determined preventive maternity services.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

Inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

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

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

Medical supplies

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Examples of covered supplies:

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

Some supplies may require preauthorization.

Nutritional education

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

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

Obesity surgery

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

- Roux-en-Y gastric bypass
- Vertical gastrectomy with duodenal switch
- Gastric sleeve

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

All other obesity surgical procedures are not covered.

Occupational therapy

Outpatient

In-network provider: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $30 copayment; you pay $30 plus any remaining amount.

Up to 30 visits per calendar year are covered.

Preauthorization is required for additional visits.

Preauthorization is required for cognitive rehabilitation therapy.

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

Inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

Office visits

In-network PCP: The plan pays 100% after your $15 copayment.

In-network specialist: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount; you pay $20 plus any remaining amount.

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

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

Osteoporosis screening

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

Preventive

In-network provider: The plan pays 100%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Two screenings per lifetime are covered for women.

Diagnostic

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

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

Pain management

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required for inpatient services, some physician services, outpatient procedures, and durable medical equipment, such as implantable pain pumps and spinal cord stimulators.

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

Physical exams

In-network provider: The plan pays 100%. A copayment does not apply.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount; you pay $20 plus any remaining amount.

Covered services:

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

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

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

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

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

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

Physical therapy

Outpatient

In-network provider: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $30 copayment; you pay $30 plus any remaining amount.

Up to 30 visits per calendar year are covered.

Preauthorization is required for additional visits.

Preauthorization is required for cognitive rehabilitation therapy.

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

All benefits are subject to DMBA's allowable amounts.

Inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

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

Preventive care services

In-network provider: The plan pays 100%. A copayment does not apply.

Out-of-network provider: Varies by service.

See the preventive care services table.

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

Examples of covered services:

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

Services not covered:

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

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

Table: Preventive care services

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
Routine exams							
• Newborn (inpatient hospital)			•			100%	70%

All benefits are subject to DMBA's allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
• Ages 0–4 years			•	Birth to 4 years (ends on fifth birthday)		100%	80% after $20 copayment
• Ages 5 and older	•	•	•	5 years and older	Once per calendar year	100%	80% after $20 copayment
• Well-woman exam (routine and gynecological)		•			Once each per calendar year for routine and gynecological	100%	80% after $20 copayment
• Well-woman maternity initial visit		•			Three times per calendar year	100%	80% after $20 copayment
• Well-woman maternity care determined preventive under ACA (antepartum, postpartum, prenatal education in a group setting)		•				100%	70%
Abdominal aortic aneurysm (AAA) screening	•			65–75	Once per lifetime	100%	90% for professional services; 70% for facility
BRCA-related cancer: genetic counseling		•				100%	80% after $20 copayment
BRCA-related cancer: genetic testing (requires preauthorization)		•				100%	100%
Breast cancer (mammography) screening		•		40 and older	Once per calendar year	100%	90% for professional services; 70% for facility
Breast pump and supplies		•			One pump every three calendar years; supplies once per calendar year	100%	70%

All benefits are subject to DMBA's allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
Breastfeeding class		•			Once per calendar year	100%	70%
Breastfeeding counseling		•			Six times per calendar year	100%	70%
Cervical cancer screening (human papillomavirus [HPV] DNA test and PAP smear)		•		21–65	Once per calendar year	100%	100%
Colorectal cancer screening (fecal occult blood [FOBT], FIT)	•	•		45–75	Once per calendar year	100%	100%
Colorectal cancer screening (FIT-DNA)	•	•		45–75	Once every three years	100%	100%
Colorectal cancer screening (colonoscopy or sigmoidoscopy)	•	•		45–75	Once every five years	100%	70%
Contraception (eligible medical benefit)		•				100%	70%
Depression screening	•	•	•	11 years and older	Once per calendar year	100%	70%
Depression screening (maternal)	•	•			Four times in a calendar year with newborn younger than age 1	100%	70%
Developmental screening/autism screening			•	3 years and younger	Four times per lifetime	100%	70%
Fluoride: topical varnish for dental caries prevention			•	5 years and younger	Four times per calendar year	100%	70%

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
Healthy weight management • Obesity screening prevention and counseling • Healthy weight and weight gain in pregnancy • Behavioral intervention for weight loss to prevent obesity-related morbidity and mortality in adults, and healthy diet and physical activity for cardiovascular disease prevention	•	•	•		Six times per calendar year	100%	Office visit 80% after $20 copayment; all other services 70%
Hearing loss screening			•	21 years and younger	Varies depending on age	100%	70%
High blood pressure screening (ambulatory)	•	•		18 years and older	Once per calendar year	100%	70%
HIV infection pre-exposure prophylaxis (PrEP)	•	•				100%	70%
Laboratory tests							
• Abnormal blood glucose and type 2 diabetes mellitus screening	•	•		35–70	Once per calendar year	100%	100%
• Anemia (hematocrit or hemoglobin) screening		•	•			100%	100%
• Asymptomatic bacteriuria screening (urinary tract infection)		•			Twice per calendar year	100%	100%
• Chlamydia infection screening		•			Once per calendar year	100%	100%
• Cholesterol or dyslipidemia screening	•	•	•		Once per calendar year	100%	100%
• Diabetes mellitus after pregnancy screening		•			Once per calendar year	100%	100%

All benefits are subject to DMBA's allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
• Gestational diabetes screening		•				100%	100%
• Gonorrhea screening	•	•	•		Once per calendar year	100%	100%
• Hepatitis B virus infection screening	•	•	•		Once per calendar year	100%	100%
• Hepatitis B screening during pregnancy		•			Once per calendar year	100%	100%
• Hepatitis C virus infection screening	•	•	•		Once per calendar year	100%	100%
• HIV screening	•	•	•	15–65	Once per calendar year	100%	100%
• Lead screening			•	6 years and younger		100%	100%
• Newborn bilirubin screening			•	Birth to 1 year	Twice per calendar year	100%	100%
• Newborn metabolic screening			•	Birth to 1 year	Once per lifetime	100%	100%
• Rh incompatibility screening		•				100%	100%
• Syphilis screening	•	•			Once per calendar year	100%	100%
• Syphilis screening (pregnancy)		•			Once per calendar year	100%	100%
• Tuberculosis (TB), latent, screening	•	•	•		Twice per calendar year	100%	100%
Lung cancer screening	•	•		50–80	Once per calendar year	100%	90% for professional services; 70% for facility
Medications (retail pharmacy) when filled at a pharmacy with a valid prescription*							
• Aspirin to prevent preeclampsia		•		15–50		100%	100%

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
• Bowel preparation medications for colorectal cancer screening	•	•		45–75	Twice per calendar year	100%	100%
• Breast cancer preventive medications (chemoprevention)		•		35 and older		100%	100%
• Fluoride supplements to prevent cavities			•	4 years and younger		100%	100%
• Folic acid supplements		•				100%	100%
• Statin use to prevent cardiovascular disease	•	•				100%	100%
• Tobacco cessation medications	•	•		13 years and older		100%	100%
Osteoporosis screening		•			Twice per lifetime	100%	90% for professional services; 70% for facility
Sexually transmitted infections, behavioral counseling to prevent	•	•	•		Twice per calendar year	100%	70%
Sudden cardiac arrest (SCA) and sudden cardiac death (SCD) risk assessment and ECG screening			•	11–21		100%	70%
Tobacco use prevention counseling and interventions	•	•	•		Eight times per calendar year	100%	70%
Tuberculosis (TB) risk assessment and testing	•	•	•		Once per calendar year	100%	100%
Unhealthy alcohol or drug use screening and counseling	•	•	•	11 years and older		100%	80% after $20 copayment
Vaccines (routine)	•	•	•		As recommended by the CDC	100%	100%

All benefits are subject to DMBA's allowable amounts.

Preventive care service	Men	Women	Children	Age	Frequency	The plan pays . . .	
						In-network provider	*Out-of-network provider (based on DMBA's allowable amount)*
Vision (acuity) impairment screening			•	5 years and younger	Once per calendar year	100%	100%
Vision impairment instrument-based screening			•	5 years and younger	Three times before age 5	100%	100%

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

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

** Purchased at an in-network pharmacy. When you purchase medications from an out-of-network pharmacy, pay the total cost and submit a claim to Navitus for reimbursement. Reimbursement is based on Navitus's allowed amount.

Review your online personal preventive care report

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

Prosthetics

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

- Prosthetics, such as artificial arms, legs, or eyes

All benefits are subject to DMBA's allowable amounts.

- Repair for normal wear and tear
- Replacement of some prosthetics, at specific intervals

Preauthorization is required.

Replacement of a lost prosthesis is not covered.

Radiation therapy

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required for some types of radiation therapy, such as proton beam therapy, IMRT, and brachytherapy.

Respiratory education

In-network or out-of-network provider: The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

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

Skilled nursing facility

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered services:

- Time in an extended-care facility after an inpatient hospitalization
- Up to 100 days per calendar year for an individual recuperating or convalescing from an acute injury or illness

Preauthorization is required.

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

Speech therapy

Initial evaluation

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is not required for the initial evaluation.

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

Outpatient

In-network provider: The plan pays 100% after your $20 copayment.

Out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $30 copayment; you pay $30 plus any remaining amount.

Preauthorization is required.

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

Inpatient

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Surgery

Outpatient facility and physician services

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required for some procedures. If outpatient services result in an inpatient hospital stay, ensure that preauthorization is obtained within two business days of admission or as soon as reasonably possible.

Inpatient facility and physician services

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Preauthorization is required for inpatient facility services. In case of emergency, ensure that preauthorization is obtained within two business days after the surgery or as soon as reasonably possible.

Telemedicine

In-network PCP: The plan pays 100% after your $15 copayment.

In-network specialist: The plan pays 100% after your $20 copayment.

All benefits are subject to DMBA's allowable amounts.

Out-of-network provider: The plan pays 80% of DMBA's allowable amount; you pay $20 plus any remaining amount.

In-network or out-of-network urgent care: The plan pays 100% of DMBA's allowable amount after your $25 copayment; you pay $25 plus any remaining amount.

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

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

Temporomandibular joint (TMJ) dysfunction

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Services such as surgery, office visits, lab work, and anesthesia are covered at the appropriate benefit levels for those services.

Services not covered:

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

Transplants

In-network provider: The plan pays 90%; you pay 10%.

Out-of-network provider: The plan pays 70% of DMBA's allowable amount; you pay the remaining amount.

Covered transplants when DMBA's medical criteria are met:

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

Preauthorization is required.

Limitations apply to donor benefits.

Prescription drugs associated with a transplant are covered by *Your Prescription Drug Benefit*.

All benefits are subject to DMBA's allowable amounts.

Other transplants are not covered.

Transportation

The plan pays 90% of DMBA's allowable amount; you pay the remaining amount.

Covered services when DMBA's medical criteria are met:

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

Preauthorization is required.

If you travel by automobile, the benefit is based on the IRS standard mileage rate—after the first 200 miles per round trip. If you travel by airplane or train, contact DMBA for more information.

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

For more information about other transportation services, see the *Ambulance* benefit.

Urgent care

In-network or out-of-network provider: The plan pays 100% of DMBA's allowable amount after your $25 copayment per visit; you pay $25 plus any remaining amount.

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

If the visit results in an inpatient hospital stay, ensure that preauthorization is obtained within two business days of admission or as soon as reasonably possible.

Your Prescription Drug Benefit

Formulary

The formulary is the complete list of drugs eligible for coverage. Medications are listed by cost levels known as tiers. Tiers can include both name-brand and generic prescription medications approved by the U.S. Food and Drug Administration (FDA) or designated medical supplies.

Formulary Tier	Description
Tier 1	Low-cost preferred medications
Tier 2	Moderate-cost preferred medications
Tier 3	Non-preferred brands; least cost-effective with reasonable alternatives in Tier 1 and Tier 2
Specialty Tier S1	High-cost generic or biosimilar specialty medications
Specialty Tier S2	High-cost specialty medications

All benefits are subject to DMBA's allowable amounts.

Call 833-354-2226 or visit www.navitus.com to learn the formulary status of a medication. The tier placement of a drug may be changed at any time.

Benefit summary

Prescription drug benefits are categorized as retail, retail 90 (90-day prescription), mail order, and specialty pharmacy.

The following tables show your costs per prescription if the medication is in the formulary and doesn't cost more than the allowable amount.

	Retail	Retail 90	Costco Mail Order Pharmacy
Tier 1	30% up to $10	30% up to $25	25% up to $20
Tier 2	30% up to $75	30% up to $110	25% up to $85
Tier 3	50% up to $125	50% up to $300	50% up to $250

Specialty Tier S1	$5
Specialty Tier S2	10% up to $85

Preventive

In-network pharmacy: The plan pays 100%.

Preventive prescription drugs as described in the *Preventive care services* benefit are covered.

Diabetic supplies and insulin

Supplies

Covered supplies:

- **Tier 1:** Syringes, pen needles, lancets, alcohol swabs
- **Tier 2:** Insulin pump supplies

See the *Diabetes* benefit for insulin pumps and other pump supplies.

Continuous glucose monitoring (CGM) systems

Covered systems at Tier 2:

- Abbott FreeStyle Libre
- Dexcom

Preauthorization is required.

Other CGM systems may be covered under the medical benefit.

Test strips

Test strips compatible with covered glucometers are covered at Tier 2.

All benefits are subject to DMBA's allowable amounts.

Insulin

Covered as retail, retail 90, and mail order.

Enteral formula

Covered at Tier 2.

Preauthorization is required.

Other nutritional formulas and dietary supplements are not covered.

Benefit administration

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

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

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

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

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

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

Common medications not covered:

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

All benefits are subject to DMBA's allowable amounts.

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

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

Pharmacies

Navitus has a network of retail pharmacies, a mail order pharmacy program, and a specialty pharmacy. To find out whether a pharmacy is in this network, call Navitus at 833-354-2226 or visit memberportal.navitus.com. If you buy prescription drugs from a non-network pharmacy, you must pay the non-network pharmacy's price and then submit a claim form for reimbursement directly to Navitus. The claim will be reimbursed according to plan guidelines based on the plan's allowable amount for that medication (not at the price paid at the non-network pharmacy) minus the applicable coinsurance that you would have paid. This means you will not be reimbursed for the difference between the discounted network pharmacy price and the non-network pharmacy price for a prescription.

Retail pharmacies typically provide up to a 30-day supply. Some medications may be subject to additional supply limits from Navitus.

Retail 90 pharmacies provide between 60 and 90 days' supply. Not all medications are fillable as a retail 90 pharmacy order.

Mail order pharmacy is for supplies of 60 to 90 days. Costco Mail Order Pharmacy is the only in-network mail order pharmacy. There is no benefit for out-of-network mail order pharmacies. Not all medications are fillable as a mail order pharmacy order.

Specialty pharmacies are for designated specialty drugs (formulary tiers S1 and S2). Most specialty drugs require preauthorization. Specialty drugs are generally limited to a 30-day supply.

To be covered, outpatient specialty medications must be filled through a participating specialty pharmacy, which includes Lumicera Health Services and Navitus SpecialtyRx designated pharmacies.

These pharmacies may fill specialty medications in certain circumstances:

- Intermountain Healthcare Specialty Pharmacy when you are receiving treatment at an Intermountain Healthcare facility contracted with the plan
- University of Utah Specialty Pharmacy when you are receiving treatment at a University of Utah facility contracted with the plan
- Specialty pharmacies contracted with certain hemophilia treatment centers for applicable drugs

Prescription drug formulary exception

A formulary exception request is needed when a participant's provider requests coverage of a prescription drug not in the formulary.

An exception request must meet a medical necessity review by Navitus. If a non-formulary medication is approved for a coverage exception it is covered at Tier 3 for non-specialty drugs or Tier S2 for specialty drugs.

Exception requests are not available for drugs excluded by the plan, lower copayments, or tier exceptions.

The formulary exception process applies to the prescription drug benefit only. It does not apply to professionally administered drugs.

For more information about the prescription drug formulary exception process, contact Navitus at 833-354-2226 or www.navitus.com.

Leaving the Service Area Temporarily

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

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

Dependents Who Live Away from Home

Within the plan service area

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

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

Outside the plan service area

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

Medical Emergencies

Emergency care is medical services needed immediately because of an injury or sudden illness. Because the time required to reach DMBA could risk permanent damage to your health in an emergency, preauthorization is not required for medical services in emergency situations.

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

If you are admitted to the hospital because of the emergency, please ensure that preauthorization is obtained within two business days or as soon as reasonably possible to preauthorize the inpatient hospital services.

Preauthorization

Preauthorization is an important step in making sure your care meets our medical criteria and helps you know what services are covered before you commit to the costs.

To preauthorize, please have your physician complete the online *Provider Preauthorization Request* form on www.dmba.com at least seven to 10 business days before your anticipated services. In an emergency situation when your physician cannot contact DMBA beforehand,

your physician must call DMBA within two business days after the emergency or as soon as reasonably possible.

Your provider must provide the following information when they call to preauthorize:

- Patient's name
- Participant's DMBA ID number
- Diagnosis (explanation of the medical problem) and, if possible, diagnostic code
- Pertinent medical history, including
  - » Previous treatment
  - » Symptoms
  - » Test results
- Name of physician or surgeon
- Treatment or surgery planned and, if possible, procedure codes and costs for each procedure
- Where and when the treatment or surgery is planned

Registered nurses and a consulting physician review the case when necessary. When the review is complete, DMBA will send you a letter to confirm the preauthorization.

Please have your provider preauthorize as soon as they have compiled the needed information so you can get a written confirmation of the preauthorization before receiving the services.

Failure to preauthorize, when necessary, will result in a denial of your claim. If you appeal a claim for benefits that was denied for failure to preauthorize, the denied claim may be approved by DMBA on post-service review. Not all denied claims are eligible for post-service review.

All procedures, services, therapies, devices, etc., must meet our medical criteria to be covered. If your situation doesn't meet our medical guidelines and DMBA ultimately denies benefits for the service, you're responsible for all charges.

Even though your physician provides much of the needed information, you're responsible to make sure your care is preauthorized by your provider.

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

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

Out-of-pocket Maximum

If your share of eligible medical expenses reaches a certain amount in a calendar year (your annual maximum out-of-pocket cost), your benefits for the remainder of the calendar year are paid according to the plan's out-of-pocket maximum.

The out-of-pocket maximum may be calculated on an individual or family basis. There are separate out-of-pocket maximums for services from in-network and out-of-network providers. Your out-of-pocket expenses for eligible medical and prescription drug services count toward your out-of-pocket maximum.

For individuals (participants or dependents)

After your share of eligible expenses reaches $2,000 for services from in-network providers or $3,000 for services from out-of-network providers, benefits increase to 100% for eligible charges, based on allowable amounts.

For families

After your family's share of eligible expenses reaches $3,500 for services from in-network providers or $7,000 for services from out-of-network providers, benefits increase to 100% for eligible charges, based on allowable amounts.

Exceptions

Lifestyle screening medical expenses do not apply to your out-of-pocket maximum and will continue to have associated copayments and coinsurance once you have met your out-of-pocket maximum.

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

- Amounts that exceed the allowable amounts
- Premium payments
- Expenses not covered by the plan

Errors on Bills or EOB Statements

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

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

Attn: Audit Reimbursement
DMBA
P.O. Box 45530
Salt Lake City, UT 84145

This is referred to as an audit reimbursement request. If the mistake is not otherwise detected, you may receive 50% of the eligible savings, up to $500 per incident, as defined by DMBA.

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

If DMBA detects an error on a medical bill before you do, we cannot forward the savings to you because this would violate our obligations based on the Employee Retirement Income Security Act (ERISA). We are obligated to maintain the integrity of our medical plans based on ERISA guidelines and regulations.

Submitting Claims

For services from in-network providers, you should not need to submit claims. These providers send bills directly to DMBA for processing. But you could mistakenly receive a bill for services covered by the plan, a bill from an out-of-network provider, or a bill for care you received in an emergency situation.

To submit a claim for benefits:

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

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

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

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

Medical Benefits During Disability

If you become disabled and unable to work, your medical coverage will continue for a period not to exceed three months after the month in which you became disabled. Benefits

are not limited to expenses you incur for treating the sickness that caused your disability. Benefits will continue as they were before you became disabled.

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

Financial Disclosure

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

Fraud Policy Statement

It is unlawful to knowingly provide false, incomplete, or misleading facts or information with the intent of defrauding the plan or DMBA. An application for benefits or a claim containing any materially false or misleading information, or any non-compliance with the terms of the plan, as determined by DMBA, may lead to reduction, denial, or termination of benefits or coverage under the plan.

Coverage under the plan may be retroactively canceled or terminated ("rescinded") if a participant acts fraudulently or intentionally makes material misrepresentations of material fact with respect to the plan. A participant whose coverage is rescinded will be provided with no less than 30 days' advance written notice of such rescission, and the rescission will be deemed to be a claim denial subject to the plan's claim and appeal procedures.

Coordination of Benefits

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

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

Coordination of benefits rules

When this is the primary plan, eligible benefits are paid before those of the other health benefit plan and without considering the other health plan's benefits.

When this is the secondary plan, DMBA calculates the amount of eligible benefits it would normally pay in the absence of other benefits, including the application of credits to any

plan maximums, and applies the payable amount to unpaid covered charges after eligible benefits have been paid by the primary plan. This amount includes deductibles and copayments you may owe.

DMBA will use its own deductible and copayments to calculate the amount it would have paid in the absence of other benefits. In no event will DMBA pay more than the participant is responsible to pay after the primary carrier has paid the claim.

DMBA does not coordinate benefits among DMBA group health plans (Deseret Alliance, Deseret Choice Hawaii, DMBA PPO 90, DMBA PPO 70, DMBA HSA 80, DMBA HSA 60, Kaiser of Northern California, Kaiser of Southern California, and Kaiser of Hawaii), nor does it coordinate among group dental plans (Deseret Dental, Deseret Dental *PLUS*, and Senior Dental—including those with MetLife).

Subrogation

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

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

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

Eligible Dependents

Your eligible dependents include your spouse and dependent children under age 26. Your spouse is the person to whom you are legally married.

There is no duplication of coverage or coordination of benefits between DMBA group health plans. Any person covered as an eligible employee may not also be enrolled as a dependent (i.e., spouse or child) under a DMBA group health medical or dental plan. In other words, an eligible employee may elect coverage as an eligible employee or may be covered as an eligible dependent of another eligible employee, but not both. In addition, a child can be covered as a dependent of only one eligible employee.

Exclusions

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

1. Custodial care

1.1. Custodial or long-term care, education, training, or rest cure, which is defined as maintaining an individual beyond the acute phase of injury or sickness and includes room, meals, bed, or skilled or unskilled medical care at any hospital, care facility, or home to assist the individual

with activities of daily living, including but not limited to feeding, bowel and bladder care, respiratory support, physical therapy, administration of medications, bathing, dressing, or ambulation; and where the individual's impairment, regardless of the severity, requires such support to continue for more than two weeks after establishing a pattern of this type of care, except as provided for by the terms of the plan

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

2. Dental care

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

3. Diagnostic and experimental services

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

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

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

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

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

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

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

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

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

This exclusion does not include services related to qualifying clinical trials as described in the plan.

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

4.1. Sterilization procedures, unless the covered individual meets DMBA's current medical criteria

4.2. Abortions, unless (i) the pregnancy is the result of rape or incest, (ii) the life or health of the mother would be in serious jeopardy, or (iii) the fetus has severe defects that will not allow it to survive beyond birth*

4.3. Emergency contraception (e.g., levonorgestrel, ulipristal acetate), unless sought (1) as a result of rape or incest or (2) in anticipation of or following unprotected intercourse that if pregnancy were to result either (i) the life or health of the female would be in serious jeopardy if the fetus were carried to term or (ii) there is an increased risk that the fetus may have severe defects that will not allow it to survive beyond birth

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

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

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

4.7. Reversal of sterilization procedures

4.8. Planned home delivery for childbirth and all associated costs

4.9. All pregnancy- and birth-related expenses (prenatal and postnatal) of an individual (including a covered individual) acting as a surrogate or gestational carrier**

4.10. Services, drugs, or supplies to treat sexual dysfunction, erectile dysfunction, enhance sexual performance, or increase sexual desire, except the external erectile vacuum erection device under the durable medical equipment benefit

* Services related to an intrauterine fetal death or a miscarriage/spontaneous abortion occurring from natural causes are not subject to this exclusion.

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

5. Government/war

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

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

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

6. Hearing

6.1. Hearing devices or services unless expressly designated as eligible under the plan

7. Legal exclusions

7.1. Services that the individual is not, in the absence of this benefit, legally obligated to pay
7.2. Care, services, operations, or prescription drugs incurred after termination of coverage under the plan
7.3. Services and supplies for an illness or injury sustained while committing or attempting to commit an assault or felony, whether or not criminal charges are filed or a conviction results, unless the injury resulted from a medical condition (including both physical and mental health conditions) or from being the victim of an act of domestic violence, subject to the nondiscrimination provisions of HIPAA
7.4. Complications resulting from excluded services
7.5. Court-ordered treatment, unless such services are medically necessary and are otherwise covered under the plan
7.6. Services and supplies provided to a covered individual while incarcerated in a federal, state, or local correctional facility; in the custody of federal, state, or local law enforcement authorities; required as a condition of parole; or participating in a work release program
7.7. Court-ordered testing, such as drug screening and confirmatory drug testing
7.8. Reports, evaluations, or examinations not required for health reasons, such as employment or insurance, or for legal purposes, such as custodial rights, paternity suits, sports physicals, legal defenses or disputes, etc.
7.9. Services not expressly specified as a benefit or covered expense
7.10. Care, treatment, diagnostic procedures, or operations for diagnostic purposes that are not related to an injury or illness except as provided for by the terms of the plan
7.11. Mandated state service charges and taxes

8. Medical equipment

8.1. General/multipurpose equipment or facilities, including related appurtenances, controls, accessories, or modifications thereof, including but not limited to buildings, motor vehicles, air conditioning, air filtration units, exercise equipment or machines, and vibrating chairs and beds; as well as certain medical equipment, including air filtration systems, dehumidifiers, hearing devices, humidifiers, nonprescription braces and orthotics, learning devices, spa and gym memberships, vision devices, and modifications associated with activities of daily living, homes, or vehicles
8.2. Upgrade or replacement of medical equipment when the existing equipment is still functional, unless otherwise specified by the plan
8.3. Replacement of a device when damage is due to the covered individual's abuse or neglect
8.4. Maintenance, repair, and upkeep of durable medical equipment

9. Medical necessity

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

9.3. Care, services, or supplies for convenience, contentment, or other non-therapeutic purposes
9.4. Cardiopulmonary fitness training or conditioning either as a preventive or therapeutic measure, except as provided for by the terms of the plan
9.5. Care, services, diagnostic procedures, or other expenses, which include but are not limited to abdominoplasty, lipectomy, panniculectomy (except when medical criteria have been met), skin furrow removal, or diastasis rectus repair
9.6. Overutilization of medical benefits

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

10. Mental health, counseling, chemical dependency

10.1. Mental or emotional conditions without manifest psychiatric disorder as described in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), or with non-specific symptoms
10.2. Counseling, including but not limited to marriage and family counseling, recreational therapy, or other therapy*
10.3. Services and materials in connection with surgical procedures undertaken to remedy a condition diagnosed as psychological
10.4. Care and services for the abuse of or addiction to alcohol or drugs, except as provided for by the terms of the plan
10.5. Care and services for learning disabilities or physical or mental developmental delay, including pervasive developmental disorders or cognitive dysfunctions, except as provided for by the terms of the plan
10.6. Mental health services provided in a day treatment program or residential care facility, unless the individual receiving such services meets the requirements for the mental health alternative care benefit, as defined by DMBA, and as otherwise provided for by the terms of the plan
10.7. Custodial and supportive care for covered individuals with mental illness

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

11. Miscellaneous

11.1. Services of any practitioner of the healing arts who

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

11.2. Care, services, supplies, or other expenses when it has been determined that brain death has occurred
11.3. Gender reassignment surgery, including all associated procedures and services (medical, psychological, pharmaceutical, surgical, etc.) used to facilitate gender transition
11.4. Reproductive organ prosthesis

11.5. Charges over and above the allowable amount or reasonable and customary amount as determined by the plan administrator
11.6. Charges for services, supplies, or drugs received as a result of medical tourism, or for traveling out of the United States to seek medical services, medications, or devices, including any complications thereof, unless provided for by the terms of the plan

12. Education and training

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

13. Obesity

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

14. Other insurance/workers' compensation

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

15. Prescription drugs

15.1. Medications such as emergency contraceptives (see *Exclusion 4.1* for other excluded contraceptives), dietary or nutritional products or supplements (including special diets for medical problems), herbal remedies, holistic or homeopathic treatments, products used to stimulate hair growth, medications whose use is for cosmetic purposes, over-the-counter (non-legend) products, vitamins (except prenatal vitamins and prescribed infant vitamins), weight-reduction aids, and non-formulary drugs, except to the extent specifically provided in the plan (including any requirements regarding preauthorization)

16. Testing

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

17. Transplants

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

18. Vision

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

Claims Review and Appeal Procedures

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

Notification of Discretionary Authority

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

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

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

such person or entity to the extent of such allocation or delegation. However, DMBA has a continuing duty to monitor the performance of any of its delegates or designees.

Notification of Non-compliance and Abuse of Benefits

If a participant seeks to either bypass or ignore appropriate medical advice in an attempt to abuse the healthcare system (which may include but is not limited to jumping from physician to physician or emergency room to emergency room or seeking medications from multiple sources), DMBA has the right to place the participant on a "medical compliance plan."

The participant will then be instructed to receive care from certain providers and facilities that are specifically named in the compliance plan, as determined by DMBA.

If the participant chooses to receive care from providers or facilities that are not included in the compliance plan, benefits will be denied and the participant will be responsible for paying all costs associated with this care, including repaying DMBA for any amounts it may have paid.

Notification of Benefit Changes

DMBA is subject to the Employee Retirement Income Security Act (ERISA) and reserves the right to amend or terminate this plan at any time.

Legal Notice

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